2025

Community Benefit Plan

(Submitted to OSHPD in February 2026 for Fiscal Year 2025)

Prepared in Compliance with
California's Community Benefit Law SB 697 By
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I: COMMUNITY BENEFIT PLAN EXECUTIVE SUMMARY

California's Community Benefit Law (Senate Bill 697), sponsored by the California Association of Hospitals and Health Systems (CAHHS) and the California Association of Catholic Hospitals (CACH), was passed in 1994. It required all private, not-for-profit hospitals in California to conduct a community needs assessment every three years and develop community benefit plans that are reported annually to the California Office of Statewide Health Planning and Development (OSHPD).

Redlands Community Hospital has completed and submitted the following SB697 requirements:

<	July 1995 & 1997	Reaffirm the hospital's mission statement
<	December 1995	Community Healthcare Needs Assessment
<	April 1996	Adopted a Community Benefit Plan
<	June 1997	Community Benefit Plan, Self-assessment
<	December 1998	Community Healthcare Needs Assessment
<	February 1999	Community Benefit Plan Update
<	February 2000	Community Benefit Plan Update
<	February 2001	Community Benefit Plan Update
<	February 2002	Community Healthcare Needs Assessment & Benefit Plan Update
<	February 2003	Community Benefit Plan Update
<	February 2004	Community Benefit Plan Update
<	February 2005	Community Healthcare Needs Assessment & Benefit Plan Update
<	February 2006	Community Benefit Plan Update
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<	February 2008	Community Healthcare Needs Assessment & Benefit Plan Update
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<	February 2014	Community Benefit Plan Update
<	February 2015	Community Benefit Plan Update
<	February 2016	Community Healthcare Needs Assessment & Benefit Plan Update
<	February 2017	Community Benefit Plan Update
<	February 2018	Community Benefit Plan Update
<	February 2019	Community Healthcare Needs Assessment & Benefit Plan Update
<	February 2020	Community Benefit Plan Update
<	February 2021	Community Benefit Plan Update
<	February 2022	Community Healthcare Needs Assessment & Benefit Plan Update
<	February 2023	Community Benefit Plan Update
<	February 2024	Community Benefit Plan Update
<	February 2025	Community Healthcare Needs Assessment & Benefits Plan Update

The next step required by SB 697 is that Redlands Community Hospital submits this February 2026 Community Benefit Plan Update and Community Health Needs Assessment (covering assessment year 2025) to the State of California OSHPD.

Mission Statement

The hospital's Mission, Vision, and Value statements are integrated into the hospital's policy and planning processes including the Community Health Needs Assessment and Community Benefit Plan. A part of this planning process was to incorporate community benefits into the hospital's strategic plans.

Our mission is to promote an environment where members of our community can receive high-quality care and service so they can maintain and be restored to good health.

Vision

Our vision is to be recognized for the quality of service we provide and our attention to patient care. We want to remain an independent, not-for-profit, full-service community hospital that continues to be the major health care provider in our primary area of East San Bernardino Valley as well as the hospital of choice for our medical staff. We recognize the importance of remaining a financially strong organization and will take the necessary actions to ensure that we can fulfill this vision.

Values

- We are Committed to Serving Our Community
- Our Community Deserves the Best We Can Offer
- Our Organization Will Be A Great Place to Work
- Our Organization Will Be Financially Strong

Community Needs Assessment 2025

Redlands Community Hospital (RCH) conducted Community Needs Assessments for reporting periods 1995, 1998, 2002, 2005, 2008, 2011, 2013, 2016, 2019, 2022, and 2025. Communities of vulnerable and at-risk populations were identified and participated in the surveys.

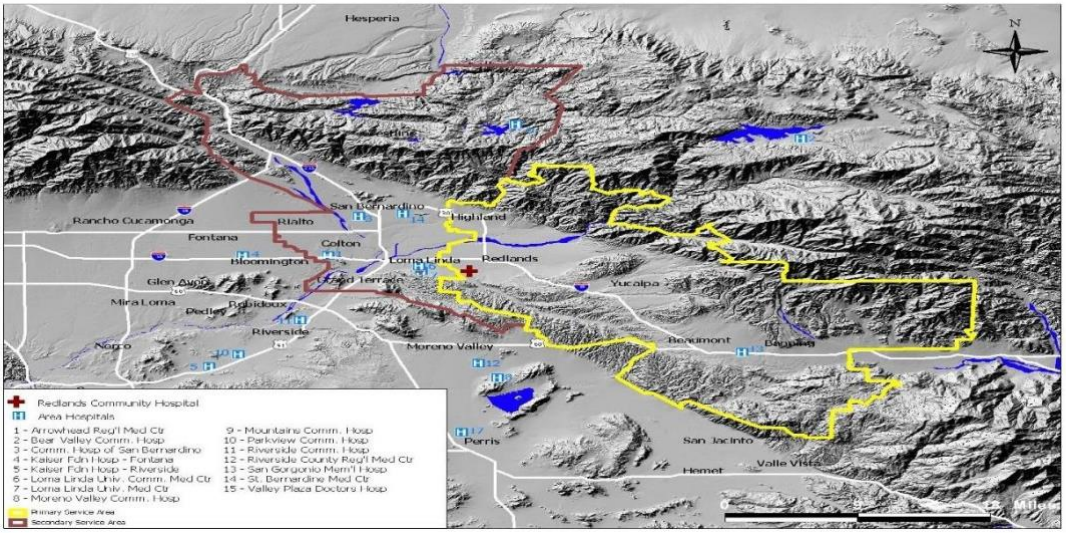
Redlands Community Hospital, in collaboration with the Hospital Association of Southern California and four hospital systems, performed a coordinated regional, Riverside and San Bernardino County, Community Health Needs Assessment in 2025. The regional needs assessment concept had been discussed and planned over the past few years. Having a regional assessment and continued collaboration amongst the health systems allowed for a coordinated effort to address the regions health and social determinants of health issues.

The goal of Redlands Community Hospital was to collect information which could enable the hospital to identify:

- Unmet health needs and problems
- Social determinants of health issues
- Vulnerable and at-risk populations
- Resources and services available
- Barriers to service and unmet needs
- Possible solutions to the identified needs and challenges

Geographic Service Area

Analyzing historical patient origin data derived from the hospital's statistical information identified the geographic service area of Redlands Community Hospital. Located in the most densely populated area of San Bernardino County, communities identified as being in the primary service area of the hospital are Banning, Beaumont, Cabazon, Colton, Calimesa, Forest Falls, Highland, Mentone, Redlands, and Yucaipa. The secondary service area is comprised of the cities of Bloomington, Bryn Mawr, Crestline, Fontana, Grand Terrace, Hemet, Loma Linda, Patton, Rialto, San Bernardino, and several mountain communities.



COMMUNITY BUILDING ACTIVITIES

Redlands Community Hospital (RCH) is engaged in many community-building activities and is committed to remaining a key partner throughout the broader community. Leadership, management, and staff alike participate in many community-wide events and activities that aim to improve the health and safety of the communities served by RCH. In practice, hospital leadership encourages and supports community outreach activities.

Community Support

Serving the community is one of RCH's core values, and many activities are carried out throughout the region. Specifically, to support senior citizen activities, the hospital provides funding for newsletters, sponsors events and informational bulletin boards, health promotion education, and health screenings.

Coalition Building and Community Health Improvement

Redlands Community Hospital recognizes the importance of collaboration and active participation with other entities and agencies. Involvement with multiple individuals and organizations allows for a stronger voice for advocacy and community-wide policy development to address health and safety issues. Leadership, management, and staff actively participate in many coalitions and boards to enhance community wellness.

Workforce Development

Health professions education continues to grow at RCH. It is achieved through collaboration between hospital staff, multiple medical staff groups, universities and colleges, and the multiple students and fellows served by the various programs. The hospital participates in advanced training and education for health care professionals, including physicians, nurse practitioners, physician assistants, physical therapists, and respiratory therapists. Additionally, hospital staff actively participate in local high schools to provide education and training for future health careers. The training of future healthcare providers, as well as medical and nursing program-specific education and training, is needed so that access to healthcare in the region may be maintained and expanded and to ensure the highest quality of care is provided at RCH.

COMMUNITY BENEFIT PROGRAMS

The following programs and the problems they address are included in the Community Benefit Plan 2025:

1) Redlands Community Hospital Family Clinics provides health care services for at-risk and underinsured, underserved children and adults.

2) The Perinatal Service Program provides early prenatal care for low-income, uninsured women and teens, lactation education, mother/infant bonding support, and education for pregnant mothers with diabetes.

3) Community Case Management Program addresses the needs for at-risk, underinsured, and complex healthcare issues as well as education on disease management and community resources.

4) The Pastoral Care Program assists concerned and grieving family members and patients.

5) Outpatient Behavioral Health Programs focus on treating each patient as a whole person, not just his or her mental illness, with absolute regard for human dignity and respect for all patient rights.

6) The Homeless Patient Discharge Planning Initiative addresses the health needs of homeless patients in compliance with California Senate Bill (SB) 1152.

7) Miscellaneous community benefit activities and hospital programs during fiscal year 2025.

8) Community Resources that address the problem of low-income and uninsured individuals' inability to access health resources through various agencies.

Community Benefits and Economic Value

Summary information identified community benefit programs and contributions for fiscal year ending September 2024 at **$ 58,089,755.**

The total of costs unreimbursed medical care services for Medicare Medi-Cal, county indigent and other services for 2024 audited was **$ 81,682,615.**

Non-quantifiable benefits

The non-quantifiable benefits are the costs of bringing benefits to the at-risk and vulnerable populations in the community that are not listed above and are estimated at **$330,000** annually. This represents expenses incurred by hospital staff providing leadership skills and bringing facilitator, convener and capacity consultation to various community collaboration efforts. These skills are an important component to enable the hospital to meet their mission, vision and value statements and Community Benefit Plan.

COMMUNITY BENEFIT PLAN

Background and Identifying Information

As outlined in the proceeding Executive Summary, Redlands Community Hospital has completed all of the SB697 requirements dating back to California's Community Benefit Law (Senate Bill 697), sponsored by California Association of Hospitals and Health Systems (CAHHS) and the California Association of Catholic Hospitals (CACH), that was passed in 1994. The next step required by SB 697 is that Redlands Community Hospital submit this February 2026 Community Benefit Plan Update, covering programs and activities during fiscal year 2025, to the State of California OSHPD.

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Redlands Community Hospital is a not-for-profit, stand-alone community hospital that began serving the Redlands area and neighboring communities in 1903 and built the first official hospital in 1904 on Nordina Street. In 1929, a new hospital building was completed at 350 Terracina Boulevard, where it has remained and expanded numerous times ever since.

Chairman of the Board of Directors
Carol Snodgress, 909-335-5505

President and Chief Executive Officer
James R. Holmes, 909-335-5515

President of Business Development
Karen Zirkle, 909-335-5593

Mission Statement

Our mission is to promote an environment where members of our community can receive high quality care and services so they can maintain and be restored to good health.

The Mission is accomplished by interacting with patients, physicians, employees, associates, and community. The hospital will be knowledgeable and responsible to the observations, traditions, philosophies, and customs of patients and their families, employees, and medical staff as the hospital delivers patient care, schedules appointments, and displays or promotes healthcare services. The hospital has adopted the philosophy of "*Patients Firs with HEARTt*" whereby we see serving our patients our primary focus and adding respect and open communication for all; patients, families, staff and providers. As a result, RCH has made *"Patients First with HEART"* part of its core culture.

These Mission, Vision and Values are integrated into the hospital's policy and planning processes including the community benefits plan. A part of this planning process sets benchmarks to measure performance of the community benefits plan. Setting measurable objectives and time frames for

programs and/or services for the community is the goal.
Employee benefits and the hospital's work environment also encourage employees to care for the members of the community. These statements encourage advocacy and collaboration within the hospital and community, as well as with community-based organizations and other not-for-profit entities.

Organizational Structure

An 18-member Board of Directors made up of volunteers from the community, and the hospital Chief Executive Officer, governs Redlands Community Hospital. The Redlands Community Hospital Foundation has a separate 17-member Board of Directors consisting of volunteers representing the community, the Hospital's Chief Executive Officer, Chief Financial Officer, Foundation President, and Director, Volunteer Services. The Foundation is a fund-raising component of the not-for-profit hospital.

Redlands Community Hospital promotes an environment for a healthy community and community collaborations within the hospital's service area, by interacting with patients, physicians, employees, volunteers, associates, and members of the community. Senior members of the hospital participate with the city of Redlands on the Healthy Redlands initiative and have staff serving on various sub-committees.

Redlands Community Hospital is an active member of the Inland Empire Regional Community Health Needs Assessment Taskforce, a group that includes non-profit hospitals, healthcare providers and agencies that meet regularly to share information about their various community programs that benefit the health and quality of life of all people in this area.

Community Benefit Plan

The Community Benefit Plan submitted February 2026 for Redlands Community Hospital represents outcomes for the 2025 reporting year and includes the programs featured on the following pages. The programs described in this section include the problems to be addressed, community partners, and unreimbursed costs of the programs. The descriptions also include measurable objectives and time frames for each community benefit.

Following is a summary of some of the community service/charity care in which the hospital is involved:

COMMUNITY-BASED PRIMARY CARE

REDLANDS FAMILY CLINIC

The Redlands Family Clinic continues to address the community's need for access to high-quality primary care services in the east end of San Bernardino County.

Purpose

The Redlands Family Clinic aims to provide high-quality, low-cost healthcare services to people who do not otherwise have access, which may be due to financial, cultural, lifestyle, or psychological barriers. An equally important goal is providing individualized patient/family education promoting health and wellness. In addition, encouraging, educating, and supporting the necessary tools the patient/family needs to promote individualized healthcare decision-making. Our ongoing objectives are to:
1) Provide an opportunity for low-income, uninsured, and underinsured to receive primary and preventive care, early medical problem identification, treatment, and access to health care resources; 2) Reduce disparity in health care services within the community; 3) Develop health-related programs and enhance the quality of services provided; 4) Provide health care for all ages, children to the elderly; 5) Assist with the application process and obtaining eligibility for public assistance programs; 6) Provide and promote community resources, and 7) Provide and facilitate community health services such as flu shots and other health care screenings.

Unique and Innovative Methods

We view our program to be unique and innovative based on the following characteristics:

1. The services are provided by a not-for-profit community hospital-based clinic utilizing skilled family practice nurse practitioners, along with physicians and support personnel
2. The services are managed by Redlands Community Hospital’s Board of Directors
3. Primarily funded, operated, and managed by the hospital
4. Collaborative relationships with community organizations providing a variety of services
5. Serves a largely Hispanic population, including recent migrants to the area.
6. Bilingual clinical staff
7. Patients are uninsured or underinsured
8. Provides access to other health care services offered by the hospital

Our Partners and Providers

1. Community Health Association Inland Southern Region: A not-for-profit organization supporting community health centers and clinics in the Inland Empire.
2. Family Services Association of Redlands: A not-for-profit organization serving low-income and homeless families utilizing a management-based case management approach and personal contact. Their mission is to alleviate poverty, encourage self-sufficiency, and promote the dignity of all people. Services provided include transitional housing, clothing, and food
3. Inland Empire Health Plan: One of two Medi-Cal Manager Care Plans in the Inland Empire that officer Medi-Cal those low-income families who qualify
4. LabCorp: provides clinical laboratory services
5. Local Pharmacies
6. Local Schools

Goals and Milestones Accomplished in 2025

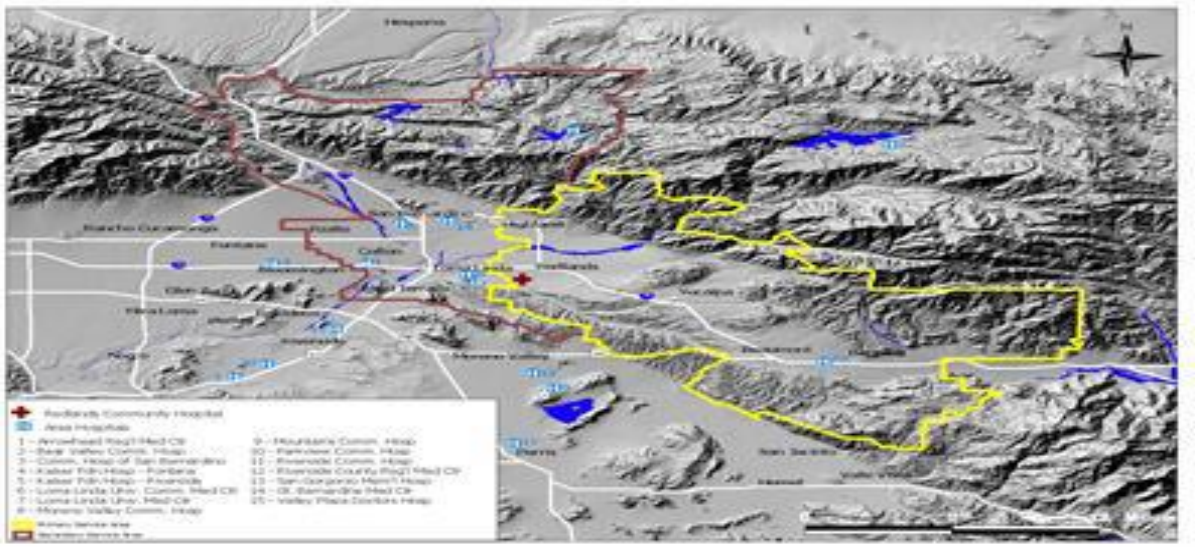
1. Continued to provide primary care services to the medically underserved population
2. Provided no-cost seasonal flu vaccinations to the community-at-large
3. Expanded awareness of the services provided by the Redlands Family Clinic
4. Supported Redlands Unified School District by providing employee TB screening
5. Worked with Inland Empire Health Plan (IEHP) to promote preventative services through their Pay four Performance (P4P) program, Prop 56, and other programs
6. Provide in-person and telemedicine services
7. Expanded services to pregnant low-income patients
8. Continue to work with our physician contract group to enable us to expand our vision of providing additional services to meet our patients' needs

Top 10 medical diagnoses treated in clinic (highest to lowest)

Hypertension Type 2
Diabetes
Breast Exam
Bacterial Infection
Fatigue
Gyn Exams
Child Exams
Increase Potassium
UTI's
Cholesterol

Redlands Family Clinic

Serving communities of Redlands, Loma Linda, Colton, San Bernardino, Highland, Yucaipa, and Mentone (refer to figure on next page).



Scope of Services

Hours of Operation	8:00 - 4:30 p.m. Monday through Friday
Personnel	Physician Nurse Practitioners Registered Nurses Licensed Vocational Nurses Medical Assistance Patient Service Coordinator Patient Account Representative Executive Director
Primary Services	
	Well Female Exams (breast exams and pap smears)
	Young adult – school exams and primary care
	Adult/Middle Age (cancer screening)
	Acute and chronic primary medical care – all ages
	Obstetric
	Physical Exams
	Government Programs for those without insurance (CHDP, FPACT, CPSP and CDP)
Other Services onsite	Laboratory
	Social Services
	Dietician
Other Services at RCH	Pharmacy
	Radiology
	Center for Cancer Care – Oncology & Pain Management
	CSSC – Neurology and Pain Management
	Cardiopulmonary
	Emergency room

	Inpatient Services
	Special procedures

Referred Services	ARMC: outpatient, acute and specialty care
	Specialty care providers within the community
	Community resource agencies
	Loma Linda University Medical Center
	SAC Health System

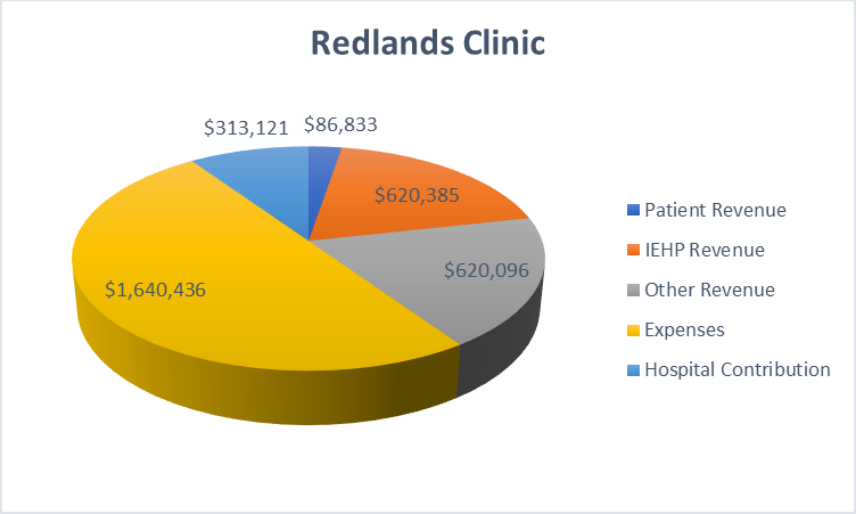
Total Visits: Historical 2022 to 2025

	2022	**2023**	**2024**	**2025**
Redlands Family Clinic	6,592	6,839	6,033	3,214

In 2025, we continued to see a steady increase in office visits. In addition, we were able to accommodate our vulnerable and at-risk population by providing visits either in person and or via Telehealth. The Redlands Family Clinic continues to provide accessible and low-cost high-quality healthcare services.

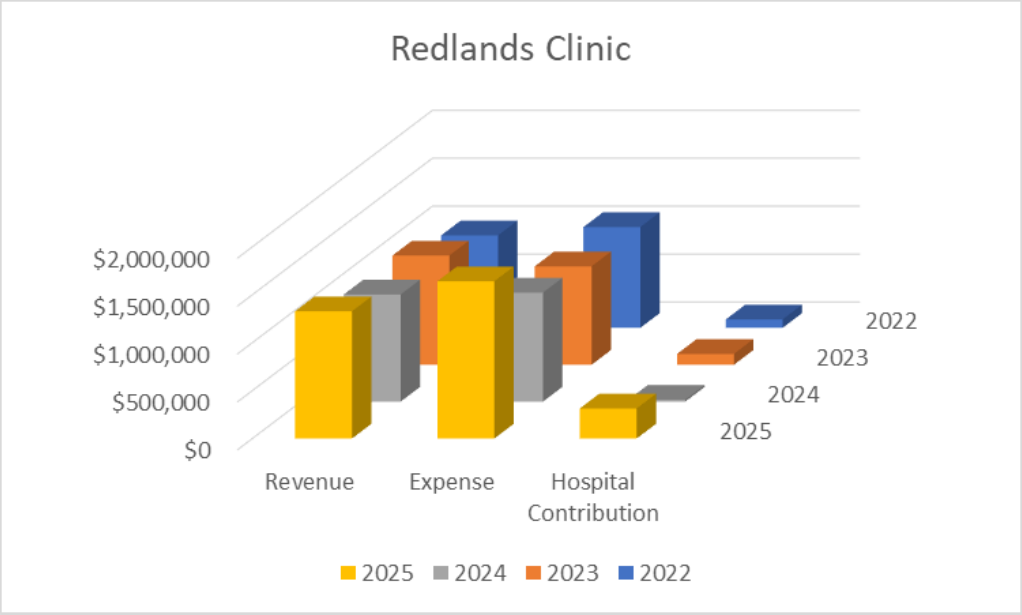
Financial Summary for the Redlands Family Clinic, 2025

The following graph shows the financial distribution and un-reimbursed costs. The Redlands Community Hospital contribution (un-reimbursed cost) for this program in 2025 was $303,121.



Expenses	**$**	**1,640,436**
Net Patient Revenue	**$**	**1,327,315**
Pt Revenue	$	86,833
IEHP Revenue	$	620,385
Other Revenue	$	620,096
Hospital Contribution	**$**	**313,121**

Financial Summary Comparison 2022 to 2025



	Revenue	Expense	Hospital Contribution
2022	$963,802	$1,050,731	$86,929
2023	$1,138,874	$1,026,286	$112,588
2024	$1,117,687	$1,137,272	$19,585
2025	$1,327,315	$1,640,436	$313,121

Goals and Objectives for 2026

1. Continue to provide primary care services for low-income and underserved individuals
2. Continue to support community-based programs and organizations
3. Continue to provide no-cost seasonal flu vaccinations to the community-at-large
4. Expand awareness of the services provided by the Redlands Family Clinic
5. Maintain support for the Redlands Unified School District by providing employee TB screening
6. Continue to collaborate with Inland Empire Health Plan (IEHP) to promote preventative services through their Pay Four Performance (P4P) program
7. Continue to expand the obstetrics program
8. Optimize our Electronic Medical Records to expand our performance capabilities
9. Continue to collaborate with other community organizations to assist us provide high-quality patient care
10. More to a new location in downtown Redlands to allow for more services and expansion

Summary

Over the past five years, the healthcare landscape has faced unprecedented challenges due to COVID-19. Despite the pandemic receding, we're still witnessing a rise in healthcare costs, from supplies to employee wages. Amidst dwindling healthcare budgets and heightened financial pressures on hospitals, Redlands Community Hospital has remained steadfast in its commitment to providing accessible healthcare resources to all. Recognizing the ongoing

need for expanded services among underserved populations, the hospital has prioritized addressing critical early intervention needs by providing primary care services. By focusing on preventative measures and reducing reliance on emergency rooms for primary care, particularly for vulnerable demographics, the clinic staff has empowered patients to take charge of their healthcare journeys. Moreover, they've assisted individuals in navigating public assistance programs, ensuring access to necessary healthcare services, irrespective of eligibility for such programs.

The dedication of the staff has been bolstered by the positive feedback received from the patients and their families. In 2024, we transitioned our patient satisfaction survey to an external platform, concentrating on the "Care Provider" aspect. This adjustment has enabled a broader patient participation and facilitated comparisons with similar clinics. Building on these efforts, 2025 saw ongoing enhancements and expansions.

Looking ahead, our vision is to sustainably deliver high-quality, affordable healthcare services tailored to the needs of low-income, uninsured, and underinsured individuals and families within the community.

YUCAIPA FAMILY CLINIC

The Yucaipa Family Clinic, a sister clinic to the Redlands Family Clinic, continues to address the community's need for access to high-quality primary care services in the east end of San Bernardino County.

Purpose

Yucaipa Family Clinic's goal is to continue providing high-quality, low-cost healthcare services to people who do not otherwise have access due to financial, transportation, cultural, lifestyle, or psychological barriers. An equally important goal is to provide disease-specific patient/family education, emphasizing promoting health and wellness and the support necessary to promote individualized healthcare decision-making. On-going objectives are to: 1) Provide an opportunity for low-income, uninsured, and underinsured to receive primary and preventive care, early medical problem identification and treatment, and access to health care resources; 2) Reduce disparity in health care services within the community; 3) Develop health-related programs and enhance the quality of services provided; 4) Provide health care for all ages, children to the elderly; 5) Assist with the application process and obtaining eligibility for public assistance programs; 6) Provide and promote community resources, and 7) Provide and facilitate community health services such as flu shots and other health care screenings

Unique and Innovative Methods

We view our program to be unique and innovative based on the following characteristics:

1. The services are provided by a not-for-profit Community Hospital clinic utilizing skilled family practice nurse practitioners and support staff
2. The services are managed by Redlands Community Hospital's Board of Directors
3. Primarily funded, operated, and managed by the hospital
4. Collaborative relationships with community organizations providing a variety of services
5. Serves a predominantly Hispanic population, including recent migrants to the area
6. Bilingual clinical staff
7. Patients are uninsured or underinsured
8. Provides access to other health care services offered by the hospital

Our Partners and Providers

1. Community Health Association Inland Southern Region: A not-for-profit organization supporting community health centers and clinics in the Inland Empire.
2. Family Services Association of Redlands: This not-for-profit organization serves low-income and homeless families utilizing a management-based case management approach and personal contact. Its mission is to alleviate poverty, encourage self-sufficiency, and promote the dignity of all people. Services provided include transitional housing, clothing, and food.
3. Inland Empire Health Plan
4. LabCorp: provides clinical laboratory services
5. Local Pharmacies
6. Local Schools

Goals and Milestones Accomplished in 2025

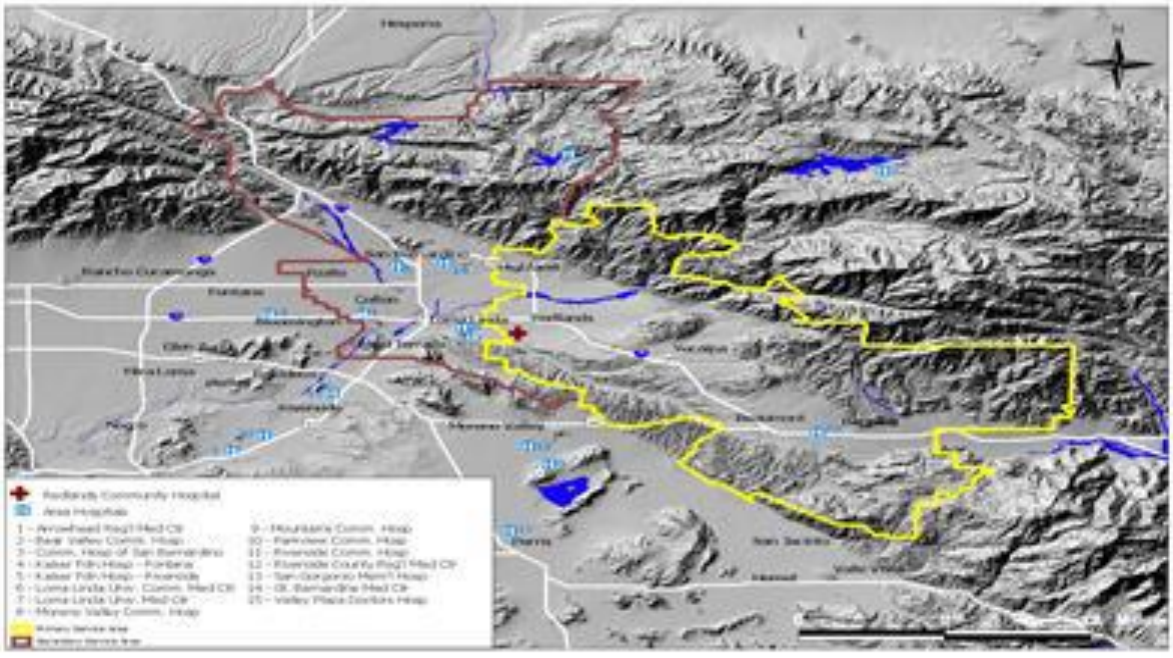
1. Continue to partner with Inland Empire Health Plan (IEHP)to provide primary care services and access for community members for health care coverage
2. Provided no-cost seasonal flu vaccinations to the community-at-large
3. Expanded awareness of the services provided by the Yucaipa Family Clinic
4. Maintained support for the Yucaipa Unified School District by providing employee TB screening
5. Continue to collaborate with IEHP to promote preventative services for their patients through the Pay Four Performance (P4P) program
6. Continue to provide in-person and telemedicine services
7. Continue to offer services to pregnant low-income patients
8. Continue to work with our our physician contract group to enable us to expand our vision of providing additional services to meet our patients' needs

Top 10 medical diagnoses treated in clinic (highest to lowest)

Hypertension
Breast Exam
Diabetes
Intestinal
Fatigue
Colon CA screening
Cholesterol
UTI
Cough
Pre- Diabetes

Yucaipa Family Clinic

Serving communities of Redlands, Loma Linda, San Bernardino, Highland, Yucaipa, Calimesa, Beaumont, Banning, and Mentone.



Scope of Services

Hours of Operation	8:00 - 4:30 p.m. Monday through Friday
Personnel	Physician Nurse Practitioners Registered Nurses Licensed Vocational Nurses Medical Assistants Preventative Service Coordinator Patient Account Representative Executive Director
Primary Services	
	Well Female Exams (FPACT and CDP)
	Young adult – school exams and primary care
	Adult/Middle Age (cancer screening and detection)
	Acute and chronic primary medical care – all ages
	Pregnancy (CPSP)
Other Services onsite	Laboratory
	Social Services
	Dietician
Other Services at RCH	Pharmacy
	Radiology
	Cardiopulmonary
	Emergency room
	Inpatient Services
	Special procedures
	Neurology
Referred Services	ARMC outpatient, acute and specialty care
	Specialty care providers within the community
	Community resource agencies

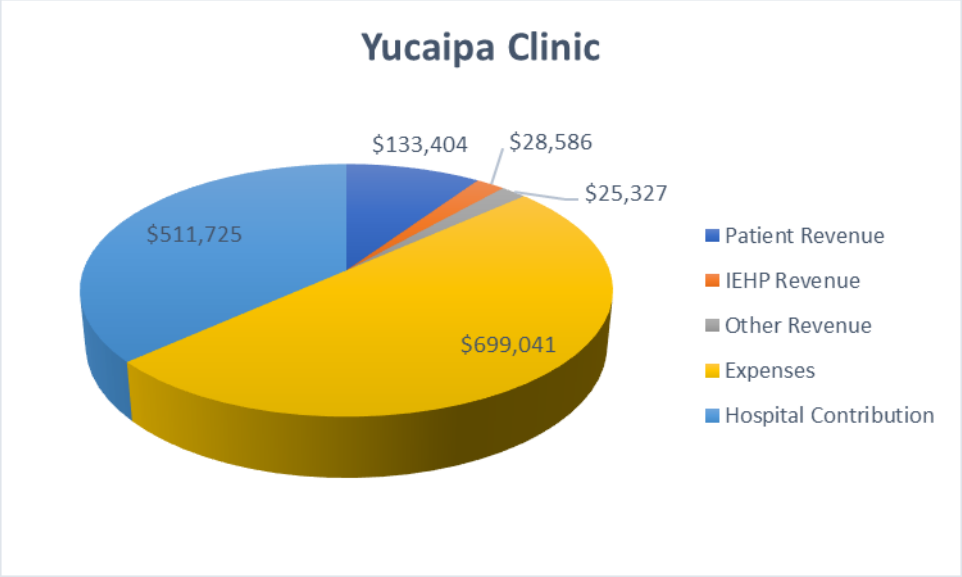
Total Visits: Historical 2022 - 2025

	2022	**2023**	**2024**	**2025**
Yucaipa Family Clinic	5,300	5,892	5,250	2,679

In 2025, Yucaipa family clinic continued to increase patient office visits and provided accessible, high-quality and low-cost healthcare services.

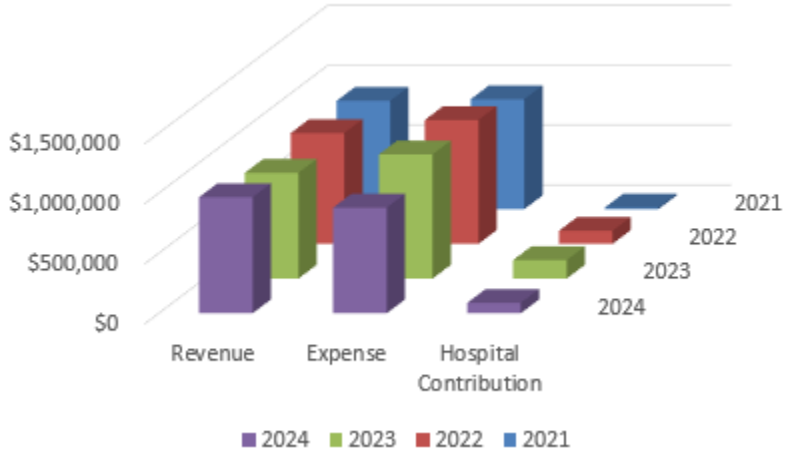
Financial Summary for the Yucaipa Family Clinic, 2025

The following graph shows the financial distribution and un-reimbursed cost. The Redlands Community Hospital contribution (un-reimbursed cost) for this program in 2025 was $511,725.



Total Expenses	**$**	**699,041**
Net Patient Revenue	**$**	**187,316**
Pt Revenue	$	133,404
IEHP Revenue	$	28,586
Other Revenue	$	25,327
Hospital Contribution	**$**	**511,725**

Financial Summary Comparison – 2022 to 2025



	Revenue	Expense	Hospital Contribution
2022	$922,549	$1,031,345	$108,796
2023	$880,641	$1,033,798	$153,157
2024	$965,666	$879,370	$-86,297
2025	$187,316	$699,041	$511,725

Goals and Objectives for 2026

1. Expand primary care services for low-income and underserved individuals
2. Continue to support community-based programs and organizations
3. Continue to provide no-cost seasonal flu vaccinations to the community-at-large
4. Expand awareness of the services provided by the Yucaipa Family Clinic
5. Maintain support for the Yucaipa Unified School District by providing employee TB screening
6. Continue to work with the Inland Empire Health Plan to promote preventative services for their patients through the Pay Four Performance (P4P) program
7. Optimize our Electronic Medical Records capabilities
8. Continue to collaborate with other community organizations to assist us provider quality patient care

Summary

Redlands Community Hospital is dedicated to serving the community by offering affordable healthcare to low-income, uninsured, and underinsured individuals and families. In 2022, we transitioned our patient satisfaction survey to an external platform, emphasizing the "Care Provider" aspect. This change allowed for increased patient participation and facilitated comparisons with similar clinics. In 2025, we observed continued enhancements in our survey results, and we remain committed to leveraging this tool for continued growth and necessary adjustments moving forward.

PERINATAL SERVICES (MATERNAL/INFANT HEALTH)

Our Perinatal Services Program offers several outpatient specialty education programs, Comprehensive Perinatal Services Program (CPSP), diabetes, pregnancy education, breastfeeding education, and childbirth education.

Problem

Timely obstetrics access issues along with perceived barriers (access, financial, transportation, etc.) to pre- and post-natal care for low-income, uninsured, or underinsured women and teens continues to be a challenge for our patients.

Program Description

The Comprehensive Perinatal Services Program (CPSP) provides a variety of services and education to women prior to delivery and up to 2 months after delivery. In addition, due to the increase in mental Health, Medi-Cal has allowed providers to extend services for up to one year to address those needs. The goals of the program are to decrease the incidence of low birth weight in infants, to improve the outcome of every pregnancy, to give every baby a healthy start in life and to lower health care cost by preventing catastrophic and chronic illness in infants and children. The Comprehensive Perinatal Services Program is a Medi-Cal sponsored program for women who are pregnant and are enrolled in straight Medi-Cal or Medi-Cal Managed Care Plan.

The Diabetes and Pregnancy Education program provides education, evaluation, and intervention for pregnant women with diabetes or for women with diabetes planning to become pregnant. The goal of the program is to improve pregnancy outcomes for women and to reduce fetal deaths and neonatal and maternal complications. Services include an initial evaluation and follow-up by a registered nurse, certified diabetes educator, and dietician.

A resource for Redlands Community Hospital is the Breastfeeding program which provides breastfeeding education and support for groups, and individual one-on-one education. Services are provided by an International Board-Certified Lactation Consultant. The Childbirth preparation courses prepare pregnant women and families for childbirth. Classes are designed to provide practical and useful tools in preparation of childbirth. These classes are both face-to-face ad or web-based.

Partnerships

1. California Diabetes and Pregnancy Program Sweet Success
2. County of San Bernardino (Public Health/CPSP)
3. Inland Empire Health Plan
4. Inland Women's Care, Dr. Hage
5. Loma Linda University Medical Center
6. High-risk Primatologist, Dr. Brar
7. Participating CPSP medical groups and community physician offices
8. SAC Health System
9. Other private insurances
10. Other local Ob/Gyn providers in the community

Goals and Outcomes Accomplished in 2025

1. Provided access to services at the Redlands perinatal services office
2. Expanded awareness of the education services provided by Perinatal Services to the local community and obstetric physicians
3. Achieved 99% patient satisfaction rating

Goals and Outcomes set for 2026

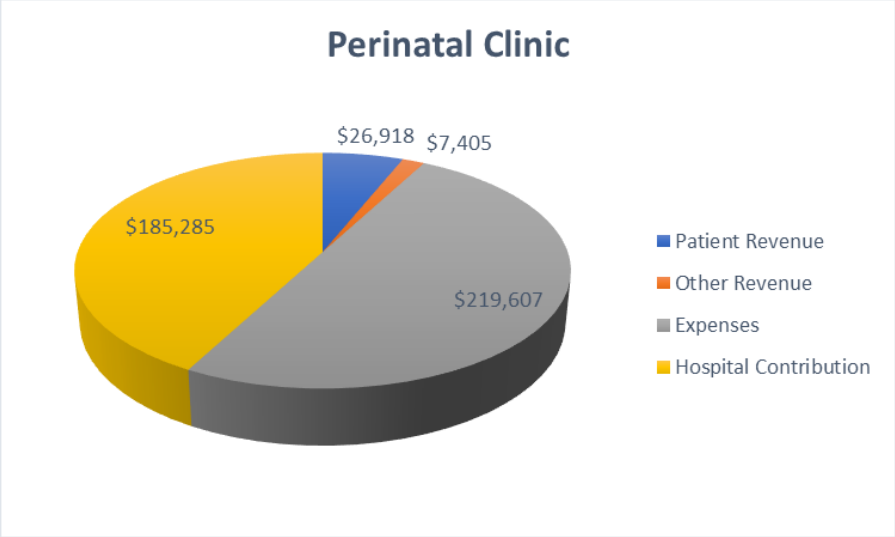
1. Meet or exceed patient expectations
2. Emphasize the benefit of the various education programs to our patients and the community- at-large
3. Promote breastfeeding initiatives
4. Continue to provide patient education through an app called Yo Mingo 24/7
5. Optimize our Electronic Medical Record capabilities
6. Expand services to other local insurances and medical groups
7. Move to a new location to expand services
8. Add a registered dietitian

Total Visits: Historical 2022 -2025

2022	**2023**	**2024**	**2025**
2,914	2,636	3,060	2,326

Financial Summary for Perinatal Services, 2025

The following graph shows the financial distribution and un-reimbursed cost. The Redlands Community Hospital contribution (un-reimbursed cost) for this program in 2025 was $185,285.



Total Expenses	**$**	**219,607**
Net Patient Revenue	**$**	**34,323**
Pt Revenue	$	26,918
Other Revenue	$	7,405
Hospital Contribution	**$**	**185,285**

COMMUNITY CASE MANAGEMENT PROGRAM

The Community Case Management Program at Redlands Community Hospital aims to improve patient outcomes by addressing real-life challenges such as communication barriers, financial issues, and medical access, as well as reducing hospital visits and readmissions.

Problem

Identifying real and perceived barriers, not limited to communication, financial, medical access, social determinants and transportation, which contributes to the increase in hospital bed days and readmissions. This process also assists with identifying those patients with complex and/or life-threatening diagnoses and those who are noncompliant with their prescribed medical regimen.

Program Description

The program focuses on identifying and assisting patients, particularly those with complex or life-threatening conditions, navigating the healthcare system, improving their relationships with providers, and specifically securing access to post hospitalization resources.

Criteria includes but is not limited to patients who have a primary diagnosis of Congestive Heart Failure and/or Pneumonia upon admission to the hospital, multiple hospitalizations, multiple comorbidities, new life-threatening diagnosis, non-compliant patterns, and those requiring assistance with coordination of care due to limited understanding of medical needs. Services include an assessment of needs, development of a plan of care, identifying goals, with implementation and collaboration with team members, education of the patient/family to enable successful management of care, and securing a smooth transition from hospital to home along with assisting the connection of appropriate outpatient services and resources.

Goals and Outcomes Accomplished in 2025

1. Referrals remained stable over the past year due to the collaborative efforts of our healthcare partners, who focused on identifying at-risk patients.
2. Met/exceeded patient expectations, especially in care transitions by facilitating referrals and securing appointment, providing solid contacts and assisting the patient/family in navigating our healthcare system.
3. Inpatient days and/or emergency room visits continue to decrease significantly for those patients with frequent hospitalizations and/or emergency room visits due to greater emphasis on care transitions.
4. We monitor and evaluate all payor 30 day readmissions for Congestive Heart Failure and Pneumonia monthly to improve communication and care coordination efforts with discharge planning.
5. Focus on care transitions has increased, along with improved communication between providers and their offices with our patients to decrease delays in care.
6. Disease-specific resource lists are available for participants.

Goals for 2026

1. Assess and explore the characteristics and needs of our patient population and define patient specific interventions, education and goals.Reinforce the benefits of the program to our physicians and patients.
2. Decrease recidivism with a focus on all payor 30 readmissions for Congestive Heart Failure and Pneumonia through multidisciplinary care coordination efforts, regular monitoring and patient follow up outreach.
3. Assess and explore recidivism rates of medicare readmissions for lower extremity joint replacement, spinal fusion and surgical hip femur fracture treatment utilizing a multidisciplinary care coordination effort, regular monitoring and patient follow up outreach.
4. Decrease readmissions from skilled nursing facilities specifically for patients with pneumonia diagnosis re-implementing our SNF Collaborative Meetings to share treatment protocols and education for this purpose.
5. Reinforce the benefits of the program to our physicians and patients

Financial Summary of the Community Case Management Program

The Redlands Community Hospital contribution (unreimbursed cost) for this program in 2025 including nursing salary, taxes, and benefits was $187,908.

PASTORAL CARE – VOLUNTEERS PASTORAL CARE – LAY MINISTRY

Clinical Chaplain

The Clinical Chaplain at Redlands Community Hospital provides spiritual and emotional support to patients, families, physicians, and staff. Serving as a part of the clinical team across various hospital units—including the ICU, surgical services, and emergency department—the chaplain addresses spiritual concerns, end-of-life issues, and religious needs impacting patient care and recovery. The chaplain also participates in the Bio-Ethics and Diversity Health Equity Inclusion + Belonging committees.

The Pastoral Care Department has reintegrated its volunteer program, which was paused during the pandemic, to enhance patient visitation and support. Additionally, the department hosted the 12th Annual Clergy Appreciation Luncheon in October to honor community faith-based partners. The chaplain continues to respond to referrals and meet the hospital community's growing spiritual and emotional needs.

No One Dies Alone Program

The Pastoral Care Department initiated this hospital program twelve years ago to provide support and a presence for patients with limited to no family or friends to be with them at the end of their life. We are all born with someone present; our goal is that no one dies alone at the end of life. After a brief hiatus the program relaunched in the spring and continues to be offered as an important patient support program.

Volunteer Pastoral Care Services

Community volunteers help support the spiritual care needs of hospital patients, and they are provided with training and education as they work alongside the chaplain.

Visiting Clergy/Lay Ministry

The Pastoral Care Department works closely with experienced faith leaders throughout the community who help to provide spiritual care support to their hospitalized parishioners at their bedside.

Community Partners

Inter-faith communities in the Redlands and neighboring areas: Churches, mosques, and temples provide spiritual support to those residing throughout the community.

Redlands Area Interfaith Council: helping to promote understanding and mutual respect of the diverse faith communities

Goals and Milestones Accomplished in 2025

1. Provided ongoing purpose-driven spiritual care.
2. Staff of all faiths utilize the chapel for spiritual reflection.
3. Provided continued engagement with previous Pastoral Care Volunteers.
4. Frequent in-person rounding in departments and nursing units to provide spiritual support for each area.
5. Provided spiritual care to surgical patients before and after their surgery – upon request.
6. Increased awareness of pastoral care support hospital-wide
7. Successfully re-launched the pastoral care volunteer program and the No One Dies Alone Program

Goals for 2026

1. Provide ongoing spiritual care to Redlands Community Hospital patients, families, and staff. Provide ongoing spiritual care to Redlands Community Hospital patients, families, and staff.
2. Increase pastoral care patient and staff visitation to promote spiritual wellness, awareness, and visibility of services and programs

Financial Summary

The unreimbursed costs to Redlands Community Hospital for the Pastoral Care Program during 2025 was $55,089.

HOMELESS PATIENT DISCHARGE PLANNING INITIATIVE AND SOCIAL DETERMINATES OF HEALTH

Redlands Community Hospital provides discharge planning services for homeless patients seeking medical and psychiatric treatment. Services provided included medical examinations and screenings, meals, transportation, clothing, and community resources. The goal of this initiative is to improve health care for the homeless population by providing direct care and linkage to follow- up services within the community.

Problem

Patients experiencing homelessness often have complex medical, psychological and social needs with limited resources such as shelter, housing and access to needed care. The Joint Commission along with CMS are focusing on the Social Determinates of Health and Equity as these all have an impact upon the health of those within our community. Senate Bill (SB) 1152 requires all acute care hospitals to comply with specific provisions for homeless patient discharge planning which include weather appropriate clothing, transportation within 30 miles/minutes of the hospital, and offer of a meal. While the hospital provides care for the immediate basic needs for this population, there are minimal resources throughout the City, County and State for the wrap-around services needed.

Program Description

During fiscal year 2025, Redlands Community Hospital identified and offered services to homeless individuals who presented to the hospital for services. The hospital utilizes a multidisciplinary approach to meet the needs of the patients which included Physicians, Registered Nurses, Case managers, Social Workers, Dietary Services, Community Health Worker and Patient Registration Staff. We continued to have collaboration with community agencies such as Family Services, Redlands Police Department, Public Health and the City of Redlands Homeless Resource Collaborative and HASC.

Goals and Outcomes Accomplished in 2025

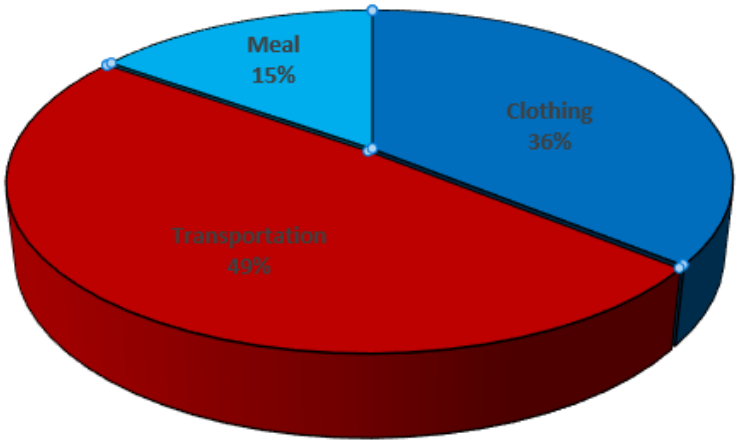
1. Received Grant for homeless services from Redlands Community Hospital Foundation
2. Continued maintaining good community relationships with local programs servicing the homeless services including the City of Redlands, Redlands Family Services and the Redlands charitable Resources Coalition Inc.
3. Distributed patient questionnaires to all admitted patients to identify social determinates of health and offered resources for 89% of the patients whom self-identified needs.

Goals and Outcomes established for 2026

1. Continue education on housing and health needs of the homeless/ near homeless population to promote better health and outcomes.
2. Collaborate with County and other community providers to promote whole person care to meet both physical and mental health conditions of the homeless/near homeless population.
3. Continue providing patient questionnaire to identify patients social determinates of health and offer assistance and resources.
4. Providing required and necessary services to improve health of homeless patients upon discharge.

Financial Summary for the Homeless Initiative, 2025

The following graph shows the categories by percent for the un-reimbursable costs of $16,291 used for providing homeless discharge services.



ADDITIONAL COMMUNITY BENEFIT ACTIVITIES, 2025

Redlands Community Hospital is continually involved in a variety of activities and programs that benefit the community.

Health Fairs and Health Screenings

Redlands Community Hospital participated in a wide variety of virtual and in person community events and provided health related services for the community at Senior Centers, churches, large employers, children events, emergency preparedness conventions, community events, high schools, Community College/University and the YMCA. An array of health education and health services were offered to the public.

Community Health Education

During 2025, the Hospital participated in 24 community events, in person providing education on the hospital's programs and services:

- Blossom Grove Senior Health Fair
- Bright Water Assisted Living
- City of Beaumont State of the City
- Discover Highland Run
- Highland Care Center
- Micah House – Back2School Jam
- Noon Kiwanis Run Through Redlands
- Redlands Believe Walk
- Redlands Bicycle Classic
- Redlands Chamber – Rise and Shine Flu Shot Clinic
- Redlands State of the City
- Redlands Health Care
- Redlands Northside Impact- City of Redlands Health Fair
- Redlands Senior Community Center
- Sun Lakes Senior Living Community
- Sunrise Kiwanis
- The Lakes Assisted Living and Memory Care Health Fair
- Villas San Bernardino
- Veterans Affairs – Mental Health Summit, Loma Linda
- Veterans Affairs – Caregiver Support Summit – Loma Linda
- Yucaipa Post Acute
- Yucaipa State of the City
- Yucaipa Senior Center Health Fair
- Yucaipa Women's Club

Free Immunization Programs

The Hospital provided free immunizations at various times during the year with the assistance from Marketing and Public Relations staff, and the Family Clinic's medical and nursing staff.

Flu shots were administered in 2025 as follows:

- To Redlands Community Hospital employees, patients, and community leaders.
- Flu shots and other immunizations were offered to underprivileged individuals at homeless shelters, the Salvation Army, and churches.
- Free seasonal/H1N1 flu educational flyers, posters and brochures were distributed to the public; educational information and public screening locations were advertised in local newspapers and the hospital website.

Senior Citizen Activities

- The hospital offered a variety of health screenings such as skin cancer screenings, blood pressure screenings, and vascular screenings.

Charity Care and Emergency Department Services

No individual with urgent health care needs is turned away from the hospital's emergency department due to an inability to pay. Admitting clerks seek to obtain health insurance information or Medi-Cal coverage. After all avenues of financial payment are exhausted, charity care is provided.

Community Outreach/Co-sponsored or Supported Events:

- Blood Drives - Sponsored monthly blood drive events in collaboration with LifeStream Blood Bank
- Stroke Support Group- provided a meeting place monthly virtually for stroke survivors
- The Believe Walk
- Emergency Medical Services Appreciation Day - Emergency Response personnel, including personnel from the Redlands Police Department, Redlands Fire Department, and American Medical Response
- Community Outreach (Family Service Association)- Throughout the year, Redlands Community Hospital continued to serve the needy within the community by:
    - Hospital-wide Food and Toy Drives
    - Thanksgiving Basket Food Drive
    - Providing volunteers to assist at the Thanksgiving Adopt-A-Family and Adopt-A-Family distribution day and family pickup.
- Community Outreach (Micah House) – Redlands Community Hospital helped at-risk youth obtain backpacks and school supplies for the up-coming school year by:
    - Hospital-wide backpack and school supply drive
    - Providing volunteers to help distribute backpacks and school supplies on distribution day

Community Health Education Lectures

Throughout the year, the hospital organized and supported community health virtual and in person education awareness programs, including:

- Grief Recovery Classes
- Adult CPR classes in San Bernardino and Riverside County
- Infant CPR for new parents
- Stroke Support Group
- Various health-related topics such as:
  - Handling the Holidays - Grief seminar
  - The Spine and Joint Disease education
  - Heart Health education
  - Diabetes Education community education
  - Breast Cancer Awareness- Women's Health Lecture
  - Infection prevention community lecture
  - Signs and Symptoms for Stroke Heath Lectures

Community Sponsorships

Donated funds, gift baskets, purchased tickets and attended nearly 50 various community non- profit events and fundraising efforts for agencies that help the community, including:

- Boys and Girls Club of Redlands
- The American Heart Association
- The Believe Walk
- Redlands Police Department Foundation
- Rotary Scholarship
- Micah House
- Family Service Association of Redlands
- Yucaipa Senior Center
- The Children's Fund of San Bernardino County
- Bonnes Meres Auxiliary of Redlands
- YMCA of Redlands
- The Redlands Bicycle Classic
- Kiwanis virtual "Run Through Redlands" Half Marathon/ 10K/5K
- Redlands Northside Impact
- Zonta Club
- Redlands Symphony
- St. Bernardines Medical Center
- Semper Fi and Americas Fund Golf Fundraiser
- Redlands Community Foundation
- Redlands High School
- Family Service Association Hunger Walk
- Redlands Symphony Annual Gala
- Redlands Bowl Children's Summer Festival
- Redlands Police Officer' Association

- San Bernardino County Medical Society
- Redlands Unified School District
- Loma Linda University Medical Center
- Lifestream (formally the Blood Bank of San Bernardino County) blood drives
- Beaumont Chamber of Commerce
- Calimesa Chamber of Commerce
- Highland Chamber of Commerce
- Redlands Chamber of Commerce
- Yucaipa Chamber of Commerce
- Yucaipa Women's Club

VOLUNTEER SERVICES

The volunteer program adds another dimension of care within the hospital setting and ultimately the community. The program has far-reaching affects both within and outside the hospital's walls. Internally, the volunteers touch the lives of the patients and their families providing comfort and support; they relieve staff of volunteer appropriate duties and provide themselves a mechanism to feel useful and give to their community. As one example of their community service, volunteers assist staff and community members at monthly blood donation drives. This involves supportive services to registered donors identified by the Blood Bank ensuring their wellbeing following donation. This valuable service ultimately impacts the lives of patients in our community.

Support of hospital programs extends to the Nancy Varner Center for Women's Health, the RCH Center for Cancer Care, and the RCH Foundation. As active community members, volunteers represent the hospital by supporting community functions and enhancing program partnerships. Volunteers and staff support hospital related projects and services including:

- Donation of 20,364 hours; 160 volunteers
- Partnership with Redlands Symphony, providing music to patients, visitors and staff
- Providing personal notes and greeting cards for hospital patients and isolated community members
- Assist in provision of clothing for homeless/indigent patient population
- Performing outreach to isolated individuals
- Mentorship for High School students across local communities and Heart Academy students of Redlands High School
- Program development for High School students with patient population providing activites and companionship
- Sewing quilts for NICU isolettes and hospice patients
- Return of all hospital volunteer programs and creation of new programs
- Support of hospital sponsored events including the Redlands Bowl, RCH Center for Cancer Care, RCH Golf Classic and many others

Emergency Planning

Redlands Community Hospital collaborates with area agencies to conduct County and City Emergency Drills. Hospital administrators, directors, safety, security and Emergency Department staff participated in numerous drills conducted throughout the year by the county, city and hospital. Different scenarios were staged to test cooperative functions between regional emergency agencies.

2025 - Year in Review

266	Free Flu Shots were given to the public by the hospital
47,550	People came to our booths at community health fairs (estimated)
1,395	Babies were born at the hospital
11,028	Patients stayed in the hospital
6,188	Patients received surgery at the hospital
59,856	Patients came through our 24-hour Emergency Department
80,703	Patients came in for outpatient visits, excluding emergency department visits
$372,451	In work hours were donated to the Hospital by over 150 active volunteers.

COMMUNITY COLLABORATION

The hospital's community needs assessment (2025) demonstrated individuals are unaware of available health and human resources. Additionally, there may be a fear of the system and a lack of understanding on how to access services they may need. Community organizations are not aware of all the programs and services provided by other agencies and there are known gaps in the health care delivery system in the region. To address this challenge, the hospital participates in a lot of community building activities.

Problem

There are known and unknown gaps in the health care system in the region.

Program description

The hospital utilizes the community health needs assessment process to identify access to care issues and to develop strategies to address the gaps. The hospital is unique in that it provides access to primary care at two safety net primary care clinics as well as the acute care hospital. These clinics serve vulnerable community members and are a vital part of the hospital's mission. Additionally, the hospital is a member of the Community Health Association Inland Southern Region which allows an opportunity to network with regional health center and clinic executives with the aim to address gaps in services at the community level. To meet the broader challenge of sustainable healthcare in the region, hospital staff collaborate with numerous community agencies (refer to the partner list below).

Partners

Community Hospital of San Bernardino
Kaiser Permanente, Fontana
Pomona Valley Hospital, Pomona
Medi-Cal health educators
Community Health Association Inland Southern Region
Riverside Community Hospital, Riverside
San Antonio Regional Hospital, Upland
St. Bernardine's Medical Center, San Bernardino
Arrowhead Regional Medical Center
California State University, San Bernardino
Interfaith Community Collaborative
Family Services Association of Redlands
Parkview Community Hospital, Riverside
Riverside County Public Health Officer
HASC – Inland Empire CHNA Taskforce
Hospital Association of Southern California
Loma Linda University Health
San Bernardino County Public Health Officer
Corona Regional Medical Center, Corona
Loma Linda University Medical Center Murrieta
Loma Linda University Medical Center
Community Health Coalition of San Bernardino County

Goals / Outcomes for 2025

Continued the collaboration to identify gaps in the health care system and develop strategies to fill the voids.

COMMUNITY BENEFITS AND ECONOMIC VALUE

The summary information below identifies community benefit programs and contributions for the fiscal year ending September 2025 for Redlands Community Hospital.

A. Medical Care Services	Audited 2025	
Medicare	$ 30,795,838	
Medi-Cal, Co.-indigent & Other	$ 54,144,001	
Unreimbursed care		$ 84,939,839
B. Community Outreach unreimbursed care		$ 669,506
Redlands Family Clinic	$ 112,588	
Yucaipa Family Clinic	$ 153,157	
Perinatal Services	$ 403,761	
C. Community Case Management		$ 187,908
D. Pastoral Services		$ 53,391
E. Homeless Patient Discharge Planning		$ 16,291
F. Community Benefits		$ 564,866
Sponsorship of specific community benefit programs In-kind sponsorship to general community benefit In-kind staff hours for community benefit		
G. Volunteer Services value of 12,876 hours donated*		$ 432,762
H. Hospital Board value of volunteer hours*		$ 56,253
I. Medical Staff value of volunteer hours*		$ 65,015
J. Funds donated to hospital by employees		$ 45,140
K. Funds donated to hospital by Volunteer Services		$ 100,000
TOTAL		**$ 87,130,971**

* This value is based on the "independentsector.org" national estimated hourly value for hospital volunteer service: $33.61 per hour (California, December 21, 2021).

Non-quantifiable Benefits

The non-quantifiable benefits are the costs of bringing benefits to the at-risk and vulnerable populations in the community that are not listed above and are estimated at $327,000 annually. Hospital staff who are providing leadership skills and bringing facilitator, convener and capacity consultation to the community collaboration efforts, incurs these expenses. These skills are an important component to enable the hospital to meet their mission, vision and value statements and community benefit plan. Leadership, advocacy and participation in community health planning costs are $327,000.

II. COMMUNITY NEEDS ASSESSMENT 2025

California's Community Benefit Law (Senate Bill 697), sponsored by California Association of Hospitals and Health Systems (CAHHS) and the California Association of Catholic Hospitals (CACH), passed in 1994. It required all private, not-for-profit hospitals in California to conduct a community needs assessment every three years and develop community benefit plans that are reported annually to the California Office of Statewide Health Planning and Development (OSHPD).

Redlands Community Hospital (RCH) conducted Community Needs Assessments for reporting periods 1995, 1998, 2002, 2005, 2008, 2011, 2013, 2016, 2019, 2022, and 2025. Communities of vulnerable and at- risk populations were identified and participated in the surveys.

Redlands Community Hospital, in collaboration with the Hospital Association of Southern California and four hospital systems, performed a coordinated regional, Riverside and San Bernardino County, Community Health Needs Assessment in 2025. The regional needs assessment concept has been performed every three years since 1995. Having a regional assessment and continued collaboration amongst the health systems allows for a coordinated effort to address the regions health and social determinants of health issues.

The goal for Redlands Community Hospital was to collect information which could enable the hospital to identify:

- Unmet health needs and problems
- Social determinants of health issues
- Vulnerable and at-risk populations
- Resources and services available
- Barriers to service and unmet needs
- Possible solutions to the identified needs and challenges

Mission Statement

The hospital's Mission, Vision and Values statements are integrated into the hospital's policy and planning processes including the Community Health Needs Assessment and Community Benefit Plan. A part of this planning process was to incorporate community benefits in the hospital's strategic plans.

Our mission is to promote an environment where members of our community can receive high quality care and service so they can be restored to good health by working in concert with patients, physicians, RCH staff, associates and the community.

Vision

Our vision is to be recognized for the quality of service we provide and our attention to patient care. We want to remain an independent not-for-profit, full-service community hospital and to continue to be the major health care provider in our primary area of East San Bernardino Valley as well as the hospital of choice for our medical staff. We recognize the importance of remaining a financially strong organization and will take the necessary actions to ensure that we can fulfill this vision.

Values

- We are Committed to Serving Our Community
- Our Community Deserves the Best We Can Offer
- Our Organization Will Be A Great Place to Work
- Our Organization Will Be Financially Strong

II. BACKGROUND

Redlands is located in Southern California in the east valley of the San Bernardino Mountains. This century-old city is known for its Victorian homes and historic public buildings, a thriving downtown, tree-lined streets, orange groves, mountain views, and cultural richness. It is home to the University of Redlands, a top-ranked private university, which offers the community a full array of social and cultural events.

Yet, just like many other communities, there are groups of people, neighborhoods, or individuals who are struggling financially and lack adequate healthcare. As our service to the community, we strive to reach out to those in need of healthcare through a variety of community service programs.

Founded in 1904, Redlands Community Hospital is a non-profit, 229 bed healthcare facility located in the east San Bernardino Valley of Southern California. The hospital offers acute healthcare, diagnostic testing, outpatient and home healthcare services. The hospital operates two community-based Family Clinics for low-income and underinsured community members. The Redlands Family clinic originated in an elementary school, however it out grew the location and now resides at a free-standing location in a high-risk area of Redlands. To further meet the needs of the community, a second family clinic, the Yucaipa Family Clinic, was opened in 2013. As a community hospital, we take pride in our ability to provide personal care, comprehensive care, and, high quality services. Our public relations department, Emergency Department, Redlands Family Clinic, Yucaipa Family Clinic, Perinatal Services Program, and several other departments throughout the hospital are involved in offering and providing a variety of community services and charity care. Individuals throughout our large service area depend on us for 24-hour emergency care, the professional delivery of healthcare and community outreach programs.

COMMUNITIES SERVED

Analyzing historical patient origin data derived from the hospital's statistical information identified the geographic service area of Redlands Community Hospital. Located in the most densely populated area of San Bernardino County, communities identified as being in the primary service area of the hospital are Banning, Beaumont, Calimesa, Highland, Loma Linda, Mentone, Redlands and Yucaipa. The secondary service area is comprised of the cities of Colton, Crestline, Fontana, Grand Terrace, Rialto, San Bernardino, and several mountain communities.

Figure 1.
Redlands Community Hospital Service Area Map

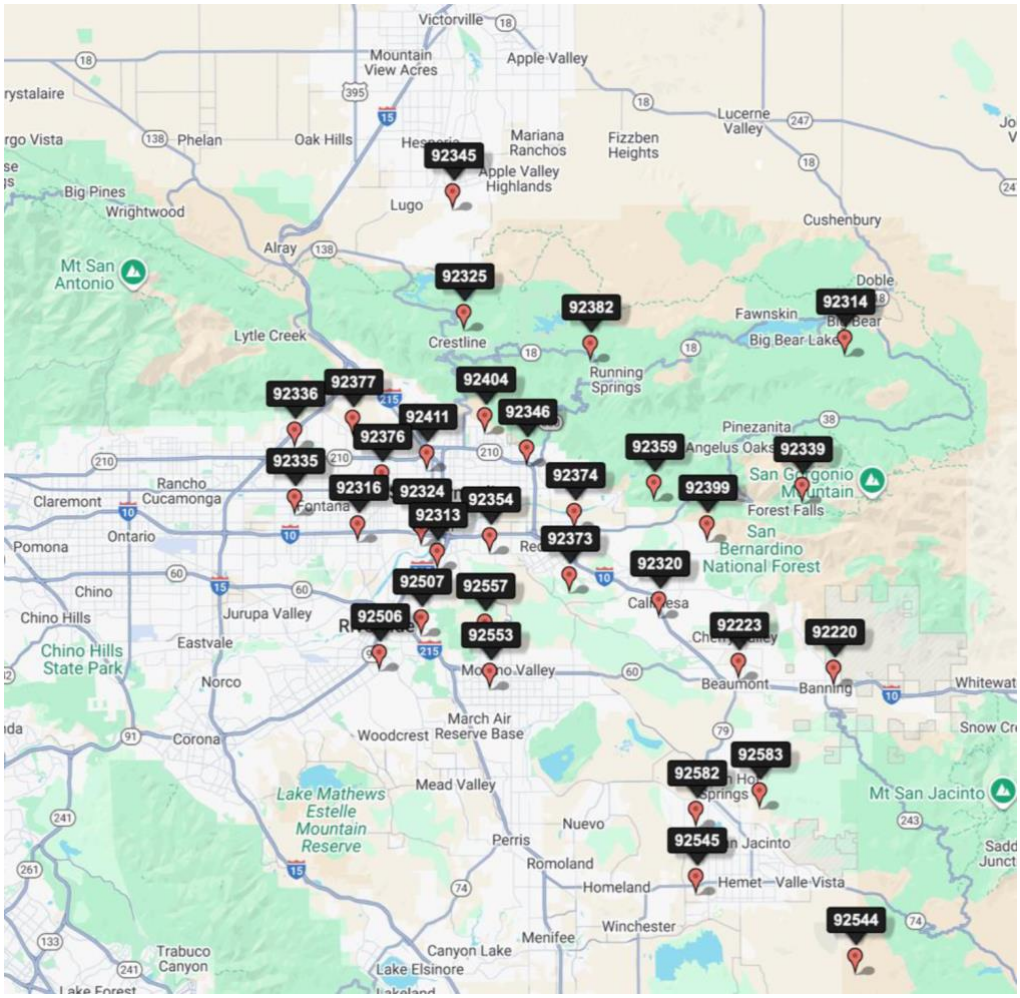
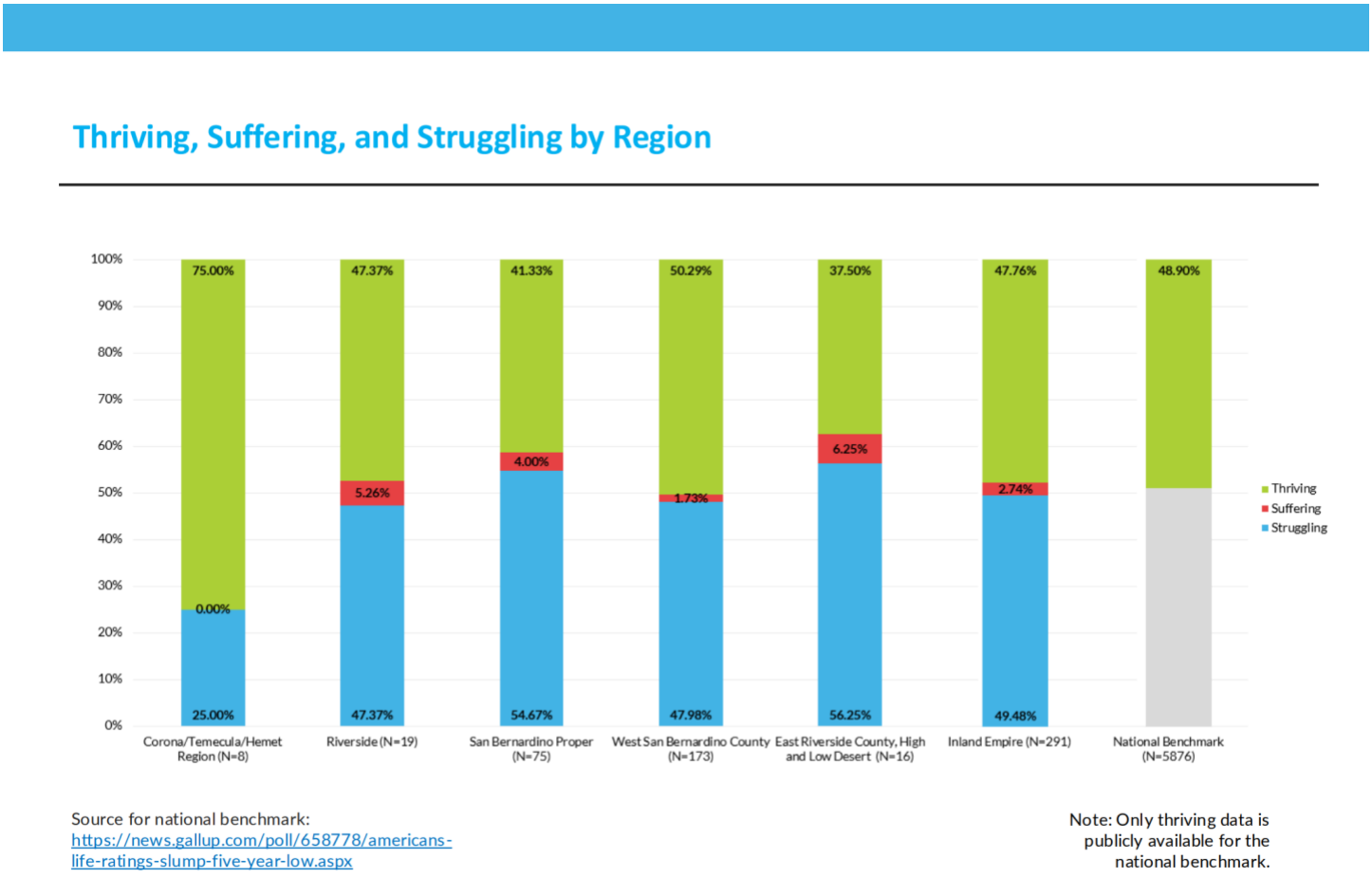


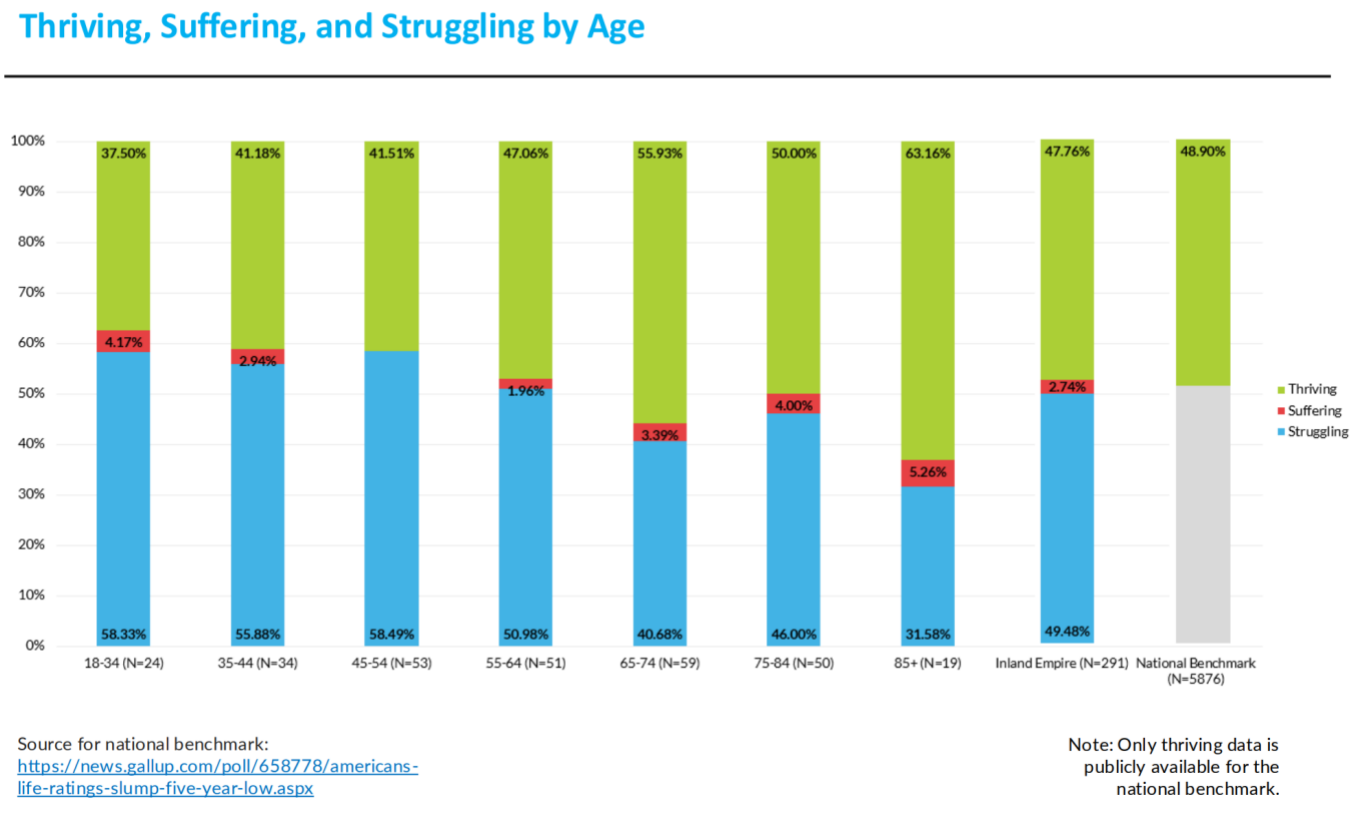
Figure 2.

Primary & Secondary Service Area – Thriving, Suffering and Struggling by Region, Calendar Years 2026 - 2029



Source: 2025 CHNA - Redlands Community Hospital PSA Population Projections by Demographic Cohort , Page 148

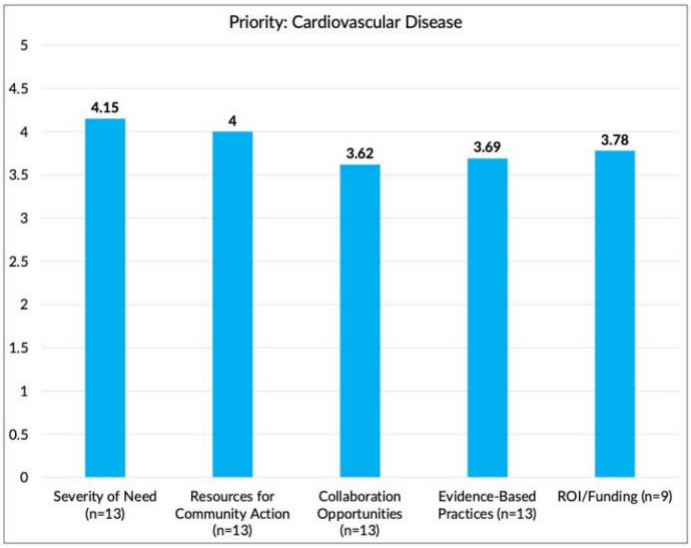
Figure 3.
Primary & Secondary Service Area – Thriving, Suffering and Struggling by Age, Calendar years 2025 - 2029

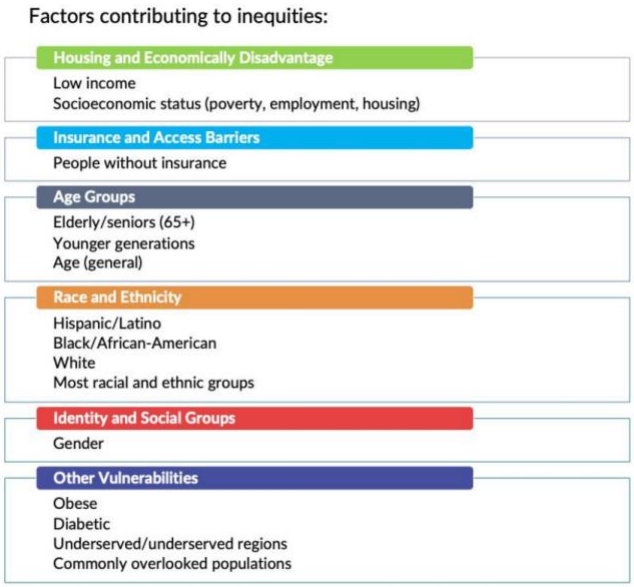


Source: 2025 CHNA - Redlands Community Hospital PSA Population Projections by Demographic Cohort , Page 149

HEALTH INDICATORS CHOSEN FOR FOCUS – Redlands Community Hospital

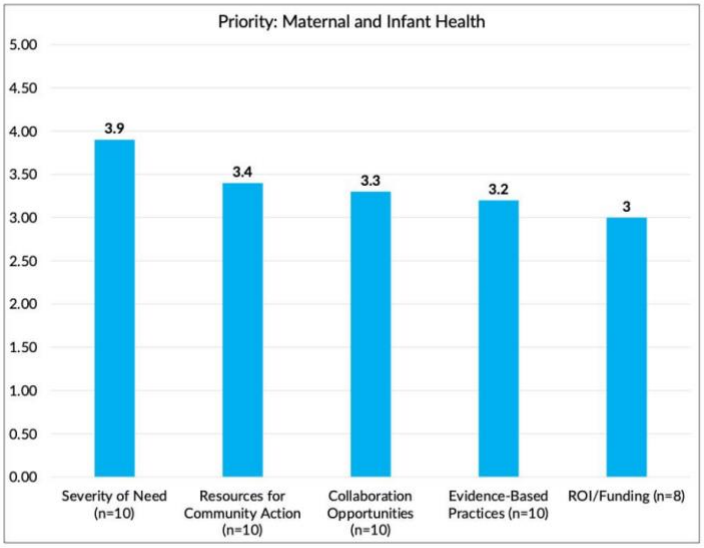
Figure 4.
Health Indicator – Priority 1 – Cardiovascular Disease, Calendar years 2026-2029

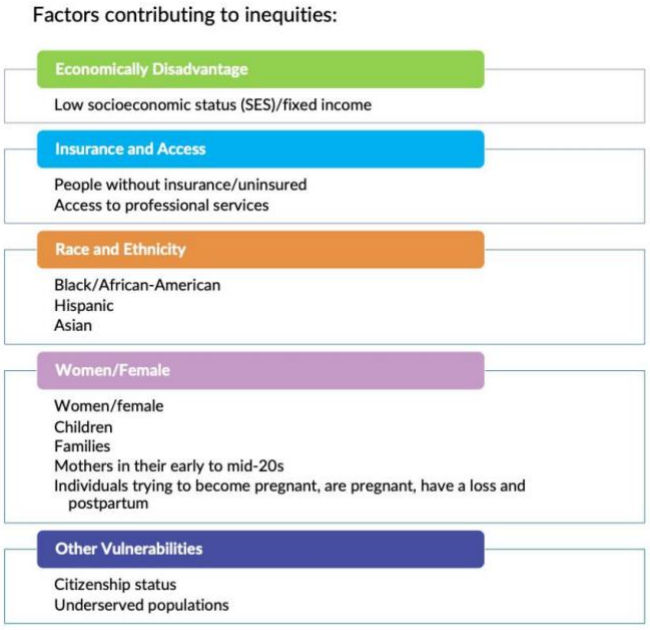




Source: 2025 CHNA - Redlands Community Hospital – Priorities, Page 239

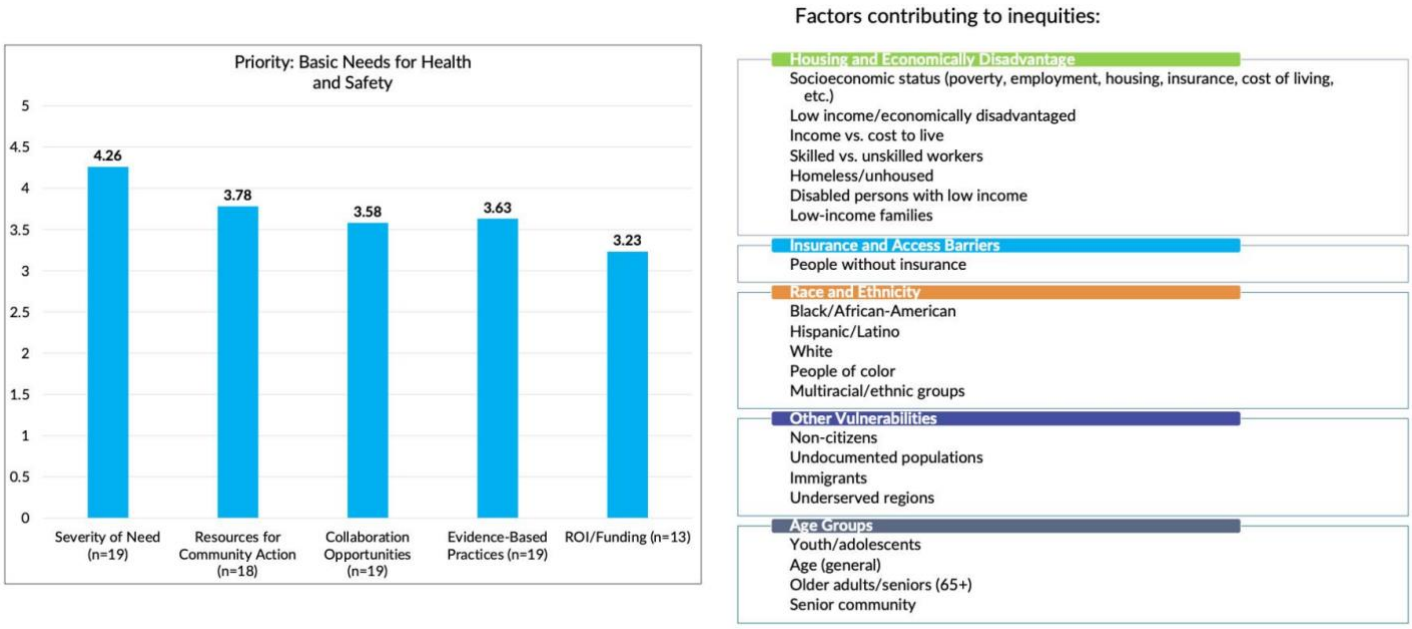
Figure 5.
Health Indicator – Priority 2 – Maternal and Infant Health, Calendar years 2026-2029





Source: 2025 CHNA - Redlands Community Hospital – Priorities, Page 240

Figure 6.
Health Indicator – Priority 3 – Basic Needs for Health and Safety, Calendar years 2026-2029



Source: 2025 CHNA - Redlands Community Hospital – Priorities, Page 241

COMMUNITY HEALTHCARE NEEDS ASSESSMENT PROCESS

METHODOLOGY

The following highlights the methodology for the 2025 needs assessment process, the participants, and the outcomes.

Executive Summary

During 2025 the Community Health Needs Assessment Report (CHNA) represented the Hospital Association of Southern California, Inland Counties' (HASC) first coordination of the CHNA for 5 local hospitals. HASC works with hospitals to advance quality healthcare delivery and supported the CHNA process with an Inland Area Community Benefit Stakeholder Committee representing the major hospitals in each county. For the 2025 Community Health Needs Assessment Redlands Community Hospital (RCH) participated in the fourth regional process hosted by HASC. In collaboration with 5 hospital systems, RCH worked collectively to design the overall 2025 CHNA strategy and the coordination of primary and secondary data collection. The complete CHNA may be found in Appendix B (page 76). The hospitals that participated in the 2025 regional CHNA included:

- Chino Valley Medical Center
- Montclair Hospital Medical Center
- Redlands Community Hospital
- San Antonio Regional Hospital
- San Gorgonio Memorial Hospital

Purpose of Community Health Needs Assessment (CHNA) Report

The Patient Protection and Affordable Care Act (ACA) of March 23, 2010 included new requirements for nonprofit hospitals in order to maintain their tax-exempt status. The final regulations and guidance on these requirements, which are contained in section 501(r) of the Internal Revenue Code, were published on February 2, 2015 in Internal Revenue Bulletin 2015. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a Community Health Needs Assessment (CHNA) and develop an Implementation Strategy (IS) to address those needs every three years. Each hospital will develop its own IS using the data from the 2025 report. There may also be identified areas that the region will work on collectively, including partners outside of the healthcare system.

Sources of Data

Primary and secondary data sources in the report include publicly available state and nationally recognized data sources available at the zip code, county and state level. Health indicators for social and economic factors, health system, public health and prevention, and physical environment are incorporated. The top leading causes of death as well as conditions of morbidity that illustrate the communicable and chronic disease burden across San Bernardino and Riverside counties are included. A significant portion of the data for this assessment was collected through a custom report generated through Community Common's Engagement Network CHNA (https://engagementnetwork.org/assessment/). Other sources include California Department of Public Health, County Health Rankings & Roadmaps, and California Environmental Protection Agency's Office of Environmental Health Hazard Assessment. When feasible, health metrics have been further compared to estimates for the state or national benchmarks, such as the Healthy People 2020 objectives.

Inpatient hospitalization discharge data for 2021 and 2024 was derived from Redlands Community Hospital's internal data source. Hospitalization discharge data is stratified by gender, race/ethnicity and age, and data containing an n-value of 10 or less were not included and are identified with an * in the table and graphs were not generated.

Voices from the Community

The hospitals participating in the two-county assessment worked to identify relevant key informants and topical focus groups to gather more insightful data and aid in describing the community. Key informants and focus groups were purposefully chosen to represent medically under-served, low-income, or minority populations in our community, to better direct our investments and form partnerships.

Prioritization Process and Identified Health Needs

During April 2025 a strategy meeting was held with the members of the Inland Empire Regional CHNA Taskforce to review the results of the CHNA and determine the top three priority needs that the hospitals will address over the next three years. To aid in determining the priority health needs, the Taskforce members agreed on selection criteria.

The top health needs across the region identified for 2026-2029 include mental health and alcohol/drug substance abuse; chronic diseases including asthma, cancer, diabetes, heart disease, obesity, and access to health care including provider shortage and insurance.

Redlands Community Hospital's Prioritized Health Needs

Analyzing historical patient origin data derived from the hospital's statistical information identified the geographic service area of Redlands Community Hospital. Located in the most densely populated area of San Bernardino County, communities identified as being in the primary service area of the hospital are Banning, Beaumont, Cabazon, Colton, Calimesa, Forest Falls, Highland, Mentone, Redlands and Yucaipa. The secondary service area is comprised of the cities of Bloomington, Bryn Mawr, Crestline, Fontana, Grand Terrace, Hemet, Loma Linda, Patton, Rialto, San Bernardino, and several mountain communities.

Table 2 shows the priority areas Redlands Community Hospital addressed in 2025 and will continue to address during 2027. Access to outpatient behavioral health was selected as one of the focus areas. Behavioral health care is a critical issue that remains a priority for the hospital, and mental health and alcohol/drug substance abuse was a key finding with the 2022 regional needs assessment. To address the behavioral health needs of the community, the hospital provides acute psychiatric services in our emergency department as well as an outpatient program. Two Access to Care clinical care areas were also identified as priority focus areas: access to primary care and access to prenatal care.

Table 2.
Redlands Community Hospital's Prioritized Needs for 2025

Health Outcomes	**Clinical Care**
Increased Access for Cardiovascular & Diabetic Disease Improved Maternal and Infant Health Improved Access for Basic Health & Safety Needs	Access to primary care

The hospital continues to own and operate two primary care medical clinics and a community- based perinatal outreach program. Both programs offer access to care for vulnerable populations and the facilities are located in high-risk areas of the community. The hospital continues to explore opportunities for partnerships and opening additional medical clinics to increase access.

The hospital continues to support individuals suffering from behavioral health issues within the community through the provision of behavioral medicine programs and services. The hospital has an outpatient programs; Partial Hospital Program and Intensive Outpatient Programs to focus on prenatal care and women's health.

In the area of community outreach and education the hospital continues to reach out using multiple methods. The staff provides community education, facilitate education, and distribute a quarterly community-wide newsletter. Multiple events were held and participated in throughout the Inland Empire. We recognize that there are many other community health needs outlined in the complete CHNA. These needs or challenges will be reviewed for future consideration.

Acknowledgements

The complete 2025 CHNA report was made possible through the contributions of the Hospital Association of Southern California Inland Empire Regional CHNA Taskforce, Communities Lifting Communities, and HC2 Strategies, Inc. under the leadership of Megan Barajas, MPA, HASC Inland Empire. The taskforce collaborated with Alexus Espino, of HC2 Strategies, Inc. HC2 Strategies, Inc. conducted key informant interviews, focus groups, and facilitated establishing priority health needs for the 2026-2029 community health needs cycle.

Additionally, the taskforce worked with the Inland Empire CHNA Stakeholder Committee worked with HC2 to gather health indicator data, analyze quantitative and qualitative data, and publish the final report. Many of the critical health indicators presented in this report were collected from the Engagement Network CHNA report provided by Community Commons, which is managed by the Institute for People, Place, and Possibility, the Center for Applied Research and Environmental Systems (CARES), and the Community Initiatives Network. The data gathered from Community Commons ensured an efficient and accurate method of collecting data from numerous sources.

Hospital Association of Southern California

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

Consultants

HC2 Strategies, Inc. is a strategy consulting company that works with health systems and hospitals, physician groups, communities and other non-profit organizations across the country to connect and transform the health and well-being of their communities. They work to integrate the clinical and social aspects of community health to improve equity and reduce health disparities.

REDLANDS COMMUNITY HOSPITAL CHARITY CARE POLICY

RCH is committed to caring for patients in need of urgent or emergent service regardless of their ability to pay. This commitment reflects RCH's value of providing services to residents of our community. RCH will balance its obligation to provide charity with its need to remain financially strong.

The Redlands Community Hospital's Administrative Policy No. A.F2, Financial (Patient) Policy, is provided in Appendix A.

Appendix A -

Redlands Community Hospital *Caring for Generations.*	POLICY # A.F2
TITLE: Financial (Patient) Policies	PAGE: 49 OF: 50
	LAST REVIEWED: 12/8/2021
	EFFECTIVE: 09/01/1980
DEPARTMENT/SCOPE: Administration	OWNER: Director, Patient Financial Services

MANUAL:	ORIGINATION DATE:	REVIEW DATE:	OWNER:
ADMINISTRATIVE	01/80	12/2025	**Director, Patient Financial Services**

PURPOSE

To define Redlands Community Hospital's ("RCH's") philosophy and rules governing charitable care, special payment arrangements and general hospital business practices regarding patient financial responsibilities.

POLICY

- RCH recognizes to the extent that it is financially able, a responsibility to provide quality health care services to persons regardless of their source of payment.
- It is RCH's philosophy that the need for charitable care or for special payment arrangements should be determined prior to the delivery of that care whenever possible. Early and deliberate efforts of RCH staff to contact the patient, resolve problems, discuss, counsel and make arrangements for payment are encouraged. The intent of this policy to comply with applicable California State laws as well as Section 501(r) of the Internal Revenue Code (the "Code"). Accordingly, this Policy should be read and interpreted in a manner consistent with such laws.
- The cost of accounts not paid must be covered by the paying patient. Proper business practices blended with the compassion in a charitable institution into patient financial policies will enable RCH to fulfill its responsibilities to those patients and third parties who pay in full for services rendered.
- RCH has a written Emergency Medical Care Policy (T-140) that provides that all patients will receive care for emergency medical conditions without discrimination or whether or not eligible for financial assistance.
- Hospital business practices regarding patient financial responsibilities shall be defined as follows:

I. General Guidelines for All Patients

The billing of private insurance is considered a courtesy to the patient; however, the patient/guarantor remains responsible for the balance.

A. RCH will bill secondary and supplemental carriers as a courtesy; however, the patient/guarantor remains responsible for the balance.

B. New patients are to be pre-registered and receive financial counseling regarding insurance verification and co-payments, coinsurance, and/or deductibles due prior to services being rendered. Description of services and estimated costs of services are to be available to all outpatients from the departments.

C. Extended Terms - Patients with an outstanding balance post discharge will be referred to Patient Financial Services for counseling.

1. Payment arrangements without interest can be extended to all Self Pay patients by the department staff not to exceed six (6) months from the date of service. Upon a supervisor's review and approval, these payment arrangements without interest can be extended to 12 months. RCH reserves the right to extend payment arrangements beyond these thresholds based on patient circumstances. In addition to the above stated internal payment arrangement plans, RCH also offers its patients the ability to sign up for an Interest Free Loan program offered through Clear Balance for extended repayment periods. A Health Savings Account held by the patient or the patient's family may be considered when negotiating a payment plan.

2. In the event that RCH staff and the patient fail to agree on the terms of a payment plan, the Reasonable Payment Formula as cited in SB 1276 and AB 1020 will be implemented. Monthly payments under this formula will not exceed 10% of the patient's family income for a month, excluding deductions for Essential Living Expenses. Patients will be required to produce written documentation in support of their Essential Living Expenses.

3. RCH will not revoke a patient's eligibility for extended payment terms unless the patient has failed to make all consecutive payments due in a 90-day period. Before revoking eligibility for extended payment terms, RCH, or any collection agency or other assignee of the patient's account, will make a reasonable attempt to contact the patient by phone and give notice by writing, at least 60 days after the first missed bill, that the extended payment plan may be revoked and the patient has the opportunity to renegotiate the extended payment plan. The notice will provide the patient with at least30 days to make a payment before RCH revokes the extended payment plan. RCH, the collection agency or other assignee will attempt to renegotiate the extended payment plan if requested by the patient. Civil action shall not be commenced against the patient or other responsible party prior to the time the extended payment plan is revoked.

4. In the event that the patient has a pending appeal for coverage of services, so long as the patient makes a reasonable effort to communicate with the hospital about the progress of the pending appeal, the 90-day nonpayment period described above shall be extended until a final determination of the appeal is made. "Pending appeal" includes the following:

    a. A grievance against a contracting health care service plan, as described in Chapter 2.2 of Division 2 of the Insurance Code, or against an insurer, as described in Chapter 1 of Part 2 of Division 2 of the Insurance Code;
    b. An independent medical review, as described in Section 10145.3 or 10169 of the Insurance Code;
    c. A fair hearing for review of a Medi-Cal claim pursuant to Section 10950 of the Welfare and Institutions Code;

d. An appeal regarding Medicare coverage consistent with federal law and regulations.

II. Insurance Coverage

RCH will accept insurance benefits as follows:

A. Medicare - with proper eligibility.
B. Medi-Cal - with proper eligibility.
C. Commercial Insurance - with verified coverage and assignable benefits.
D. Private Insurance - with verified coverage and assignable benefits.
E. Workers' Compensation - with verified coverage.
F. HMO/PPO/Capitation - with verified coverage.
G. Other State- or County-funded health coverage – with verified coverage

III. Bad Debt/Collection Policy

When required insurance coverage documentation and/or patient balance payments per agreement are not provided, RCH will transfer the account to a Bad Debt file and the reserve for Bad Debt will be charged. Solely in a manner consistent with Section 501(r) of the Code and applicable state laws, Bad Debt accounts may be referred to a collection agency at the discretion of the Collection Supervisor and Director of Patient Financial Services; provided that Bad Debt accounts will not be referred to a collection agency unless RCH has found the patient ineligible for financial assistance or the patient has not responded to any attempts to bill or offer financial assistance for 180 days.

A. RCH will recognize any account as a Bad Debt when the account is older than 120 days except as follows:

1. The account is pending insurance payment for a known reason.
2. Extended payment terms have been authorized. Payment arrangements can be extended to all Self-Pay patients by department staff not to exceed six months from the date of service. Upon a supervisor's review approval, these payment arrangements without interest can be extended to 12 months. RCH reserves the right to extend payment arrangements beyond these thresholds based on patient circumstances.
3. The Director of Patient Financial Services or Collection Supervisor has documented a good reason for maintaining the account.
4. The account has been recognized and documented as "high risk" and a prior determination made by the Director of Patient Financial Services or Collection Supervisor that the account should be aggressively followed by an outside agency.
5. The patient applies for financial assistance under the FAP within the Application Period as defined in Attachment A to this Policy.

B. RCH and its assignees of any patient Bad Debt, including collection agencies, will not report adverse information to any consumer credit reporting agency.
C. RCH will require all assignees of any patient Bad Debt, including collection agencies, to agree to comply with the AB 774, SB 350, SB 1276, AB 1020, AB 2279, and SB 1061 requirements regarding all collection activity. A written agreement requiring compliance with AB 774, SB 350, SB 1276, AB 1020, AB 2279, SB 1061, IRS 501(r) and RCH's standards and scope of practice will be required for all assignees of patient Bad Debt, including collection agencies.
D. RCH and its assignees of any patient Bad Debt, including collection agencies, will not use wage garnishments for patients whose income is at or below 400% of the Federal Poverty Level.
E. RCH and its assignees of any patient Bad Debt, including collection agencies, will not place liens on any real property as a means of collecting unpaid hospital bills.
F. A collection agency, or other assignee that is not an affiliate or subsidiary of RCH, shall not use the sale of any real property owned, in part or completely, by the patient as a means of collecting unpaid hospital bills.
G. Bad Debt shall be approved by the PFS Management Team according to policy.
H. Prior to commencing collection activities against a patient, RCH and its assignees of any patient Bad Debt, including collection agencies, shall provide the patient with a clear and conspicuous notice containing all of the following items:

1. A plain language summary of the patient's rights pursuant to AB 774 and SB 350, the Rosenthal Fair Debt Collection Practices Act, and the federal Fair Debt Collection Practices Act of Chapter 41 of Title 15 of the United States Code, and a statement that the Federal Trade Commission enforces the federal act.
2. A statement that nonprofit credit counseling may be available.
3. The Date of service of the bill that is being assigned to collections.
4. The name of the Collection Agency that the account is being assigned to.
5. Notice on how to obtain an Itemized bill from the hospital.
6. The name and type of health coverage plan for the patient on record with the hospital at the time of services or a statement that the hospital does not have that information.
7. An application for the hospital's Financial Assistance program.
8. The date or dates that the patient was originally sent a notice about applying for financial assistance.
9. The date or dates that the patient was sent a Financial Assistance Application and if applicable, the date a decision on the application was made.

IV. Financial Assistance, AB 774, SB 350, SB 1276, Prop 99 and AB 1020

Application for Self-Pay/Financial Assistance/Prop 99 Funds see **Attachment A**.

V. Employment and Medical Staff Courtesy Allowances

No courtesy allowances for RCH employees, medical staff or their dependents are allowed except as otherwise provided in this policy and attachments.

VI. Other Courtesy / Administrative Allowances

A. Small balance allowances of $14.99 and under that have been billed at least once may be written off by the Patient Financial Services Department.
B. OB Cost-Saver Package Plan, see **Attachment B**.
C. Self-Pay and Financial Assistance Discounts see **Attachment A**.
D. Perinatal Services, Center for Surgical and Specialty Care, Redlands Family Clinic and Yucaipa Family Clinic, see **Attachment C**.
E. Other Courtesy / Administrative allowances shall be approved by the PFS Management Team according to policy.

VII. Overpayment on Patient Accounts

A. Insurance Overpayments

RCH will refund insurance overpayments in a reasonable manner, after review and a determination that refund is appropriate. Interest will be applied at the rate set forth in Section 685.010 of the Code of Civil Procedure, beginning on the date of the verified credit balance.

B. Patient Overpayment

1. RCH will refund overpayments of $5.00 or more to the responsible party. Interest will be applied at the rate set forth in Section 685.010 of the Code of Civil Procedure, beginning on the date of the patient's payment that created a credit balance. For patients retroactively presenting valid Medi-Cal cards, patient payments may be refunded after all retroactive documentation has been approved by the Department of Health Services.
2. In the event that a patient applies for Financial Assistance and is approved for Charity Care, any payments made by the patient will be reviewed and refunded with interest within 30 days of the Charity Care approval date. If the patient is approved for Financial Assistance at a level less than Free Care, any payments made will be evaluated based upon the Federal Poverty Levels / RCH Income Indicator and Reimbursement Matrix Tables to determine if a refund is due to the patient. If it has been five or more years since the patient's last payment on an account approved for Financial Assistance, RCH is not required to refund patient overpayments.

C. Deviations from Policy

The President/CEO, Vice President/CFO or designee may authorize a deviation from any of the above policies, provided, that any deviations shall be consistent with applicable law.

Responsibility for review and maintenance of this policy is assigned to Vice President/Chief Financial Officer.

Attachments:

A. Self-Pay and Financial Assistance Discounts
B. OB Cost Saver Package Plan
C. Service / Location Specific Policies

REFERENCE(S)

California Administrative Code, Title 22, Section 707179(a)

ATTACHMENT A

SELF-PAY AND FINANCIAL ASSISTANCE DISCOUNTS

The Self-Pay and Financial Assistance Discount policies provided herein are intended to comply with California Assembly Bill 774 (Health and Safety Code § 127400 et seq.) and California Senate Bill 350 (Chapter 347, Statutes of 2007) effective January 1, 2008, SB 1276 (Chapter 758) effective January 1, 2015, AB 1020 (Chapter 473) effective January 1, 2020, AB 2297 (Chapter 511) effective January 1, 2025, SB 1061 (Chapter 520) effective January 1, 2025, and Section 501(r) of the Code.

I. DEFINED TERMS

A. *"Amounts Generally Billed"* ("AGB"). Charges for emergency and medically necessary services shall be limited to no more than amounts generally billed ("AGB") to individuals who have insurance covering such care. In calculating AGB, RCH has selected the "prospective" method, which is one of the two permissible methods identified by the IRS. In the prospective method, the AGB is determined based on a percentage of the applicable Medicare reimbursement for the services provided. Following a determination of approval for financial assistance, a FAP- eligible individual may not be charged more than the amounts generally billed for emergency or medically- necessary care. In addition, RCH will not charge FAP eligible individuals gross charges (or higher) for any medical care (that is not emergency or medically necessary care).

B. *"Application Period"* means the time period in which patients may submit an application for financial assistance under this Policy by completing a FAP Application. The patient or legal representative may submit an application at any time.

C. *"Bad Debt"* means an account of a patient who demonstrates an ability to pay but who has not done so after repeated requests for payment.

D. *"Financial Assistance"* encompasses both the Charity Care and Discounted Payment programs.

E. *"Charity Care"* means free care provided to a patient whose responsible party has an income that does not exceed 400% of the "Federal Poverty Level" or "FPL" (as defined below).

F. *"Discounted payment"* means any charge for care that is reduced but not free.

G. *"Federal Poverty Level"* or *"FPL"* means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services.

H. *"Financially Qualified Patient"* means a patient who is: (1) a "Self-Pay Patient" (as defined below) or a "Patient with High Medical Costs" (as defined below), and (2) a patient who has a family income that does not exceed 400% FPL.

I. *"High Medical Costs"* means: To include annual out of pocket costs and expenses at the hospital that exceed the lesser of 10% of the patient's current family income or the family income in the prior 12 months.

J. *"Out of pocket costs and expenses"* mean any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing.
K. *"Patient's Family"* for the purpose of determining family income and size, means, for persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act, whether living at home or not. For persons under 18 years of age or for a dependent child 18 to 20 years of age, inclusive, parent, caretaker relatives, and parent 's or caretaker relatives' other dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act
L. *"Patient with High Medical Costs"* means a patient with High Medical Costs whose family income does not exceed 400% FPL.
M. *"RCH" means* Redlands Community Hospital.
N. *"Self-Pay Patient"* means a patient who does not have third-party health coverage.
O. *"Self-Pay Discount"* means a discount applied by RCH for any medically necessary inpatient or outpatient hospital service provided to a patient with High Medical Costs who is uninsured or whose documented income exceeds 400% FPL.
P. *"Reasonable Payment Formula"* means monthly payments that are not more than 10% of a patient's family income for a month, excluding deductions for essential living expenses.
Q. *"Essential Living Expenses"* means expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas and repairs, installment payments, laundry and cleaning and other extraordinary expenses.
R. *"Underinsured Patient"* means a patient with insurance coverage who has charges for services not covered by their health care coverage.

II. SELF-PAY POLICY

All Self-Pay Patients or Underinsured Patients who have ability to pay and whose income exceeds 400% FPL will receive the standard Self-Pay Discount. All Self-Pay Patients and Underinsured Patients whose documented income falls below the 400% FPL threshold will be considered for Financial Assistance. All Self-Pay Patients will be screened for linkage to and provided with an application (or instructions on how to obtain an application) for any appropriate form of assistance, including but not limited to California Health Benefit Exchange, Medi-Cal, Healthy Families, San Bernardino Medically Indigent Adult program, Section 1011 or, any 3rd party liability insurance (Automobile Insurance, Workers' Compensation, Home Owners Insurance, etc.). A pending application for another health coverage program shall not preclude eligibility for RHC's Financial Assistance or Self-Pay Discount programs. RCH reserves the right to review these instances on a case by case basis.

III. STANDARD SELF-PAY DISCOUNT

For qualifying Self-Pay and Underinsured Patients who receive medical procedures (excluding implants and high cost drugs, which are billed at cost plus 5%), a 76% discount will be applied to charges at the time of final billing. Additional Self-Pay Discounts offered by RCH may be provided based on financial ability, mental capability, physical ability, or other related reasons. An additional prompt-pay discount of 10% may also be provided if full payment is made promptly. Any Self-Pay Discounts that exceed the standard Self-Pay Discount and prompt-pay discount must be approved by the Business Services management team.

IV. FINANCIAL ASSISTANCE

RCH is committed to providing appropriate medical care to patients in its service area to ensure that a patient in need of non-elective care will not be refused treatment because of his or her inability to pay. Therefore, it is the policy of RCH to provide Financial Assistance for those who demonstrate an inability to pay.

V. FINANCIAL ASSISTANCE

A. Services Eligible under this Policy

The following healthcare services are eligible for Financial Assistance:

1. Emergency medical services provided in an emergency room setting;
2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting;
4. Other medically necessary services, evaluated on a case-by-case basis at RCH.
5. Non-covered and denied medically necessary services for all payors.

B. Eligibility Criteria for Financial Assistance Programs

Self-Pay Patients, Underinsured Patients and Patients with High Medical Costs with verified income at or below 400% of the FPL will be eligible for Financial Assistance Programs.

1. The granting of Financial Assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.
2. In determining eligibility for Financial Assistance, eligibility will be based on income consistent with the application of Federal Poverty Levels as described in this policy.

C. Financial Assistance for Insured patients

Financial Assistance is available for both uninsured and insured patients. Insured patients can qualify for assistance to help cover the costs not covered by insurance, such as copays,

deductibles, coinsurance, and non-covered amounts. Eligibility for this form of charity is determined according to the patient's income in relation to the FPL requirements described in this policy.

D. Method by Which Patients May Apply for Financial Assistance

1. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need. Such procedures will include:

   a. An application process, in which the patient or the patient's guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need. Required documents include proof of identity (driver's license, ID card, U.S. Citizenship, Passport, or Social Security card). Documentation of income will require recent pay stubs or income tax returns. The hospital may accept other forms of documentation of income, which might include but is not limited to: Social security, unemployment, disability, alimony, bank statements, W-2, or other sources of income. Financial Assistance may not be denied based on failure to provide information or documentation not specified in this policy or on the FAP Application. Information obtained during the collection of Eligibility documents (including, without limitation, pay stubs, tax returns, and bank statements) shall not be used in collection activities.
   b. Reasonable efforts by RCH to verify information submitted and explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs. Whether such reasonable efforts have been made shall be determined by the Patient Financial Service Department;
   c. The use of external publicly available data sources that provide information on a patient's or a patient guarantor's ability to pay (such as credit scoring) to verify financial information provided;
   d. A review of the patient's and/or family's available financial resources; and
   e. A review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history. If the patient's Financial Assistance application is approved, all prior accounts will be evaluated for possible Financial Assistance reclassification.

2. The need for Financial Assistance shall be re-evaluated at each subsequent time of services if the last financial evaluation was completed more than six months prior, or at any time additional information relevant to the eligibility of the patient for Financial Assistance becomes known.

3. RCH may deny Financial Assistance on the grounds of failure to provide required requested information. In the event the patient or the patient's representatives provide the requested information at a later date, RCH shall reopen their applications. Patients who

have had their Financial Assistance application denied for any reasons have the right to appeal the denial and can do so by submitting their appeal in writing to the attention of the Director of Patient Financial Services (PFS) or the PFS Manager at RCH at any time. If denied, the patient will be informed as to the basis for the denial of Financial Assistance.

4. RCH values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of charity. Requests for Financial Assistance shall be processed promptly and RCH shall notify the patient or applicant in writing once the application has been approved or denied.

5. The emergency physician who provides emergency medical care at RHC is also required by California law section 127450 to provide discounts to Self-Pay Patients and Patients with High Medical Costs who are at or below 400 percent of the federal poverty level. The processing, determination and application of discounts for emergency physician services is the sole responsibility of the providing emergency physician and shall not be construed to impose any additional responsibilities upon the hospital. RCH shall provide contact information for the treating emergency room physician to each Self Pay Patient and Patient with High Medical Costs.

E. Presumptive Financial Assistance Eligibility

There are instances when a patient may appear eligible for Financial Assistance, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with Financial Assistance. In the event there is no evidence to support a patient's eligibility for Financial Assistance, RCH reserves the right to use outside agencies in determining estimated income amounts as the basis of determining Financial Assistance eligibility and potential discount amounts. Any patient approved for Financial Assistance on a presumptive basis shall receive free care (100% discount). Examples of these exceptions where documentation requirements are waived include, but are not limited to:

1. An independent credit-based financial assessment tool indicates indigence;
2. An automatic financial assistance determination of 100% assistance is applied in the following situations provided other eligibility criteria are met:
   a. Patient has an active Medicaid plan.
   b. Patient is eligible for Medicaid or patients with current active Medicaid coverage will have assistance applied for past dates of service.
   c. Patient is deceased.
3. Determination of patient financial assistance eligibility by director of patient financial services.

Presumptive eligibility tools may not be used for indigent Medicare patients

F. Non-Covered/Denied Medicaid or Indigent Care Program Service

Non-covered and denied services provided to Medicaid eligible beneficiaries are considered a form of Financial Assistance. Medicaid beneficiaries are not responsible for any forms of patient financial responsibility and all charges related to services not covered, including all denials, are considered Financial Assistance. Examples may include, but are not limited to:

1. Services provided to Medicaid beneficiaries with restricted Medicaid (i.e., patients that may only have pregnancy or emergency benefits, but receive other hospital care)
2. Medicaid-pending accounts
3. Medicaid or other indigent care program denials
4. Charges related to days exceeding a length-of-stay limit
5. Medicaid claims (including out of state Medicaid claims) with “no payment””
6. Any service provided to a Medicaid eligible patient with no coverage and no payment

G. Non-Covered/Denied Charges for all Payors

Any unreimbursed charges from non-covered or denied services from any payor, such as charges for days beyond a length-of-stay limit, exhausted benefits, balance from restricted coverage, Medicaid-pending accounts, and payor denials are considered a form of patient financial assistance at RCH. Charges related to these denials/non-covered amounts written off during the fiscal year are reported as uncompensated care.

H. Examples of Intended Beneficiaries

1. The following are examples of patients intended to benefit from RCH’s Financial Assistance policy:
   a. Uninsured or underinsured patients with income at or below 400% of the FPL.
   b. Patients with High Medical Costs
   c. Patients who qualify for the Medically Indigent Adult program through the State of California or the County of San Bernardino.
   d. Patients who have applied to the Medi-Cal program and have been denied for reasons other than failure to comply or noncompliance with requested information.
   e. Patients who have been referred to outside collection agencies and who are later determined to be unable to pay according to RCH’s Financial Assistance eligibility guidelines.
   f. Patients who are undocumented aliens from other countries who have demonstrated no ability to pay or who did not or were not able to provide RCH adequate demographic information.
   g. Patients who have a green card or other Immigration Department issued Identification (“ID”) Card allowing them to be in this country legally but who have demonstrated no ability to pay or who did not or were not able to provide RCH adequate demographic

information, provided that the patient complies with all Section 1011 requirements and applications.

h. Patients who are homeless.
i. Patients who, due to their condition, are unable or unwilling to provide adequate demographic information for billing.
j. Patients who are able to pay a portion but not all of their outstanding balance due to financial constraints.

VI. IRS Section 501(r) Compliance

In order to meet the Section 501(r) of the Code and the regulations thereunder, RCH has implemented the following practices:

A. A plain language summary of our Financial Assistance Program ("FAP") will be issued to all patients. The summary document will include information on how to apply, eligibility requirements and whom to contact for assistance.
B. A conspicuous statement identifying the fact that RCH has a FAP will be included on all billings and statements. The statement will identify that financial assistance is available to our patients and whom to contact for assistance.
C. RCH will widely disseminate its FAP, FAP Application and plain language summary through a variety of means including, but not limited to: posting the FAP, FAP Application and a plain language summary of the FAP on an RHC's website dedicated to financial assistance (all downloadable in pdf or equivalent format). The website will also provide a link to download a PDF application along with information on whom to contact for assistance.
D. RCH will ensure that all vendors and collections agencies are in full compliance with the Section 501(r) of the Code, Health and Safety Codes 127010, 127436, and the regulations thereunder.
E. At least thirty (30) days prior to initiating Extraordinary Collections Actions ("ECAs") RCH's Patient Financial Services staff will ensure that reasonable efforts were made to notify the patient/guarantor of our FAP and how to apply. These efforts will include letters, statements and phone attempts.
F. RCH's FAP only pertains to the services provided by RCH employed staff. All Physicians and other non-RCH Medical Professionals are not employed by RCH and have not adopted RHC's FAP. Accordingly, patients who receive financial assistance under this policy may still have financial obligations to RCH Medical Professionals and physicians for the care provided. A list of providers (listed by individual or by group name) who are covered under this policy and those that are not covered under this policy is contained at **www.redlandshospital.org**.

VII. ADMINISTRATIVE MATTERS

A. Questions about this Financial Assistance Policy may be directed to Patient Financial Services, (909) 335-5534.
B. Administrative or courtesy write-offs are the sole discretion of RCH and are not included in this policy.
C. Accounts which develop a credit balance due to a Financial Assistance or a Self-Pay Discount write-off and a subsequent payment from any source must have the Financial Assistance or Self-Pay Discount write-off reversed before any refunds are disbursed.
D. RCH will make available a plain language summary of our Financial Assistance policy that is clear, concise and easy to understand at the time of all registrations or admissions. This information will also be made available on the hospital's web site. The summary will include basic eligibility guidelines, instructions on how to obtain an application for financial assistance and who to contact for assistance as well instruction on how to access it on the website. In the case that the patient does not speak English, we will have this contact information available in fifteen different languages.
E. When RCH bills a patient that has not provided proof of coverage by a third-party at the time care is provided or upon discharge, as a part of that billing, RCH will provide the patient with a written notice in hardcopy format, which shall include the following:

1. A statement of charges for services rendered by RCH.
2. A request that the patient inform RCH if the patient has third party health coverage.
3. A statement that if the patient does not have health insurance coverage the patient may be eligible for California Health Benefit Exchange, Medicare, Healthy Families, Medi-Cal, other State- or County-Funded Health Coverage Programs, Financial Assistance or Self-Pay discount.
4. A statement indicating how a patient may obtain an application for the California Health Benefit Exchange, Medicare, Healthy Families, Medi-Cal, or other State- or County-Funded Health Coverage Programs and that RCH will provide such applications;
5. Information on where the patient may access RCH's Financial Assistance policies;
6. The internet address for RCH's list of shoppable services;
7. Information on the Hospital Bill Complaint Program, including the following statement:
   - The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.
8. Information on the Health Consumer Alliance, including the following statement:
   - Help Paying Your Bill: There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information.
9. A referral to a local consumer assistance center housed at legal services offices; and

10. Eligibility information for RCH's Self-Pay Discount and Financial Assistance programs and who to contact for assistance is given to patients at time of service (if the patient is conscious and able to receive the written notice at that time) and at time of first billing to all uninsured patients.

F. If a patient does not provide information indicating coverage by a third-party payor or request a discounted price or Financial Assistance, prior to discharge (if the patient has been admitted) or when receiving emergency or outpatient care, RCH shall provide the patient with an application for the Medi-Cal program, the Healthy Families Program, or other State- or County-Funded Health Coverage Programs. RCH shall not require the patient to apply for Medi-Cal or other coverage before the patient is evaluated for eligibility for Financial Assistance; however, RCH may require the patient to participate in screening for Medi-Cal eligibility.

G. RCH will provide posted written notice of its Financial Assistance / Self-Pay Discount policy in all areas that are visible to the public including:

1. The ER department.
2. The Admissions department.
3. The Cashier and Business Office.
4. Other outpatient settings, including observation units as applicable.
5. RCH's internet website, with a link to the policy itself.

H. RCH will provide all required written notices, FAP application determinations, and correspondence, including the FAP, FAP Application and plain language summary of the FAP, to patients related to the Self-Pay Discount and Financial Assistance programs in English and in any language that exceeds 5% of our patient population. Required written correspondence includes: requests for information to determine eligibility for the Self-Pay Discount, Financial Assistance, or insurance programs; information concerning potential eligibility for the Self-Pay Discount, Financial Assistance, and public insurance programs and how to apply for such programs; statements of estimated or actual charges; notice of expiration of an extended payment plan; notice of intent to commence collection activities; and notice of collection policies.

I. RCH may require patients who have received financial assistance or discounted payment assistance (or their guarantors) to pay RCH any (a) funds received by the patient or guarantor from a third-party payor for RCH's services, or (b) any funds received from legal settlements, judgements or awards that includes payment for health care services or medical care related to an injury, up to the amount reasonably awarded for that purpose.

VIII. FINANCIAL ASSISTANCE / SELF PAY DISCOUNT METHODOLOGY

A. Documented income for all Financial Assistance must be at or below 400% of the FPL.
B. Discounted amounts will be based on the government fee schedules from Medicare or Medi-Cal, whichever is greater. At no time will a patient with documented income at or

below 400% of the FPL be charged for any amounts in excess of the Medicare or Medi-Cal fee schedule, whichever is greater.

C. If there is no established government fee schedule amount for a service provided to a patient eligible for Financial Assistance, RCH shall establish an appropriate discount on a case-by-case basis.

D. Reimbursement to be applied is as follows:

FEDERAL POVERTY LEVELS / RCH INCOME INDICATOR

Family Size	100%	200%	300%	350%	400%
1	A	A	B	C	D
2	A	A	B	C	D
3	A	A	B	C	D
4	A	A	B	C	D
5	A	A	B	C	D
6	A	A	B	C	D
7	A	A	B	C	D
8	A	A	B	C	D

1. Federal Poverty Levels are available at: https://www.healthcare.gov/glossary/federal-povertylevel-FPL/
2. Income must be equal to or below the amount in each column. Family Size is defined as:
   a. For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act, whether living at home or not.
   b. For persons under 18 years of age or for a dependent child 18 to 20 years of age, inclusive, parent, caretaker relatives, and parent 's or caretaker relatives' other dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act.

REIMBURSEMENT MATRIX

RCH INCOME INDICATOR	REIMBURSEMENT
A	Free Care - Charity Care
B	Patient amount due reduced to 50% of Medicare Fee Schedule
C	Patient amount due reduced to 75% of Medicare Fee Schedule
D	Patient amount due reduced to 100% of Medicare Fee Schedule

IX. ELIGIBILITY DETERMINATION LETTERS

Upon determination of a patient's eligibility for a Self-Pay Discount and/or Financial Assistance, RCH will issue a letter to the patient, which includes all of the following information:

A. A clear statement of RCH's determination of the patient's eligibility for a Self-Pay Discount and/or Financial Assistance.
B. If the patient was denied eligibility for a Self-Pay Discount and/or Financial Assistance, a clear statement explaining why the patient was denied a Self-Pay Discount, Charity Care, or both.
C. If the patient was approved for a Self-Pay Discount and/or Financial Assistance, a clear explanation of the reduced bill and instructions on how the patient may obtain additional information regarding a reasonable payment plan, if applicable.
D. Name of the hospital office, contact name, and contact information where the patient may appeal RCH's decision.
E. Information on the Hospital Bill Complaint Program, including the following statement:
   - The Hospital Bill Complaint Program is a state program, which reviews hospital decision about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.
F. Information on the Health Consumer Alliance, including the following statement:
   - Help Paying Your Bill: There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information.

ATTACHMENT B

OB COST-SAVER PACKAGE PLAN

REQUIREMENTS FOR ELIGIBILITY:

The entire cost must be paid on or before discharge. Please be advised that prices will apply to the date of admission, not the date of payment. The Cost-Saver Package Plan applies to patients having normal vaginal deliveries or Cesarean section patients, with no complications. Should either the mother or baby become ill, regardless of whether payment has been made or not, the discount will be nullified and the patient's financial class reverts to self-pay. Patients covered under insurance plans with **NORMAL MATERNITY COVERAGE** are **not eligible** for the OB Cost-Saver Package Plan. **No itemized billing will be provided.**

- Charges incurred for conditions unrelated to the maternity visit are not included in the original OB Cost-Saver Package Plan, i.e., Tubal Ligations and OBSERVATION visit.
- The hospital does not bill for, or include in its charges, fees for professional services rendered by independent contractors and more specifically those physicians and surgeons furnishing professional services to the patient, including the radiologist, pathologist, emergency room physicians, anesthesiologist, dentist, hearing screenings, podiatrist, and the like. **The undersigned understands that all such professional services will be billed separately.**

SUMMARY OF ELIGIBILITY REQUIREMENTS:

A. Payment in full on or before discharge. (Cash, Check, Cashier's Check, Money Order, Visa, MasterCard or American Express).
B. Normal delivery and a well-baby, or Cesarean section and a well-baby.
C. No insurance involved.

CASH PAYMENT SCHEDULES (Mother and baby charges combined):

		Mom & Baby
1 Day	Normal Delivery	$4,200
2 Days	Normal Delivery	$5,850
3 Days	Normal Delivery	$7,425
2 Days	Cesarean Section	$8,450
3 Days	Cesarean Section	$10,500

NOTE: Patients who elect to have tubal ligation must pay for this service on or before discharge along with the OB Cost-Saver Package Plan discount.

Any payment made by check written to Redlands Community Hospital and returned unpaid by the bank will void the OB Cost-Saver Package Plan discount. Prices are subject to change without notice. If you have any questions, please call (909) 335-6414.

ATTACHMENT C

PERINATAL SERVICES

1. Administrative Policy A.F2 (Financial (Patient) Policies) does not apply to the Perinatal Services program because the Perinatal Services program provides professional services only.
2. Lactation services are provided and billed using a fee-for service flat rate fee schedule. No self- pay discount is available for the professional fees for lactation services. Diabetes education and comprehensive perinatal education is provided using a hospital approved fee schedule. Self- Pay Patients with incomes at or below 400% FPL receiving diabetes education may receive a 50% self-pay discount. Comprehensive perinatal services are provided for Medi-Cal patients only and therefore do not qualify for a self-pay discount. When supplies are purchased as a self-pay/cash- pay, a 50% self-pay discount may apply.
3. Patients indicating, they qualify for and request a self-pay discount shall provide documentation of income as requested prior to service being rendered. Pay stubs, income tax returns, W2's or Bank Statements shall be provided to RCH as requested. In the event that the required documentation is not provided by the patient or patient representative, the discount may be denied on the grounds of failure to provide the requested information.

REDLANDS FAMILY CLINIC & YUCAIPA FAMILY CLINIC

1. Administrative Policy A.F2 (Financial (Patient) Policies) applies to the Redlands Family Clinic and Yucaipa Family Clinic, except as described below.
2. Financially Qualified Patients are eligible for sliding-scale discounts based on the matrix below. Some professional services and/or supplies may not be discounted and include, for example: a) the cost for external laboratory testing services, b) vaccines, c) immunizations, and d) tuberculosis screening and testing.
3. Documented income must be at or below 400% of the most current Federal Poverty Guideline (maintained at the clinic and available at: https://www.healthcare.gov/glossary/federal-poverty-level-FPL/.) to qualify for a discount. A patient with reported and/or verified income higher than 400% of the guideline would not qualify for a discount.
4. At no time will a Financially Qualified Patient be charged for any amounts in excess of the Medicare fee schedule. If there is no established government fee schedule amount for a service provided to a Financially Qualified Patient, RCH shall establish an appropriate discount on a case-by-case basis.

SLIDING-SCALE DISCOUNT MATRIX

Family Size	100%	200%	300%	350%	400%
1	1	1	1	2	3
2	1	1	2	2	3
3	1	1	2	2	3
4	1	2	2	3	4
5	1	2	3	3	4
6	1	2	3	3	4
7	1	3	3	3	4
8	1	3	3	3	4

- Federal Poverty Levels are available at: https://www.healthcare.gov/glossary/federal-povertylevel-FPL/
- Income must be equal to or below the amount in each column.
- Family Size is defined as: for persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act, whether living at home or not. For persons under 18 years of age or for a dependent child 18 to 20 years of age, inclusive, parent, caretaker relatives, and parent 's or caretaker relatives' other dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act.

DISCOUNT MATRIX - Income for all family members included in the family size (per above definitions). Apply the appropriate discount percentage based on the patient's income and family size using the sliding-scale discount matrix above.

PERCENTAGE DISCOUNT LEVELS

Discount Level	Discount Percent
1	Eighty Percent (80%) Discount Applied
2	Seventy Percent (70%) Discount Applied
3	Sixty Percent (60%) Discount Applied
4	Fifty Percent (50%) Discount Applied

2025 Inland Empire: Community Health Needs Assessment

Participating Hospitals:

Chino Valley Medical Center

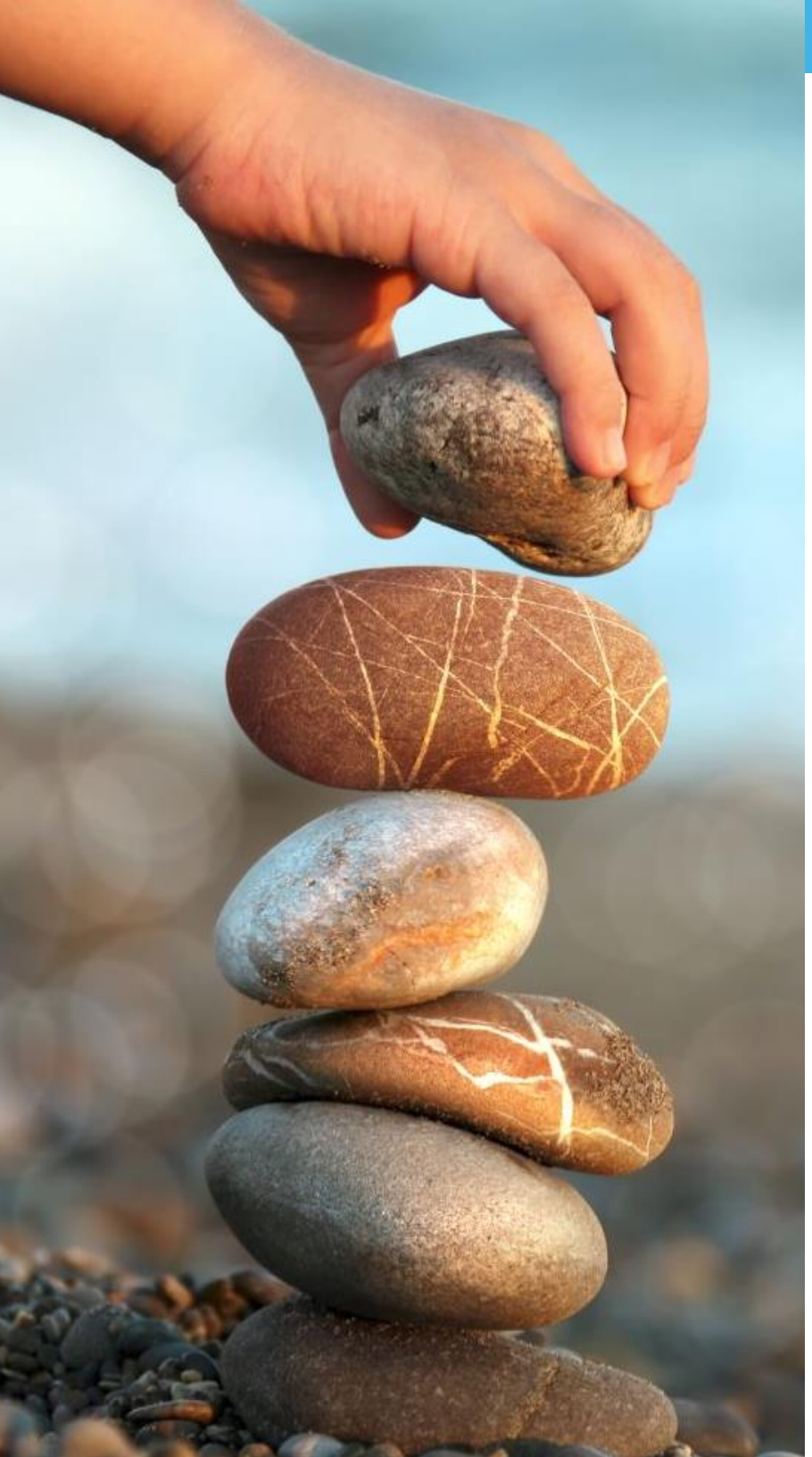
Montclair Hospital Medical Center

Redlands Community Hospital

SAN ANTONIO REGIONAL HOSPITAL

San Gorgonio Memorial Hospital

With technical assistance from: Communities Lifting Communities and HC2 Strategies



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Welcome

Dear Friends,

A Community Health Needs Assessment and its transformational tools bring an opportunity for renewal—a time to study our community's needs and think about new ways to support each other in our health and well-being.

This assessment will guide how our hospitals invest in community health over the next three years. **Beyond charts and numbers, it tells our community's story, the story of our neighbors, our families, and ourselves.**

The priorities you'll see in this report reflect the challenges we face together and are part of the ongoing work to ensure every community member has a chance to thrive. They consider not only the urgent health issues of **mental and behavioral health**, **cardiovascular and diabetes disease**, and **maternal and infant health,** but also the conditions that shape our well-being—**basic needs for health and safety** and **humane housing**. These are the foundations of a healthier future for us all.

Thank you for joining us on this journey. We hope you'll see yourself in our community's story and in the actions we'll take together to build a thriving Inland Empire for ourselves and generations to come.

Gail Aviado, CEO
Chino Valley Medical Center
Montclair Hospital Medical Center

Joyce Volsch, VP, Patient Care Services, Interim Hospital Administrator
Redlands Community Hospital

John T. Chapman, President & CEO
San Antonio Regional Hospital

Steve Barron, CEO
San Gorgonio Memorial Hospital

Executive Summary

Building Health Together in the Inland Empire

The Inland Empire Community Health Needs Assessment (CHNA) shines a light on both the challenges and opportunities facing the people of Riverside and San Bernardino counties.

This collaborative effort was led by Communities Lifting Communities (CLC), an affiliate of the Hospital Association of Southern California (HASC), in partnership with five local hospitals:

- Chino Valley Medical Center
- Montclair Hospital Medical Center
- Redlands Community Hospital
- San Antonio Regional Hospital
- San Gorgonio Memorial Hospital

What makes this report unique is that it combines data—on disease burden, vital conditions, and hospital utilization—with the voices of more than 11,000 residents, health care professionals, and community leaders.

Together, their insights paint a clear picture of what matters most to our region's health and highlight five shared priorities that can guide the way toward stronger, healthier communities. This CHNA report meets requirements of the Patient Protection and Affordable Care Act that nonprofit hospitals conduct a CHNA at least once every three years.

Burden of Disease

Across Riverside and San Bernardino counties, three health challenges stand out above all others:

Mental Health and Substance Use
Emotional, psychological, and social well-being, including depression, anxiety, and substance use

Cardiovascular and Diabetes Disease
Conditions affecting the heart and blood vessels, such as heart disease, heart attacks, and strokes, as well as health issues related to blood sugar regulation, including diabetes

Maternal and Infant Health
Health of mothers during pregnancy, childbirth, and postpartum, and the health and development of infants

Vital Conditions That Shape Community Health

Beyond specific diseases, the CHNA points to two vital conditions that strongly influence the community's well-being:

Basic Needs for Health and Safety
Access to routine health care and healthy foods.

Humane Housing
Safety, affordability, diversity, proximity, and adequate space.

Executive Summary

Factors Contributing to Inequities

The CHNA is grounded in equity, with a commitment to ensuring every community member has the chance to thrive. Through community input, several groups emerged as especially vulnerable to health challenges and barriers to care:

Financial and Housing Barriers
- Individuals experiencing homelessness
- People living with economic hardship
- Those facing insurance gaps and access barriers

These are community members who struggle to meet basic needs, such as housing, income, or affordable health care.

Challenges Across Life Stages
- Youth, navigating critical growth and development
- Older adults managing aging, independence, and chronic conditions

Different ages bring different needs. Supporting both the youngest and the seniors is key to building a healthy community.

Inequities Related to Race, Ethnicity, Gender, and Other Factors
- Communities of color
- Women, who encounter gender-specific health challenges

The Inland Empire's diversity is a strength, but systemic and historic inequities mean that not everyone has the same chance to thrive.

Partnering for Change: What's Ahead

The insights from this CHNA will shape the hospitals' Community Health Improvement Plans (CHIPs), ensuring that strategies truly reflect community priorities.

Moving forward, success will rely on working together—hospitals, public health agencies, community organizations, and community members—joining forces to create equity-focused solutions that uplift health and well-being in the Inland Empire.

This report was created for the Inland community. **Together, we can turn these findings into action and build a healthier, stronger future for all.**

2025 Inland Empire Community Engagement

In 2025, the Inland Empire CHNA process was strengthened through deep collaboration with regional partners.

Communities Lifting Communities and the five hospitals worked alongside the Inland Empire Behavioral Health Collaborative and the CalAIM PATH Collaborative Planning and Implementation group, which brings together providers delivering Enhanced Care Management and Community Supports to Medi-Cal members with complex health and social needs.

In partnership with San Bernardino and Riverside County Departments of Public Health, as well as hospitals and managed care plans across the region, the hospitals gathered insights from key informant interviews and focus group conversations. These collective contributions informed the development of the CHNA and will continue to guide shared efforts to improve community health across the Inland Empire.

Thank You to Our Partners:

Counties
Riverside University Health System Public Health
San Bernardino County Department of Public Health

Collaboratives
CalAIM PATH Collaborative Planning and Implementation group and Steering Committee (including Enhanced Managed Care and Community Support providers)
Inland Empire Behavioral Health Collaborative

Hospitals
Dignity Health: Community Hospital of San Bernardino and St. Bernardine Medical Center
St. Mary Medical Center, Apple Valley
Kaiser Permanente Fontana
Kaiser Permanente Ontario
Kaiser Permanente Riverside
Loma Linda University Health
Hospital Association of Southern California

Medi-Cal Managed Care Plans
Inland Empire Health Plan
Molina Healthcare

About This Assessment

Every three years, hospitals must conduct a CHNA, a process that gathers data and community voices to identify health priorities for the next three years. This report highlights those needs and outlines next steps for action, guiding hospitals and partners toward solutions that improve health across the region.

Participating Hospitals

This CHNA was developed through a unique collaboration among five hospitals serving the Inland Empire:

- Chino Valley Medical Center
- Montclair Hospital Medical Center
- Redlands Community Hospital
- San Antonio Regional Hospital
- San Gorgonio Memorial Hospital

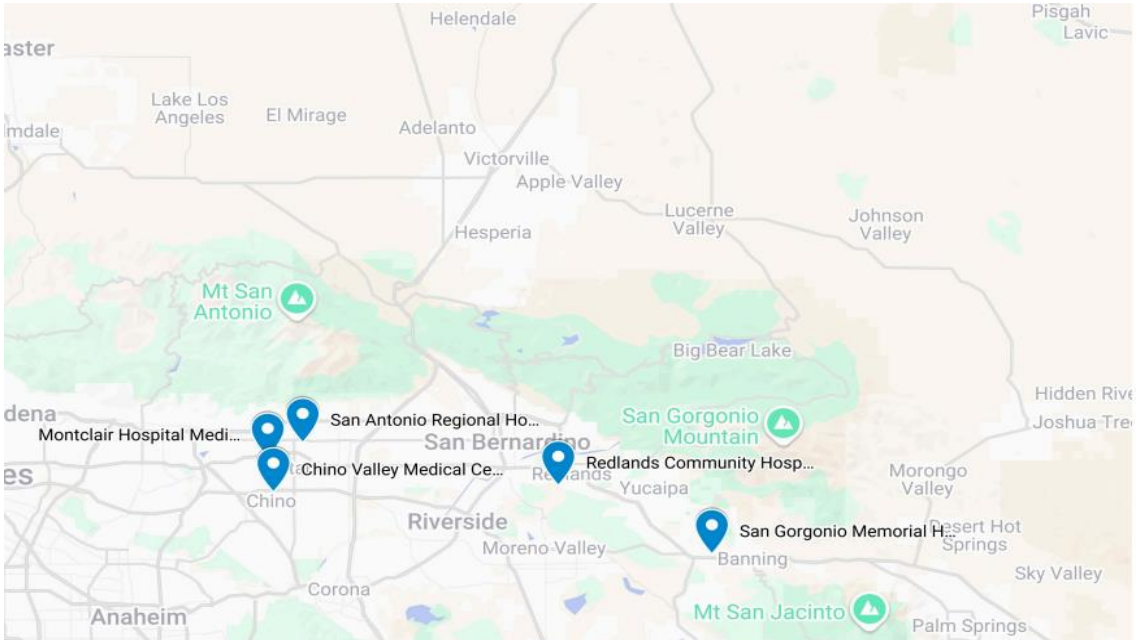
While each hospital has its own service area, they share a common goal of improving health outcomes across Riverside and San Bernardino counties. By working together in a collaborative CHNA, these hospitals are able to pool resources, gather broader community input, and identify shared priorities that encompass individual service areas. This alignment strengthens the region's capacity to address health disparities, leverage partnerships, and design solutions that are more coordinated and impactful.

At the end of this report, a profile highlights the hospital's primary service area and provides a snapshot of the community it serves.

The Inland Empire Community:

The Inland Empire covers 27,000 square miles across Riverside and San Bernardino counties, about 16% of California's landmass. It is home to 4.7 million residents and is one of the state's fastest-growing regions. Growth driven by affordability and opportunity continues to outpace much of California. Without action, existing health disparities and poor outcomes will deepen as the population expands. The following chapter describes the community demographics.

The Inland Empire is a designated Medically Underserved Area (MUA) and a Health Professional Shortage Area (HPSA) for Primary Care, Dental Health and Mental Health.



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Inland Empire Community Profile

A Snapshot of the People: Demographics and Life Expectancy

The Inland Empire is a young and increasingly diverse region, with **nearly 37% of residents under 25 years old**. Over the past decade, the White population has declined while **Hispanic and Latino communities have grown** to become the largest group, reflecting the region's shifting demographics and cultural vibrancy. Yet, life expectancy remains slightly **below the state average,** showing that even as diversity and youth bring new strengths, work remains to ensure all communities can thrive.

Demographics and life expectancy compared to state benchmarks:

4,704,354 Population of the Inland Empire *(California: 39,538,223)*

37% Residents under 25 years old *(California: 30%)*

34% White | 28% Other Race | 22% Two or More Races | 8% Asian | 7% Black

53% Hispanic or Latino Ethnicity *(California: 39%)*

79 Years Life expectancy *(California: 81.7 years)*

Sources:
US Census, 2023, https://data.census.gov/
Institute for Health Metrics and Evaluation, 2019, https://www.healthdata.org/

Inland Empire Community Profile

The Conditions Shaping Lives: Income, Poverty, Unemployment

In the Inland Empire, many families are doing well, with a **median household income of $91,500**, higher than the state overall. Still, about **1 in 8 residents lives below the poverty line**, showing that not everyone shares in this stability. The **unemployment rate of 4.8%** is slightly better than California's, pointing to steady job opportunities. These numbers show that while many households in the Inland Empire are doing well, too many neighbors still face economic struggles. Addressing these gaps is key to building a healthier, more stable future for families right here in our community.

Median household income, poverty level, and unemployment rate compared to state benchmarks:

$91,500 Median household income of the Inland Empire
(California: $86,600)

12.2% Residents living below the poverty level
(California: 12%)

4.8% Unemployment rate
(California: 5%)

Sources:
US Census, 2023, https://data.census.gov/
US Bureau of Labor Statistics, 2023, https://www.bls.gov/lau/tables.htm#cntyaa

Inland Empire Community Profile

Barriers and Opportunities for Health: Insurance and Access to Care

Health insurance makes a big difference in whether people can receive the care they need. In the Inland Empire, just **over half of residents (56.8%) have commercial insurance**, while many rely on the public programs **Medi-Cal (40%) and Medicare (16.2%)**. A smaller group (4.1%) are enrolled in both Medicare and Medi-Cal. Still, **8% of people in the region do not have insurance**, which is higher than the state average of 6.4%. Being uninsured makes it harder to see a doctor, stay on top of preventive care, and receive treatment when it is needed most. Closing this gap is an opportunity to help more people stay healthy and reduce health problems down the road.

Insurance payer mix breakdown for the Inland Empire:

56.8%	Commercial insurance recipients
40.0%	Medi-Cal recipients
16.2%	Medicare recipients
4.1%	Dual-eligible recipients
8.0%	Uninsured *(California: 6.4%)*

Sources:
US Census, 2023, https://data.census.gov/
California Health and Human Services, https://data.chhs.ca.gov/dataset/medi-cal-certified-eligibles-with-demographics-by-month/resource/2c28bf78-a385-4d0c-88d5-7d1eef09a5ab
Centers for Medicare and Medicaid Services, https://data.cms.gov/tools/medicare-enrollment-dashboard

Projected Impacts of the Budget Reconciliation Bill in the Inland Empire

Passed by Congress in July 2025, the Budget Reconciliation Bill cuts the public health insurance program, Medicaid, reduces Affordable Care Act coverage, and redirects billions, threatening health care access in the Inland Empire.

Coverage Losses

281,092 Medi-Cal members are at risk of losing coverage (14.4% reduction), and **67,088 residents** could lose Covered California insurance.

Economic Impacts

The Inland Empire economy is projected to experience a **$1.07 billion loss** from the Inland Empire Health Plan (IEHP) membership decline and **$4 billion–$8 billion losses** to Inland Empire hospitals.

Community Consequences

Job losses, longer wait times, and **reduced health care access** are expected across the region.

These projected losses underscore the needs for strong community partnerships and innovative solutions to care.

Sources

- IEHP CEO LinkedIn post, July 2025
- IEHP Medicaid Economic Impact
- Congressional Budget Office report, June 24, 2025
- Certified Medi-Cal eligibles, by month
- California Hospital Association Summary and Impact Estimate On One Big Beautiful Big Bill
- Updated employment multipliers for the U.S. economy

Community Health Insights: The 2025 CHNA

- How This Report Was Created
- Burden of Disease
- Vital Conditions
- Voices of the Community
- Prioritization of Community Needs
- 2025 CHNA Priorities

How This Report Was Created

This report combines community indicators and voices to identify health needs across the Inland Empire. Hospitals reviewed and discussed the findings through a series of five meetings from May through September 2025. In the final session, partners validated and confirmed the priority issues for the region.

Community Indicators

Includes burden of disease, vital conditions, and hospital utilization measures. *Data is provided in each of the priority areas in the main report and in Appendixes B, C and D.*

Burden of Disease and Vital Conditions

Quantitative data was collected from a variety of sources and organized into the two following frameworks:

1. **Burden of Disease:** Shows the main health problems affecting people in the community, such as heart disease or diabetes.
2. **Vital Conditions for Well-Being:** Highlights seven social and environmental drivers that shape the health and well-being of people and communities.

Together, these provide both the immediate picture of health challenges and the bigger view of what helps communities stay healthy over time.

Hospital Utilization Data

Hospital utilization data is local hospital data that reveals gaps in care and highlights whether services are effective and equitable across populations. Including this perspective reflects both the community's health needs and how well the system is meeting them.

Community Voices

Includes a region-wide survey and an analysis of findings from existing health assessments across the Inland Empire. *Data is provided in each of the priority areas and in Appendixes E and F.*

Health and Well-Being Survey

A 15-question region-wide well-being survey was conducted between May and July 2025 to capture the voices of community members directly. The survey helps identify how people are experiencing health and quality of life, grouping responses into three categories—thriving, suffering, or struggling. It also highlights differences across populations and uncovers strengths and challenges that may not appear in hospital or public health data alone. By gathering this input, the CHNA reflects both the data and the lived experiences of residents.

Other CHNA/CHAs in the Region

Findings from other community health assessments, including key informant interviews, surveys and focus groups across the Inland Empire, were reviewed and analyzed. Partner organizations included Kaiser Permanente, Dignity Health, Loma Linda University Health, Riverside University Health System Public Health, and San Bernardino County Department of Public Health. By drawing on this shared knowledge, the CHNA builds on existing work and strengthens alignment across the region.

Community Indicator: Burden of Disease
12 Domains | 75+ Indicators

An Introduction to the Burden of Disease Framework

The Burden of Disease Framework provides a full picture of what's affecting the community's health — not just in terms of deaths, but in sickness, disability, and quality of life. It organizes health challenges (illnesses, injuries, risk factors) into clear domains to reveal which problems are the biggest, where there's room to improve, and which populations might be falling behind.

Definition

Burden of disease is defined as death and loss of health due to diseases, injuries, and risk factors that reflect leading causes of morbidity and mortality. As community stewards, it's important to understand the burden of disease impacting the communities we serve and the unequal distribution.

How it Works

The framework is divided into the 12 domains. For the purposes of this CHNA, Mental and Behavioral Health is renamed to Mental Health and Substance Use. Each domain is measured by indicators, such as rates of disease, deaths, risk factors, and outcomes, which are drawn from public, reliable data sources.

Burden of disease data is provided in the Priority Areas section of this report and in Appendix B.

Community Indicator: Vital Conditions

An Introduction to the Vital Conditions

The Vital Conditions Framework illustrates the building blocks that allow people and communities to thrive. Instead of focusing only on illness, it looks at the broader conditions that shape health over time, such as housing, education, environment, and economic stability. Viewing health through this wider lens shows not just where people are struggling, but also where investments can create long-term improvements in health and well-being.

How it Works

The framework is made up of seven "vital conditions" for well-being that capture essential aspects of daily life. When these needs are not met, people face greater risks of illness and instability. Evaluating vital conditions data by populations and places reveals inequities and opportunities for collaborative efforts to ensure every community member can thrive.

Vital conditions data is provided in the Priority Areas section of this report and in Appendix C.

Thriving Natural World: Sustainable resources, connect with nature, freedom from hazards	**Basic Needs for Health and Safety:** Access to health care and healthy foods
Humane Housing: Adequate space, safety, affordability, diversity, proximity	**Meaningful Work and Wealth:** Rewarding work, careers, and standards of living
Lifelong Learning: Continuous learning, education, literacy, and development	**Reliable Transportation:** Close to work, school, food, and leisure; safe; active; and efficient
Belonging and Civic Muscle: Social support, civic association, freedom from discrimination and oppression; central to all conditions	

Voices of the Inland Empire Community

A regional health and well-being survey was distributed to capture community perspectives and experiences. In a separate effort, hospitals and agencies across the Inland Empire, including Kaiser Permanente, Dignity Health, Loma Linda University Health, St. Mary Medical Center, Riverside University Health System Public Health, and San Bernardino County Department of Public Health, shared findings from their own CHNAs, surveys, interviews, and focus groups. Taken together, these sources create a fuller picture of community needs and support a more coordinated approach to improving health. The following chapter highlights key insights from this data.

2025 Regional Health and Well-Being Survey

291

Community Survey Respondents

Community members participated in the regional survey, conducted in both English and Spanish across the Inland Empire

Existing CHNA/CHAs in the Region—Combined Voices

11,485

Community Survey

Community members engaged in community surveys by Riverside University, San Bernardino County and St. Mary Medical Center

212

Community Conversations

Community members participated in 25 focus groups hosted by Dignity Health, and Loma Linda University Health

101

Interviews with Key Informants

Key informant interviews across Kaiser, St. Mary Medical Center, Dignity Health, and Loma Linda University Health

Health and Well-Being Survey

Community Participation

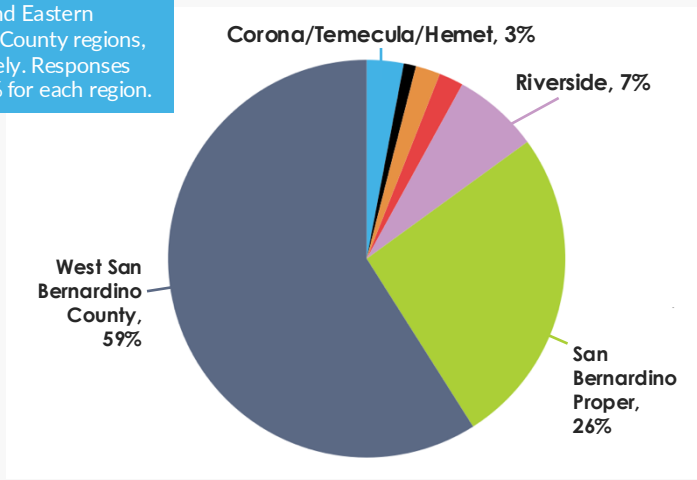
Statistics do not tell the whole story. To further understand the health of the community, **a region-wide health and well-being survey was distributed between May and July 2025.** A total of 319 community members participated, with the survey offered both online and on paper in English and Spanish. After data cleaning, 291 responses were analyzed. The survey included core questions from the Institute for Healthcare Improvement (IHI) and Gallup, allowing local findings to be compared with a national benchmark for thriving. These insights provide valuable context for identifying community priorities and guiding action in this CHNA.

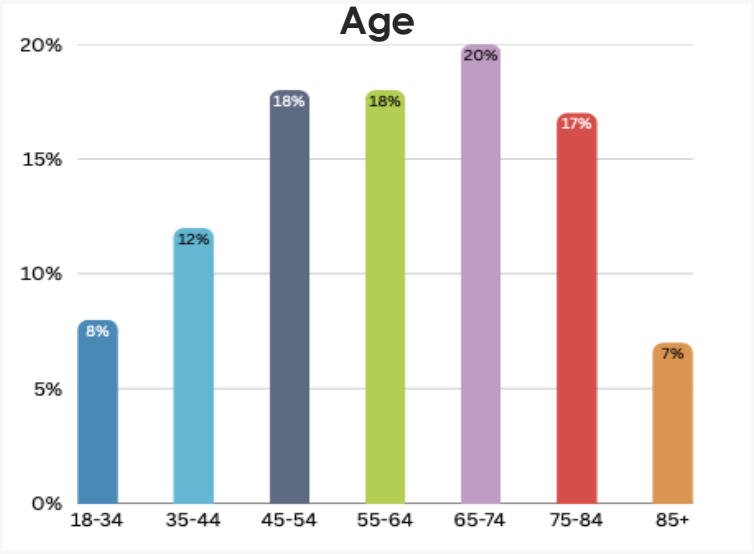
Although this report is evidence-based and contains many statistics, we acknowledge data limitations. Community input is limited to the those who participated in the survey and may not fully represent Inland Empire demographics, strengths, and challenges.

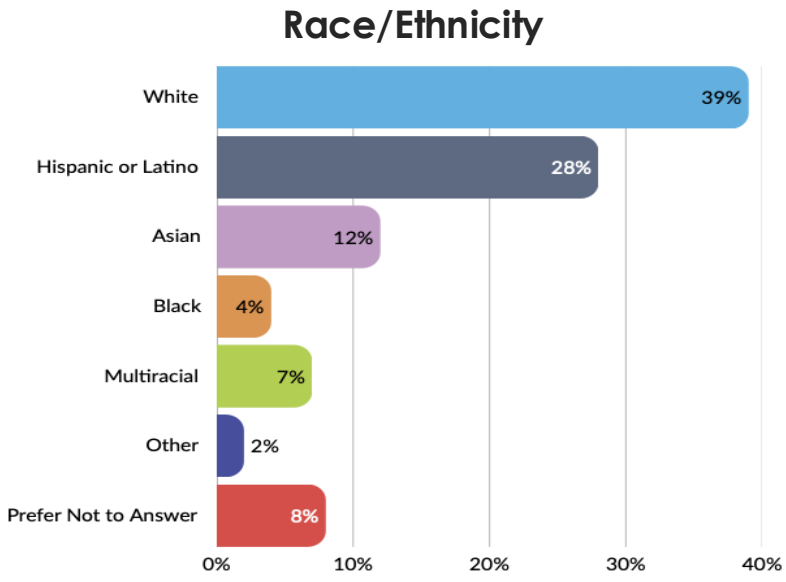
Additional information on the survey process and questions is available in Appendix F.

2025 Health and Well-Being Survey participants:

*The red, orange, and black sections represent the High Desert, Low Desert, and Eastern Riverside County regions, respectively. Responses were <2% for each region.







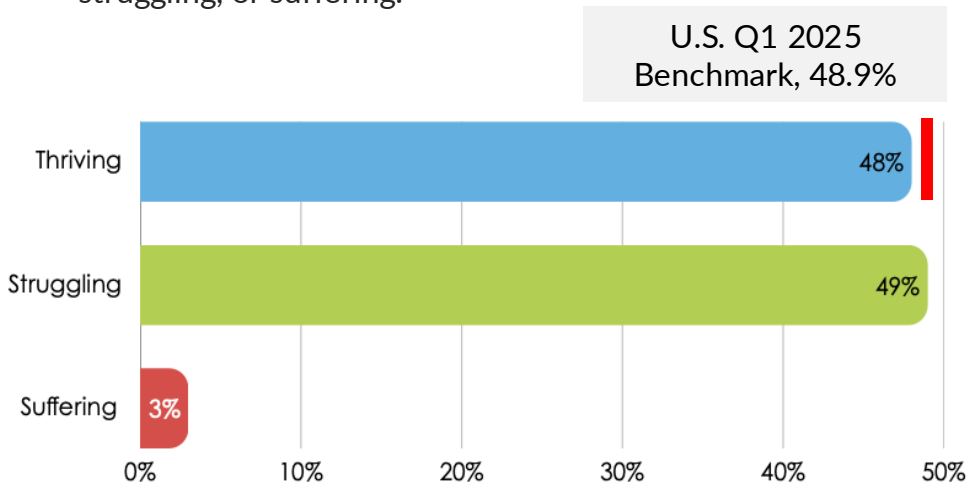
Health and Well-Being Survey

What the Community Said

The survey revealed that not all community members are thriving equally. Respondents in the San Bernardino Proper, East Riverside County, and desert regions reported thriving at a lower percentage than the national benchmark. Younger adults, older residents, and men reported thriving at lower levels, while Black, multiracial, LGBTQ+, and lower-income respondents reported suffering at higher levels. This serves as a reminder that health is not only about treating illness but also about creating the conditions for people to thrive. Moving forward, equity, stronger community supports, and inclusive strategies are essential to improving well-being for those most at risk.

Thriving, Struggling & Suffering in the Inland Empire

The Cantril ladder measures well-being by asking people to rate their lives today and in five years on a 0-10 scale and sorts them into three groups based on their answers: thriving, struggling, or suffering.



Gallup: Americans' Life Ratings Slump to Five-Year Low

2025 Health and Well-Being Survey participant insights compared to the Inland Empire for Thriving (48%) and Suffering (3%):

Region	Lower thriving percentages reported in **San Bernardino Proper, East Riverside County, and desert regions.**
Age	**18-34** and **over 85** age groups recorded higher percentages of suffering.
Race and Ethnicity	**Blacks and multiracial respondents** reported higher rates of suffering than other races.
Household Income	Respondents with **annual household income under $49,999** reported higher rates of suffering.
Educational Attainment	Lower thriving percentages reported in those with a **high school diploma or GED, and Associate's degree.**
Gender	**Men** reported lower thriving rates.
Sexual Orientation	**Lesbian, gay, bisexual, and asexual respondents** recorded thriving at a lower percentage.

Additional Well-Being Survey methodology information and results are provided in Appendix F.

Other CHNAs and CHAs in the Region

Empowering Community Voices through Collaboration with Other Organizations

In addition to the survey, data was reviewed from surveys, key informant interviews, and focus groups included in other CHNAs and CHAs across the region. Sources included:

- Riverside University Health System Public Health
- San Bernardino County
- Kaiser Permanente
- Dignity Health
- Loma Linda University Health
- St. Mary Medical Center

Collaboration across hospitals and health systems strengthens this work. **When data and insights are shared regionally, a fuller picture of community needs emerges.** This alignment prevents duplication and builds a stronger foundation for collective solutions, ensuring that efforts to improve health are coordinated, equitable, and impactful.

Cross-Cutting Themes:

- Mental health—depression and anxiety among youth
- Substance use disorder
- Chronic disease—diabetes, obesity, respiratory, heart
- Financial strain—job and income loss
- Unemployment and lack of job skills training
- Health professional shortage
- Housing affordability
- Lack of walkability, green spaces, and safe neighborhoods
- Access to affordable, culturally sensitive health care
- Oral health
- Sexual health
- Violence
- Educational opportunities

Riverside University Health System

Community Survey
- 4,804 adults participated in a paper survey distributed across Riverside County

San Bernardino County

Community Survey
- 6,210 engaged community members in a county-wide community themes and strengths assessment (CTSA) survey

Kaiser Permanente

Key Informant Interviews
- 18 key informant interviews conducted in April-August 2024
- 10 key informant interviews conducted in June 2024

Dignity Health

Focus Groups
- 4 focus groups were conducted with a total of 62 community members participating

Key Informant Interviews
- 11 community stakeholders took part in a phone interview

St. Mary Medical Center

Community Survey
- 471 surveys completed

Key Informant Interviews
- 46 interviews were conducted from May to November 2023

Loma Linda University Health

Focus Groups
- 21 focus groups were conducted with 150 participants

Key Informant Interviews
- 16 in-depth interviews were conducted with regional leaders in public health, education, housing, transportation, behavioral health, nonprofit services, faith-based ministries, and local government

Additional CHNA and CHA details are provided in Appendix E.

Health Assessment Crosswalk

The crosswalk highlights how priorities from this assessment align with other regional CHNAs and CHAs led by counties, hospitals, and health organizations. Alignment ensures community needs are seen in a broader context, strengthens collaboration, reduces duplication, and directs resources toward coordinated strategies that improve community health.

	San Bernardino County	Riverside University Health System	Kaiser Permanente — Fontana, Ontario and Riverside	Dignity Health – Community Hospital of San Bernardino, and St. Bernardine Medical Center	Loma Linda University Health	St. Mary Medical Center, Apple Valley
Mental-Behavioral Health*	X	X		X		X
Injury and Violence Prevention	X					
Chronic Disease *	X					X
Shortage of Health Professionals *		X				
Access to Care*		X	X		Basic Needs for Health and Safety	X
Housing *			X	X		
Substance Use *				X		
Income and Employment			X		Lifelong Learning, and Work and Meaningful Wealth	
Thriving in a Natural World					Strengthening environmental stewardship across their health system	

**Included in priority areas in this CHNA*
More information from the CHNAs and CHAs is provided in Appendix E.

Prioritization of Community Needs

The Prioritization Process

Listening to the Community

Hospitals began by reviewing local health data and invited community stakeholders to share perspectives through a prioritization survey. Participants identified the most pressing issues and the populations most impacted.

Gathering Input

The survey was shared with key community partners and discussed in regional collaboratives and meetings. Voices from across the Inland Empire, not just the numbers, were included in shaping the process.

How It Was Analyzed

Votes were counted for each identified priority, and scores were averaged across rating criteria, including severity, community concern, opportunities for collaboration, availability of solutions, and funding opportunities. Populations noted as disproportionately impacted were grouped into themes.

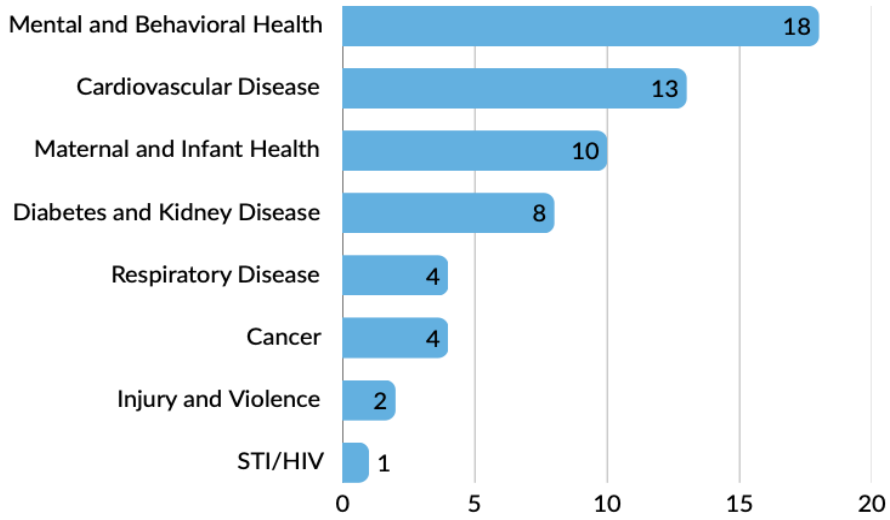
Agreeing on Priorities

Hospitals validated the results and reached consensus on the top regional priorities. The outcome reflects both data and lived experience, creating a strong foundation for collective action.

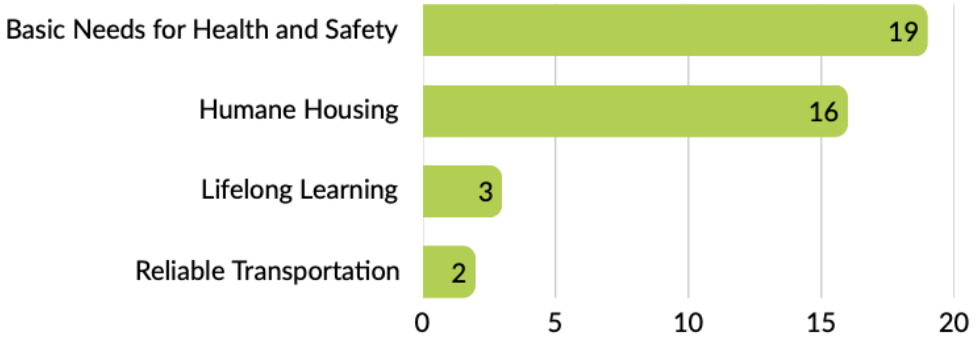
More information about the prioritization methodology and survey results is provided in Appendix G.

Prioritization Survey Results

Burden of Disease by Vote:



Vital Conditions by Vote:



Factors Contributing to Inequities

Most Impacted Populations Identified in the Prioritization Process

The CHNA is grounded in equity, with a commitment to ensuring every community member has the chance to thrive. Through community input, several groups were identified as being more affected by health challenges and barriers to care. These main groups were organized into three main categories that highlight the factors contributing to poorer health outcomes and widening health disparities.

The Inland Empire community's diversity is a strength, but systemic inequities mean that not everyone has the same chance to thrive.

Financial and Housing Barriers

- Individuals experiencing homelessness
- People living with economic hardship
- Those facing insurance gaps and access barriers

Challenges Across Life Stages

- Youth, navigating critical growth and development
- Older adults, managing aging, independence, and chronic conditions

Inequities Related to Race, Ethnicity, Gender, and Other Factors

- Communities of color
- Women, who encounter gender-specific health challenges

5 Strategic Health Priorities for 2026-2028

Based on the prioritization criteria, the hospitals identified five overarching strategic priorities for the next three years:

Burden of Disease

Mental Health and Substance Use
Emotional, psychological, and social well-being, including conditions such as depression, anxiety, and substance use

Cardiovascular and Diabetes Disease
Conditions affecting the heart and blood vessels, such as heart disease, heart attacks, and strokes, as well as health issues related to blood sugar regulation, including diabetes

Maternal and Infant Health
Health of mothers during pregnancy, childbirth, and postpartum, and the health and development of infants

Vital Conditions

Basic Needs for Health and Safety
Access to health care and healthy foods

Humane Housing
Adequate space, safety, affordability, diversity, proximity

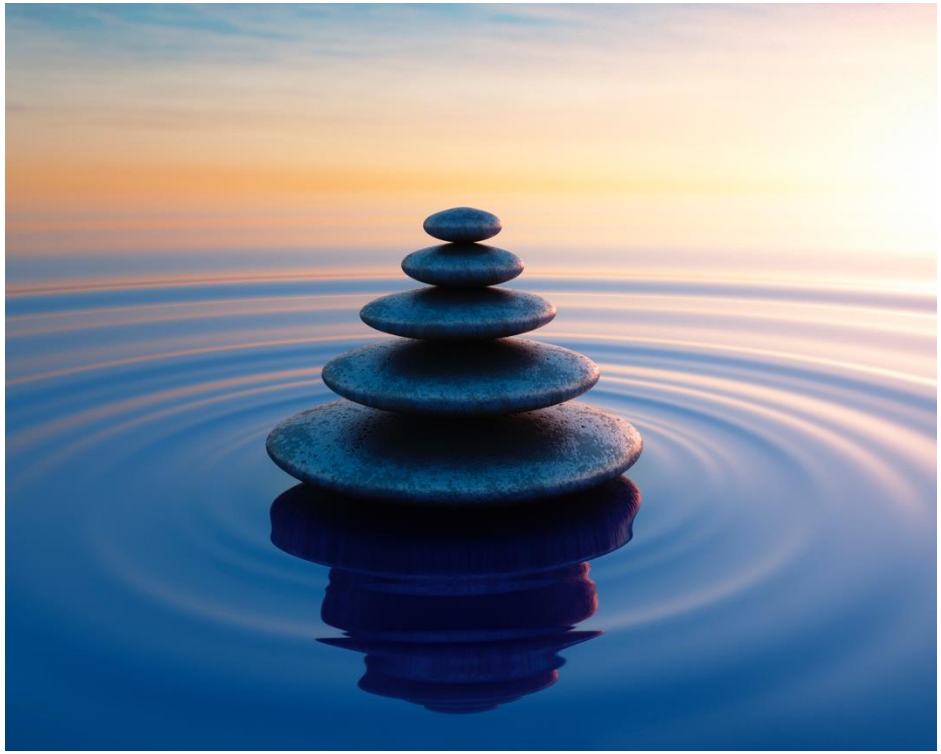
Looking Ahead: Addressing Community Health Needs
The hospital will build on the 2025 CHNA by developing a new Community Health Improvement Plan (CHIP) for 2026–2028. This three-year plan will set clear goals and strategies, guided by community strengths and input, and will be developed in collaboration with partner organizations. Once finalized, the report will be publicly available on the hospital's websites.

Priority Area 1: Mental Health and Substance Use

Mental Health and Substance Use

What is Mental Health and Substance Use?

Mental health refers to emotional, psychological, and social well-being, including conditions such as depression, anxiety, and substance use. It influences how stress is managed, how relationships are formed, and how decisions are made. Substance use refers to alcohol, prescription medications, or drugs that, when misused, can negatively impact health and daily life. These issues often overlap, as challenges with mental health can lead to substance use, and substance use can worsen mental health.



Inland Empire mental health and substance use benchmarks compared to state benchmarks:

39.9 per 100k	People reporting suicidal ideation *(California: 35.0 per 100k)*
39.5 per 100k	People at risk for severe depression *(California: 32.8 per 100k)*
19.2 per 100k	Deaths due to substance use disorders *(California: 17.2 per 100k)*

What the Numbers Are Telling Us

Across the Inland Empire, more people are struggling with suicidal thoughts and symptoms of severe depression than in California overall. The region also experiences a heavier toll from substance use disorders, with deaths occurring more often here than statewide. Together, these patterns point to the significant impact of mental health and substance use on the community.

Sources:
Mental Health America, 2024, https://mhanational.org
Institute for Health Metrics and Evaluation 2019, https://www.healthdata.org/

Mental Health and Substance Use

Local Hospital Utilization

Since 2022, **general acute inpatient hospital admissions for behavioral health conditions have risen by 4,000.**

Well-Being Survey Input

Youth aged 18-34, residents earning less than $35,000 year, and **Black residents** reported the lowest mental health scores.

Other Regional Assessments

4 health care organizations in the region identified mental health and substance use as a top health concern for the community.

Community Partners' Input on Populations Most Impacted

- Older Adults
- Youth
- Hispanic/Latino
- Older Black Communities
- LGBTQ+
- Single Adults
- Homeless
- Low-Income
- Disabled
- Undocumented
- Uninsured

What This Means

Mental health and substance use are top concerns in the Inland Empire, with a growing demand for care, and community input highlighted the impacts on low income, youth, and communities of color. This issue is a top concern for four additional health organizations in the region.

Sources:
CDC: Places, 2022, https://www.cdc.gov/places/index.html
California Department of Health Care Access and Information, 2021-2024 https://hcai.ca.gov/data/data-and-reports/
Speedtrack, 2021-2024, https://speedtrack.com/healthcare/

Our Community Story

Addressing mental health and substance use saves lives, reduces hospitalizations, and builds healthier families.

Both community indicators and community voices underscore the urgency of this issue. Community indicators show that the region experiences higher rates of suicidal ideation, severe depression, and deaths due to substance use disorders than the state overall, while hospital data reveals a troubling rise in general acute inpatient behavioral health utilization.

Community voices add further context, with youth aged 18-34, residents earning less than $35,000 year, and Black residents reporting the lowest mental health scores. There is broad agreement across the region that mental health and substance use are pressing issues, with three health care organizations identifying them as priority areas.

Based on community voices, mental health and substance use weigh most heavily on:

- **Black**
- **Low-income**
- **Youth**

What Community Partners Said

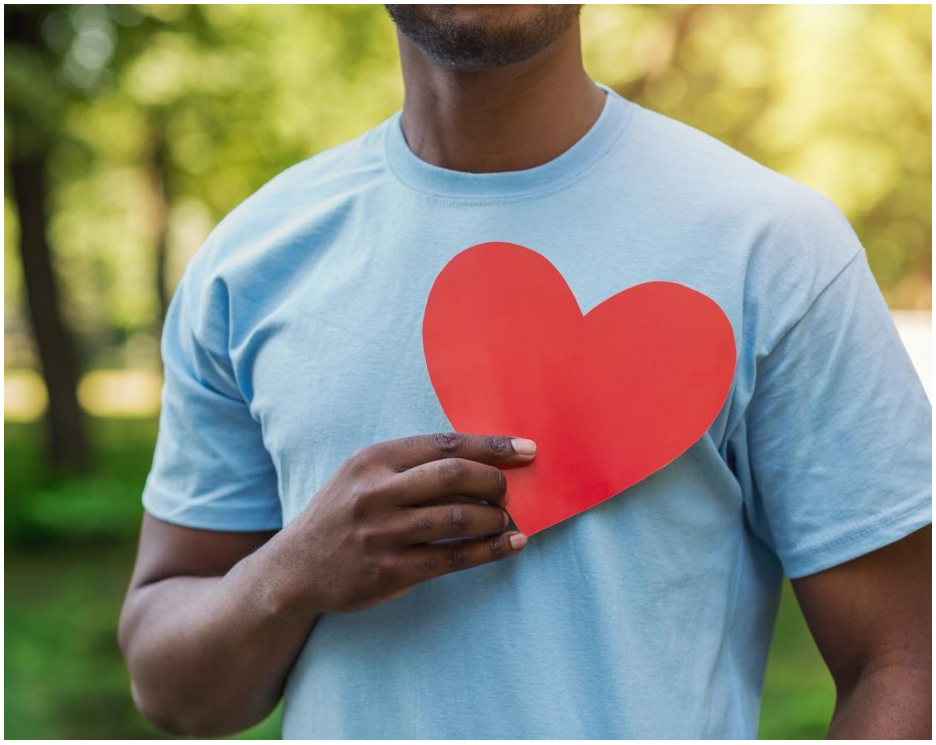
Community partners recognize mental and behavioral health as a highly severe issue. They point to limited community capacity, collaboration, evidence-based practices, and funding as ongoing challenges, highlighting significant gaps that must be addressed to strengthen support for action.

Priority Area 2: Cardiovascular and Diabetes Disease

Cardiovascular and Diabetes Disease

What Is Cardiovascular and Diabetes Disease?

Cardiovascular disease refers to conditions that affect the heart and blood vessels, such as heart disease, heart attacks, and strokes. Diabetes is a condition where the body has trouble regulating blood sugar, which over time can damage the heart, kidneys, eyes, and nerves. These are chronic diseases that affect the body's ability to circulate blood and maintain energy. They are closely linked, as diabetes significantly increases the risk of developing cardiovascular disease.



Inland Empire cardiovascular and diabetes disease benchmarks compared to state benchmarks:

24 per 100k	Deaths due to hypertensive heart disease *(California: 15.7 per 100k)*
24.8 per 100k	Deaths due to type 2 diabetes *(California: 21.2 per 100k)*
10.2%	Adults 20 or older told by a provider they have diabetes (excluding gestational) *(California: 9.4%)*

What the Numbers Are Telling Us

Across the Inland Empire, more people are affected by hypertensive heart disease and type 2 diabetes than in California overall. The region also has a higher share of adults who report being diagnosed with diabetes compared to the state. Together, these patterns highlight the significant impact of cardiovascular disease and diabetes on the community.

Sources:

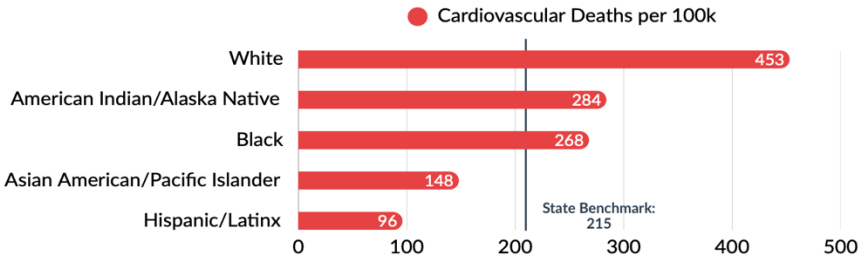
CDC: Wonder, 2022, https://wonder.cdc.gov/

CDC: United States Diabetes Surveillance System, 2019, https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html

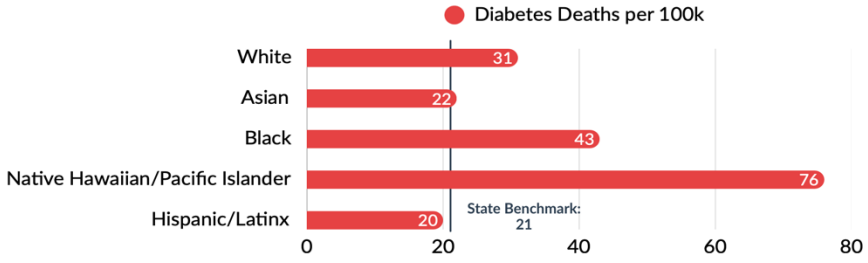
Cardiovascular and Diabetes Disease

How Health Differs for People of Different Races and Ethnic Backgrounds in the Inland Empire

Disparity Gap
White residents experience cardiovascular death rates **more than 2 times** the state benchmark and **nearly 5 times** higher than Hispanic/Latinx residents.



Disparity Gap
Native Hawaiian/Pacific Islander residents face diabetes death rates **more than 3 times the state benchmark,** while Hispanic/Latinx residents have the lowest.



Source:
Institute for Health Metrics and Evaluation, 2019, https://www.healthdata.org/

Other Regional Assessments

2 health care organizations in the region identified chronic disease as a top health concern for the community.

Community Partners' Input on Populations Most Impacted

- Black
- White
- Hispanic/Latino
- Underserved regions
- Non-citizens
- Women
- Low-income
- Uninsured
- Age (general), seniors and youth
- People living with chronic illness: obesity, diabetes
- Homeless

What this means

Cardiovascular disease and diabetes are top concerns in the Inland Empire, with sharp racial disparities and higher death rates and diagnoses compared to the state. Chronic disease has also been identified as a priority by two health care organizations in the region.

Our Community Story

Inland Empire residents face higher death rates from cardiovascular and diabetes disease than Californians overall.

Community indicators show that the region experiences higher rates of deaths due to hypertensive heart disease and type 2 diabetes. In addition, 1 in 10 adults over the age of 20 have been diagnosed with diabetes.

Heart disease and diabetes affect the community unevenly. White residents experience cardiovascular deaths at rates more than two times the state average. Meanwhile, Native Hawaiian and Pacific Islander residents face diabetes deaths more than three times the state benchmark. Two health care organizations across the region have identified chronic disease, which includes cardiovascular and diabetes disease, as an urgent priority.

Based on community indicators, and voices, cardiovascular and diabetes disease weigh most heavily on:

- **White**
- **Black**
- **American Indian/Alaska Native**
- **Native Hawaiian/Pacific Islander**

What Community Partners Said

Community partners recognize cardiovascular disease as a critical and pressing health concern. They point to strong community capacity and promising funding opportunities as key strengths, while noting that collaboration and the consistent use of evidence-based practices remain areas for further growth.

Priority Area 3: Maternal and Infant Health

Maternal and Infant Health

What is Maternal and Infant Health?

Maternal and infant health focuses on the well-being of mothers during pregnancy and childbirth and after delivery, as well as the health and development of infants. It includes access to quality prenatal and postnatal care, safe and supportive birthing experiences, good nutrition, and resources that help prevent complications. Strong maternal and infant health is not only critical for families but also reflects the overall strength, equity, and effectiveness of a community's health care system.

Sources:
County Health Rankings, 2021, https://www.countyhealthrankings.org/
Institute for Health Metrics and Evaluation, 2019, https://www.healthdata.org/
County Health Rankings, 2022, https://www.countyhealthrankings.org/
CDC: Wonder, 2019, https://wonder.cdc.gov/
County Health Rankings, 2022, https://www.countyhealthrankings.org/

Inland Empire maternal and infant health benchmarks compared to state benchmarks:

5 per 1,000	Deaths among infants less than 1 year of age *(California: 4.1 per 1,000)*
3.3 per 100k	Deaths due to maternal and neonatal disorders *(California: 2.5 per 100k)*
7.4%	Percentage of live births with low birthweight *(California: 7%)*
9.6%	Percentage of births occurring before the 37th week of pregnancy *(California: 9.1%)*
15.3 per 1,000	Number of births by females aged 15-19 per 1,000 *(California: 12.4 per 1,000)*

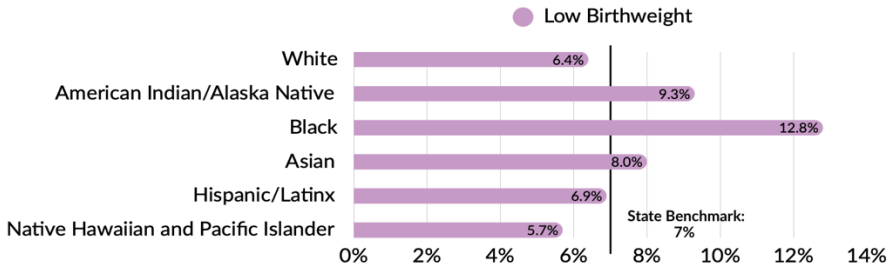
What the Numbers Are Telling Us

Inland Empire newborns face higher risks of being born too early or too small, or not surviving their first year, while mothers experience more pregnancy-related complications than the state. Higher teen birth rates add further challenges for young mothers and their infants.

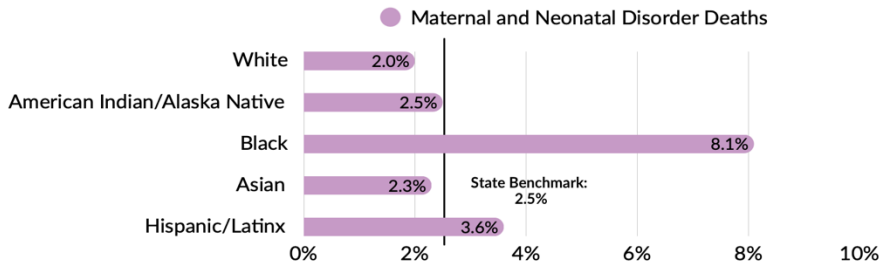
Maternal and Infant Health

How Health Differs for People of Different Races and Ethnicities in the Inland Empire

Disparity Gap
Black mothers experience the **highest percentage of live births with low birthweight** (less than 2,500 grams), **nearly 2 times** that of White and Native Hawaiian and Pacific Islander mothers.



Disparity Gap
Black mothers are at **nearly 4 times** the risk of maternal and neonatal disorder deaths compared to the state benchmark.



Sources:
County Health Rankings, 2022, https://www.countyhealthrankings.org/
Institute for Health Metrics and Evaluation, 2019, https://www.healthdata.org/

Community Partners' Input on Populations Most Impacted

Individuals who are pregnant, postpartum, experiencing loss, or trying to conceive

Mothers in their early to mid-20s

Women, children, and families

Black

Hispanic/Latino

Asian

Low income

Uninsured

Non-citizens

What This Means

Maternal and infant health disparities are stark in the Inland Empire. Black mothers experience the highest rates of low birthweight births and are at the greatest risk of maternal and neonatal disorder deaths, with rates more than three times higher than the state average.

Our Community Story

Addressing maternal and infant health saves lives and builds healthier families.

Maternal and infant health is a pressing concern in the Inland Empire, where outcomes consistently fall behind state benchmarks. Infant mortality is higher than the California average, and mothers in the region face greater risks of maternal and neonatal disorder deaths. Low birthweight, preterm births, and teen pregnancy are also more common in the Inland Empire than statewide.

Disparities across race and ethnicity are alarming. Black mothers experience the highest rates of low birthweight and deaths due to maternal and neonatal disorders. These data points highlight how health outcomes vary across communities and the need to take care of the most vulnerable in society.

These challenges weigh most heavily on:

- **Black**
- **Hispanic/Latino**
- **Asian**
- **American Indian/Alaska Native**

What Community Partners Said

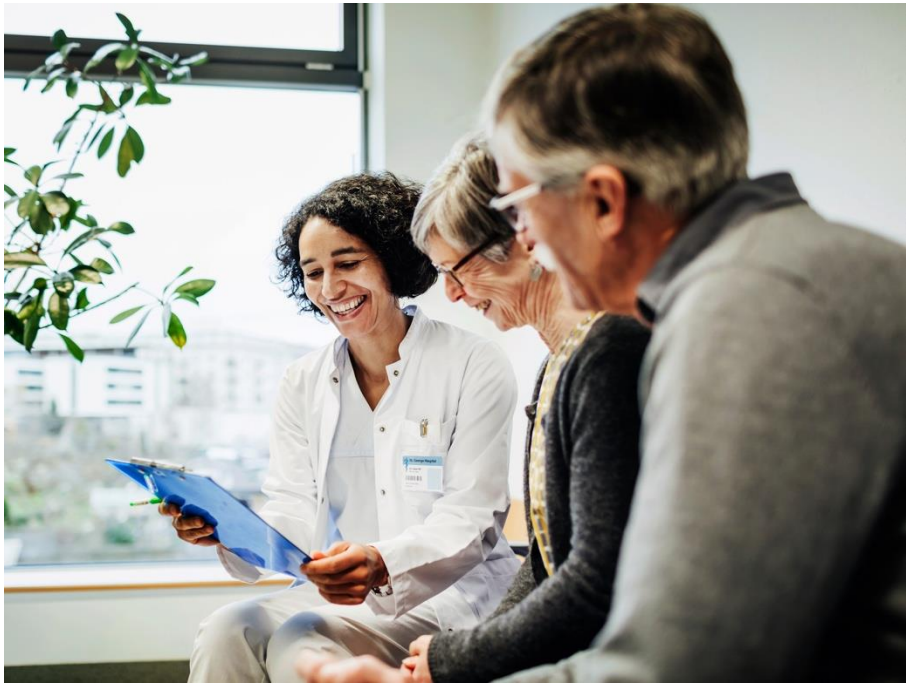
Community partners recognize maternal and infant health as a severe concern. They note moderate community capacity, collaboration, and use of evidence-based practices as strengths, while pointing to limited funding as a continuing challenge.

Priority Area 4: Basic Needs for Health and Safety

Basic Needs for Health and Safety

What Is Basic Needs for Health and Safety?

Basic needs for health and safety focus on the essentials that allow people to live stable, healthy lives. It also means having supportive environments and resources that prevent crises before they happen. The areas uniquely identified for this CHNA include access to health services and nutritious food. Meeting these needs is not only vital for individuals and families but also reflects the overall resilience, equity, and effectiveness of a community's health and social systems.



Inland Empire basic needs for health and safety benchmarks compared to state benchmarks:

282.3 per 100k	Number of Mental Health Care Providers *(California: 449.7 per 100k)*
66.8 per 100k	Number of Dentists (California: 92.9 per 100k)
33.8%	Percentage of Medicare enrollees who had an annual flu vaccination (California: 41.5%)

What the numbers are telling us

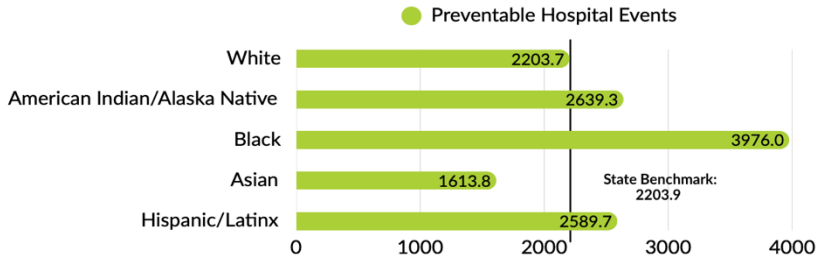
The conditions for basic needs for health and safety in the Inland Empire are significantly lower when it comes to access to care and flu vaccination rate. There is an alarming lower number of dentists and mental health care providers when compared to the state. These gaps limit preventive care, delay treatment, and leave many residents without the support they need to stay healthy, ultimately worsening health outcomes across the community.

Source:
County Health Rankings, 2023, https://www.countyhealthrankings.org/
County Health Rankings, 2022, https://www.countyhealthrankings.org/
County Health Rankings, 2021, https://www.countyhealthrankings.org/

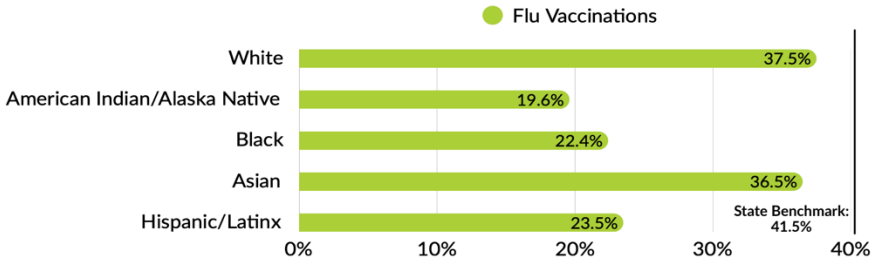
Basic Needs for Health and Safety

How Health Differs for People of Different Races and Ethnic Backgrounds in the Inland Empire:

Disparity Gap:
Black residents face **nearly 2x** the rate of preventable hospital events compared to the state benchmark.



Disparity Gap:
Flu vaccinations fall dangerously low **across all groups**. Black, Hispanic/Latinx, and American Indian/Alaska Native residents receive shots at nearly half the state rate.



Source:
County Health Rankings, 2021, https://www.countyhealthrankings.org/

Other Regional Assessments

4 health care organizations in the region identified Basic Needs for Health and Safety as a top concern for the community.

Community Partners' Input on Populations Most Impacted:

- Age (general), seniors, youth
- People of color
- Black
- Hispanic/Latino
- White
- Multiracial
- Low-income individuals, families , and persons with disabilities
- Unemployed
- Uninsured
- Homeless
- Non-citizens/undocumented

What this means

Access to health care is a basic need for building a thriving, healthy community. In the Inland Empire, gaps in access are evident, with lower flu vaccination rates and higher rates of preventable hospital visits compared to the state. These trends are especially concerning because missed preventive care can lead to more serious health problems. Four health care organizations in the region have endorsed the urgent need to close these gaps and reduce disparities.

Our Community Story

Meeting basic needs for health and safety protects lives and strengthens community resilience.

The Inland Empire falls behind state benchmarks in several key areas that shape stability and well-being. Access to care is limited, with significantly fewer dentists and mental health providers per capita compared to California overall. Preventive care also lags, as fewer Medicare enrollees in the region receive annual flu vaccinations. These gaps make it harder for families to stay healthy and prevent crises.

Lack of access to health care does not affect all populations equally. Black residents in the Inland Empire face nearly twice the rate of preventable hospital events compared to the state benchmark, highlighting how access gaps drive inequities in health outcomes.

Disparities in can be seen in the following populations:

- **All racial groups, specifically Black residents**
- **All age groups**
- **Uninsured**
- **Low-income and unemployed**
- **Homeless**
- **Undocumented**

What Community Partners Said

Community partners recognize basic needs as a highly severe issue. They note moderate levels of community capacity, collaboration, and evidence-based practices, while identifying funding and sustainability as the weakest areas requiring attention.

Priority Area 5: Humane Housing

Humane Housing

What is Humane Housing?

Humane housing means having safe, stable, and affordable homes that protect people's dignity, health, and well-being. It extends beyond shelter to include clean water, reliable utilities, secure environments, and access to schools, jobs, and services. One way to understand where humane housing falls short is through the Homeless Point-in-Time (PIT) Count, which measures how many people are unhoused on a single night each year. This snapshot highlights local trends and guides resources to better meet community needs.

Inland Empire humane housing benchmarks compared to state benchmarks:

18.1% Percentage of housing structures with 2+ units per structure
(California: 31.8%)

5% Students experiencing homelessness
(California: 4%)

2025 Point In Time Homeless Count:

Region	Total Homeless	Year-over-Year Change	Unsheltered Change	Notes
San Bernardino County	3,821	↓ 10.2%	↓ 14.2%	Strongest decline
Riverside County	3,990	↑ 7%	↓ 19%	Growth slowed
LA County	~72,308	↓ 4%	↓ 7.9%	Modest progress
San Diego County	~9,905 (region)	↓ 7% (regionwide)	–	Region-level drop
California Overall	N/A (est. 275k unsheltered)	Mixed	–	Highest national burden

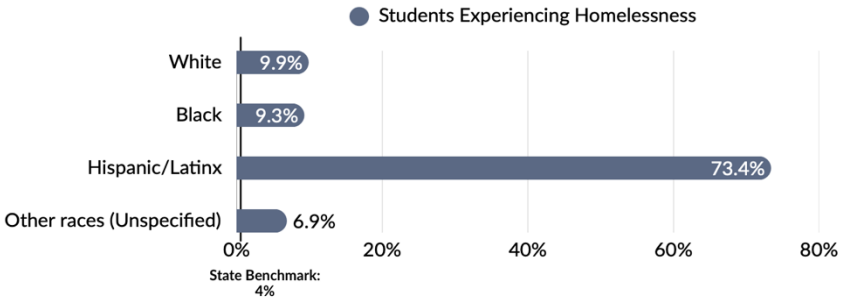
What the Numbers Are Telling Us

The Inland Empire has fewer multi-unit housing options than the state, making it harder for families to find affordable homes. Student homelessness is higher here than the state average, affecting well-being and school success. The homeless point-in-time counts show homelessness rising in Riverside County and declining in San Bernardino County.

Sources:
US Census: American Community Survey, 2023, https://www.census.gov/programs-surveys/acs
Urban Data Catalog, 2021, https://datacatalog.urban.org/

Humane Housing

How Health Differs for People of Different Races and Ethnic Backgrounds in the Inland Empire:



Disparity Gap:
Students **across all racial and ethnic groups** experience homelessness at higher rates than the state average. Hispanic students are most affected, facing rates **nearly 20x higher.**

Other Regional Assessments

2 health care organizations in the region identified humane housing as a top concern for the community.

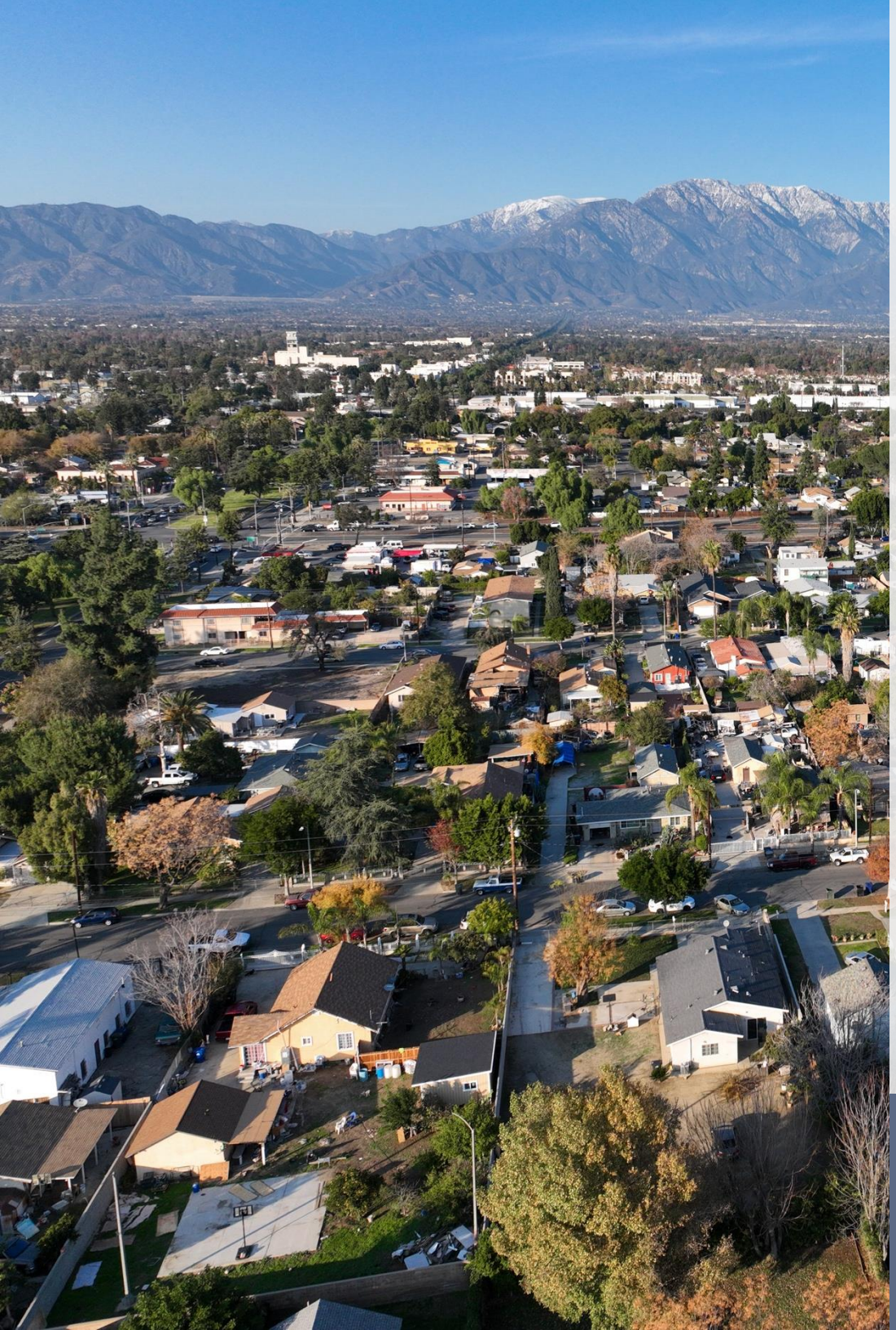
Community Partners' Input On Populations Most Impacted:

- Older adults (65+)
- Young adults
- Working adults
- White
- Hispanic/Latino
- Black
- Low income
- Homeless
- Uninsured
- Non-citizens
- Persons with disabilities
- Those using substances
- Underserved populations/ regions/communities

What This Means

Housing and homelessness are severe in the Inland Empire, with student homelessness far above state benchmarks—especially among Hispanic, White, and Black students. Older adults, low-income residents, people with disabilities, and those with substance use challenges are also heavily affected. This issue is a top concern for 2 additional health organizations in the region.

Sources:
Urban Data Catalog, 2021, https://datacatalog.urban.org/



Our Community Story

Expanding humane housing protects dignity, stability, and well-being.

The Inland Empire falls behind state benchmarks in key housing measures. Only 18% of housing units are multi-family, compared to 32% statewide, limiting affordable options for families. Student homelessness is higher than the state average. Homelessness affects students of all backgrounds at higher rates than the state average, with Hispanic students experiencing the greatest disparity—nearly 20 times higher. Rising homelessness in Riverside County alongside declines in San Bernardino County highlights an opportunity to learn from local strategies and build on what's working to strengthen solutions across the region.

Disparities weigh most heavily on:

- **Students of all racial groups, specifically Hispanic/Latino, Black, and White**
- **Low-income and uninsured individuals**
- **All ages, older and younger adults**
- **Persons using substances**
- **People with disabilities and those experiencing homelessness**
- **Non-citizens**

What Community Partners Said

Community partners recognize humane housing as a highly severe issue. They highlight strong community capacity to act as a key strength, while noting that collaboration remains moderate and evidence-based practices and funding continue to be weaker areas.

Emerging Health Concerns

Three emerging health concerns are rising in the region: kidney disease, respiratory disease, and cancer. Monitoring emerging health trends is critical because they signal where new challenges are developing, often before they become widespread crises. Understanding these patterns allows hospitals and communities to prepare, target resources, and respond with strategies that prevent greater harm. The snapshot below highlights key data points on these issues. *Burden of Disease data tables can be found in Appendix B*.

Kidney Disease

What the data show
- Higher rates of renal failure in the region
- More deaths from kidney disease compared to the state average

Why it matters
- Reduces quality of life and limits daily activities
- Increases need for ongoing treatment such as dialysis
- Adds strain on individuals, families, and the health care system

Respiratory Disease

What the data show
- Rising rates of chronic obstructive pulmonary disease, asthma, and chronic respiratory illnesses in the region
- Deaths from respiratory conditions higher than the state average

Why it matters
- Makes it harder to breathe, work, and stay active
- Reduces quality of life across all ages
- Adds strain on families and the health care system

Cancer

What the data show
- Cancer is a major emerging health concern in the region
- Delays in care and lower use of preventive screenings limit early diagnosis and treatment
- Top 5 cancers in the Inland Empire:
  - **Breast**
  - **Prostate**
  - **Lung and bronchus**
  - **Colorectal**
  - **Melanoma of the skin**

Why it matters
- Contributes to preventable suffering and loss
- Affects every community across the region
- Highlights the urgent need for access to prevention, early detection, and timely treatment

Sources:
Institute for Health Metrics and Evaluation, 2019, https://www.healthdata.org/
CDC: Wonder, 2022, https://wonder.cdc.gov/
CDC: Places, 2022, https://www.cdc.gov/places/index.html
California Registry, 2017-2021, https://www.ccrcak.org

Next Steps

- The CHIP
- Acknowledgements
- Pathways to Collaborative Action

Community Health Improvement Plan

Next Steps

The hospitals will build on the 2025 CHNA by developing a Community Health Improvement Plan (CHIP) for 2026–2028.

Why a CHIP?

A CHIP is a three-year roadmap that takes the priorities identified in the CHNA and turns them into clear goals, strategies, and partnerships for action. Each hospital will create its own CHIP, and improvement opportunities lie in aligning these plans and working side by side with the community. Guided by local data, community strengths, and lived experiences, and developed in collaboration with partner organizations, these CHIPs will help ensure progress is both measurable and meaningful.

When data is fragmented or siloed, the story becomes incomplete, and solutions fall short. By aligning CHIPs and sharing data, hospitals and communities can build a clearer picture and drive lasting change. Data on its own is just numbers—it's how we use it that matters. Turning data into action allows us to close gaps, build trust, and improve health and well-being across the region.

2025 Inland Empire Acknowledgments

A special thank you to the hospital representatives who dedicated their time and insight throughout this process, and to the community members who shared their voices. Your input and engagement were vital in shaping this report and guiding the path toward healthier communities.

2025 Inland Empire CHNA Committee members represented the following organizations:

Listed in Alphabetical Order by First Name

Aileen Dinkjian, EdD, MPH
San Antonio Regional Hospital

Ariel Whitley, MHA
San Gorgonio Memorial Hospital

Indira Singh, MPH
San Antonio Regional Hospital

JaNaya Eggert, RN, MSN, HACP
Montclair Hospital Medical Center

Jennifer Giacona
Redlands Community Hospital

Karen Ochoa, MA, CDP
Communities Lifting Communities

Karen Zirkle, MSHSA
Redlands Community Hospital

Minerva Grish,
San Gorgonio Memorial Hospital

Roxanne Meyers
Chino Valley Medical Center and Montclair Hospital Medical Center

Saira Ramachhita, MPH, CHES
San Antonio Regional Hospital

Sara Khan, MD
San Antonio Regional Hospital

Susan Harrington
Communities Lifting Communities

Pathways to Collaborative Action

Existing collaboratives and assets in the Inland Empire

Exciting Opportunities

What is a collaborative?

Collaboratives bring people and organizations together around a shared goal. They create space for hospitals, community groups, and public health partners to align efforts, share resources, and tackle challenges that are too big to solve alone. By working collaboratively, communities can build stronger networks of support and create strategies that reflect a wide range of voices and expertise.

One example is the **Inland Empire Behavioral Health Collaborative (IEBHC).**

Inland Empire Behavioral Health Collaborative Summary

The Inland Empire Behavioral Health Collaborative (IEBHC) was launched to address critical gaps in behavioral health care across Riverside and San Bernardino Counties, as identified in recent CHNAs. Led by Communities Lifting Communities (CLC) and supported by the Hospital Association of Southern California (HASC), HC2 Strategies, and key regional partners, the collaborative aims to align hospitals, health systems, behavioral health agencies, and community stakeholders around shared strategies and best practices. *For a full list of partners, see Appendix A.*

Since its launch in early 2024, IEBHC has:

- ✓ Convened over 100 regional leaders and launched specialized workgroups focused on asset mapping, cross-sector case conferencing, and emergency department care coordination.
- ✓ Initiated a behavioral health resource mapping project and submitted funding proposals to support data infrastructure and pilot programs.
- ✓ Developed a work plan for sobering centers and contributed to the SB 43 Implementation Delay Workplan to strengthen infrastructure.

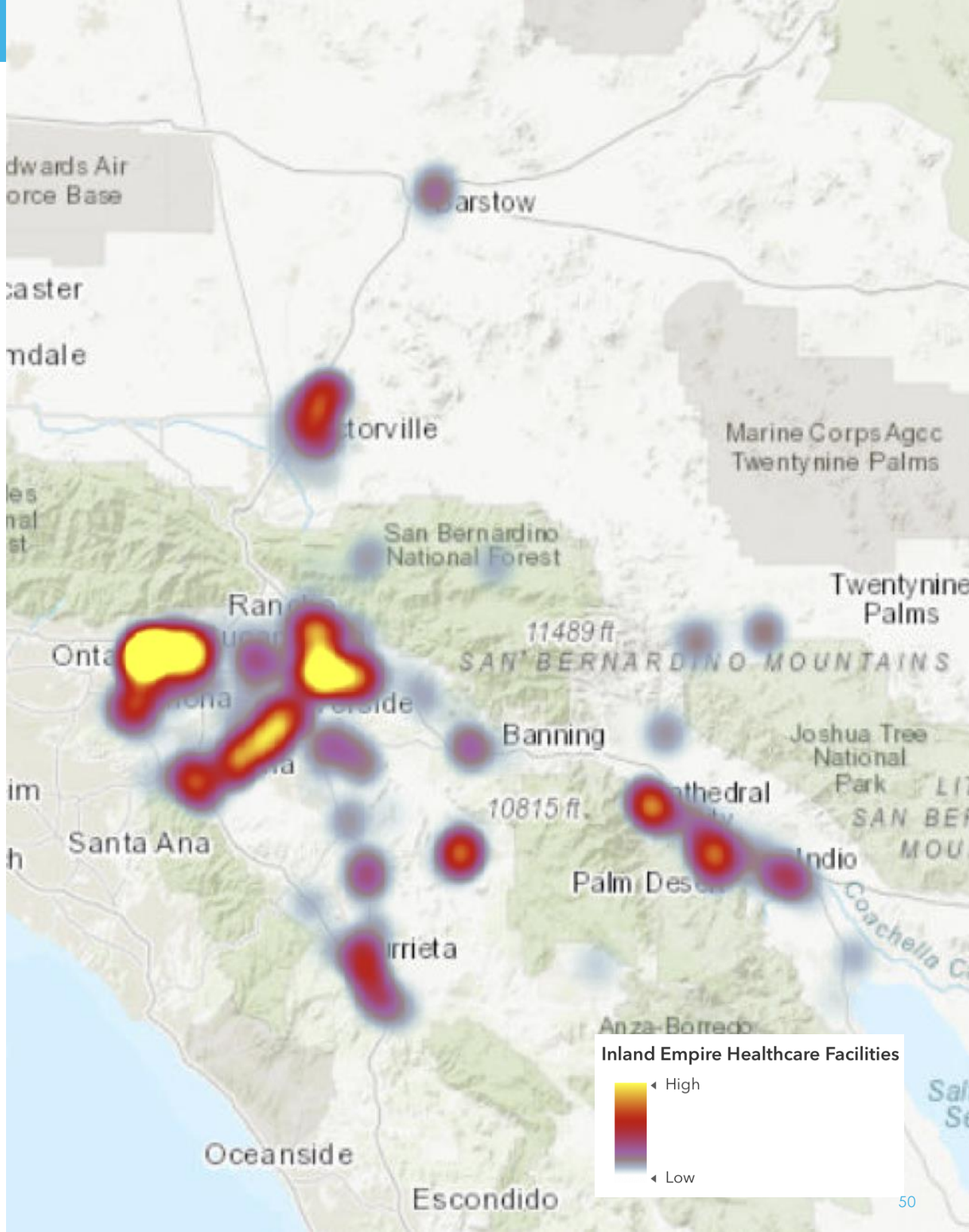
IEBHC will continue to drive progress by finalizing the asset map, piloting crisis response models, and integrating regional efforts to improve patient outcomes and system coordination. The collaborative remains committed to fostering cross-sector alignment, data-informed planning, and sustainable behavioral health solutions for the Inland Empire.

Heat Map of Health Care Facilities in the Inland Empire

Existing Assets: Health Care Facilities

This heat map shows where health care facilities are located across the Inland Empire. Most facilities are concentrated around larger cities, such as San Bernardino, Riverside, and Ontario, with additional clusters in Coachella Valley and Temecula/Murrieta.

These hubs reflect strong existing resources, but the map also highlights gaps in rural, mountain, and desert areas, where residents often need to travel farther for care. This creates an opportunity to build on current assets—through regional partnerships, mobile care, and new access points—to ensure health services reach every community.



Source:
California Department of Health Care Access and Information, 2024,
https://hcai.ca.gov/data/data-and-reports/

Community Based Asset Inventory

What is a Community Asset Inventory?

An asset inventory is a catalog of community resources, mapped across the continuum of care. It highlights community strengths such as hospitals, clinics, housing, and behavioral health services, while identifying where more support is needed. This ensures planning builds on what already exists, not just on the challenges.

What Exists

For this assessment, three asset maps exists for homelessness, mental health, and substance use. **Click on the following links to review and download each asset map:**

- Homelessness Asset List
- Mental Health Asset List
- Substance Use Asset List

Asset inventories connect needs with strengths, building on what works and strengthening the local network of care.

Inland Empire Hospitals By County

Riverside County

Betty Ford Center (Rancho Mirage)

Coachella Valley Behavioral Health (Indio)

Corona Regional Medical Center (Corona)

Corona Regional Medical Center (Magnolia)

Desert Regional Medical Center (Palm Springs)

Eisenhower Health (Rancho Mirage)

Encompass Health Rehabilitation Hospital of Murrieta (Murrieta)

Hemet Global Medical Center (Hemet)

JFK Memorial Hospital (Indio)

Kaiser Permanente Moreno Valley Medical Center (Moreno Valley)

Kaiser Permanente Riverside Medical Center (Riverside)

Kindred Hospital – Riverside (Perris)

Loma Linda University Medical Center – Murrieta (Murrieta)

Menifee Global Medical Center (Menifee)

Pacific Grove Hospital (Riverside)

Parkview Community Hospital Medical Center (Riverside)

Palo Verde Hospital (Blythe)

Rehabilitation Hospital of Southern California (Rancho Mirage)

Riverside Community Hospital (Riverside)

Riverside University Health System Medical Center (Moreno Valley)

San Gorgonio Memorial Hospital (Banning)

Southwest Healthcare Inland Valley Hospital (Wildomar)

Southwest Healthcare Rancho Springs Hospital (Murrieta)

Southwest Healthcare Temecula Valley Hospital (Temecula)

Inland Empire Hospitals By County

San Bernardino County

Arrowhead Regional Medical Center (Colton)

Ballard Rehabilitation Hospital (San Bernardino)

Barstow Community Hospital (Barstow)

Bear Valley Community Hospital (Big Bear Lake)

Canyon Ridge Hospital (Chino)

Chino Valley Medical Center (Chino)

Colorado River Medical Center (Needles)

Community Hospital of San Bernardino (San Bernardino)

Desert Valley Hospital (Victorville)

Hi-Desert Medical Center (Joshua Tree)

Kaiser Permanente Fontana Medical Center (Fontana)

Kaiser Permanente Ontario Vineyard Medical Center (Ontario)

Kindred Hospital – Ontario (Ontario)

Kindred Hospital – Rancho (Rancho Cucamonga)

Loma Linda University Medical Center (Loma Linda)

Loma Linda University Children's Hospital (Loma Linda)

Montclair Hospital Medical Center (Montclair)

Redlands Community Hospital (Redlands)

St. Bernardine Medical Center (San Bernardino)

St. Mary Medical Center (Apple Valley)

San Antonio Regional Hospital (Upland)

San Bernardino Mountains Community Hospital (Lake Arrowhead)

Patton State Hospital (San Bernardino)

Totally Kids Rehabilitation Hospital (San Bernardino)

VA Loma Linda Healthcare System (Loma Linda)

Victor Valley Global Medical Center (Victorville)

Hospital Profile

- **Redlands Community Hospital**

Redlands Community Hospital

"Our mission is to promote an environment where members of our community can receive high-quality care and service so they can maintain and be restored to good health."[55]

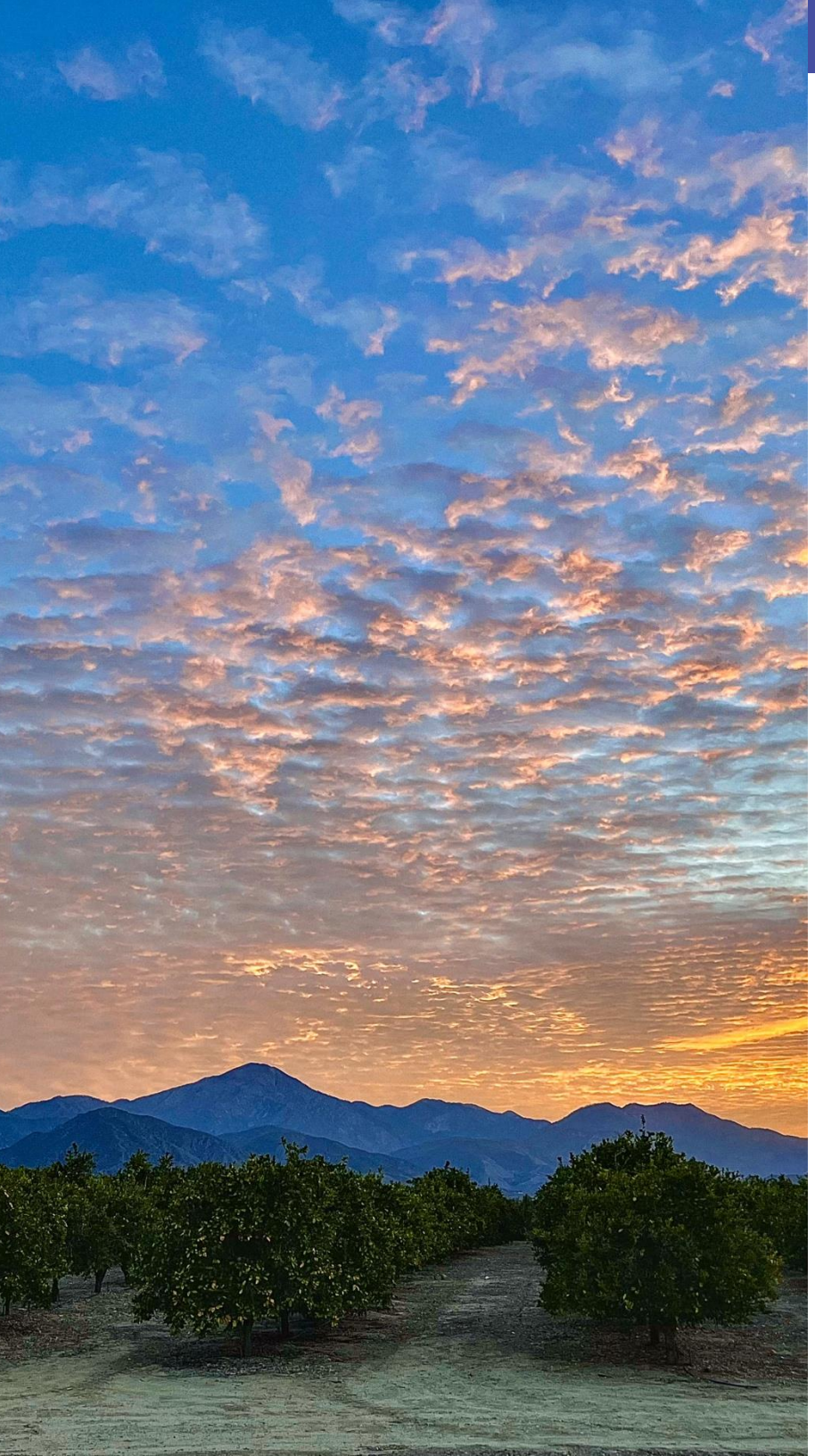


Table of Contents

About This Hospital

Redlands Community Hospital, founded in 1904, is a nonprofit, independent, full-service facility with 229 beds, located in Redlands, in the East San Bernardino Valley. The hospital serves a broad mix of urban, suburban, and rural communities across the Inland Empire.

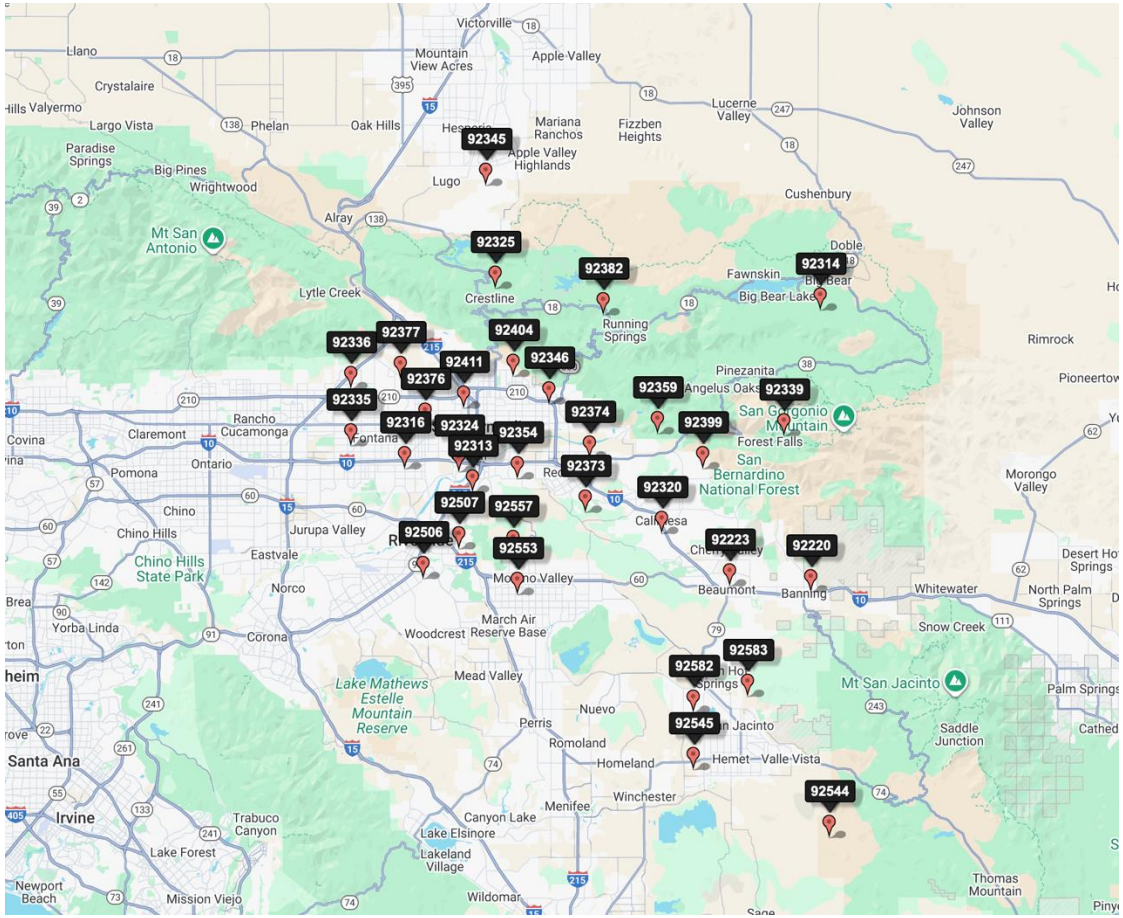
Voted by patients as one of the best hospitals of 2021 in the *Redlands Daily Facts* and *San Bernardino Sun*, Redlands Community Hospital employs more than 1,800 staff and has a medical team of more than 300 physicians. Its comprehensive services include 24-hour emergency care, advanced surgical and imaging capabilities, robotic surgery, orthopedic and maternity care, rehabilitation programs, and a wide range of specialty services.

Redlands Hospital Primary Service Area (PSA):

92220	92553	92316
92223	92557	92583
92373	92376	92345
92374	92335	92314
92399	92336	92377
92346	92313	92339
92359	92506	92582
92354	92507	
92404	92544	
92411	92545	
92324	92325	
92320	92382	

Our Community: Redlands Community Hospital

Redlands Community Hospital serves a diverse community across more than 25 zip codes, including Redlands, Loma Linda, Highland, Yucaipa, Colton, San Bernardino, Beaumont, and Banning. The hospital's service area spans urban centers, growing suburban neighborhoods, and nearby mountain and rural communities, each with distinct health needs, assets, and challenges.



Redlands Community Hospital

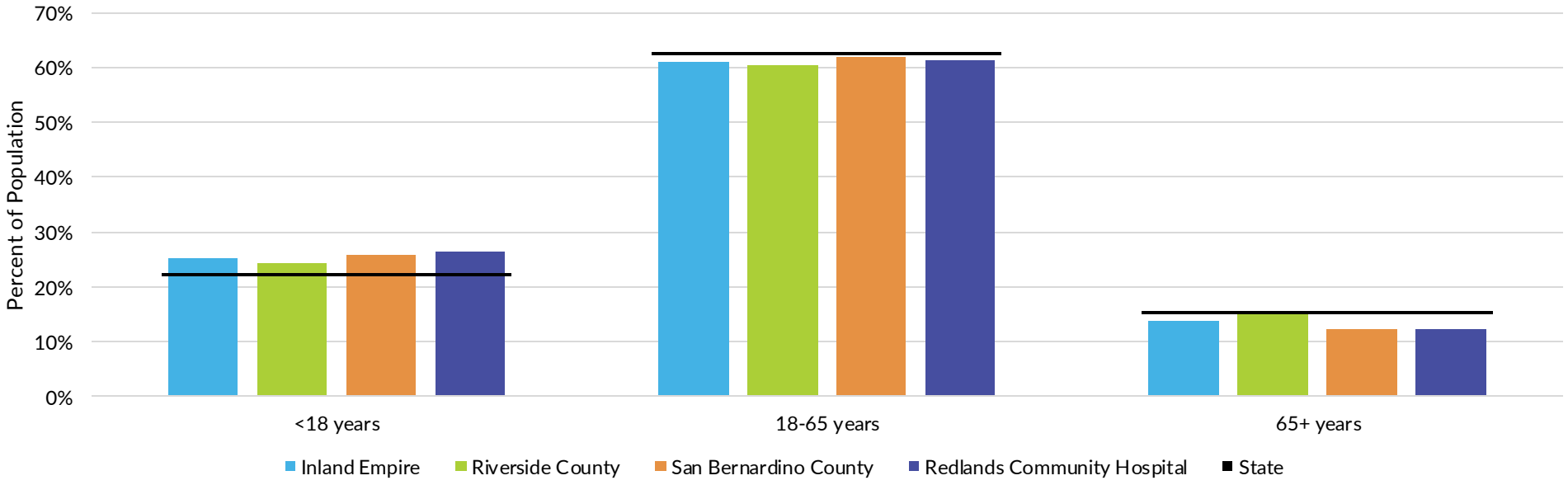
A Snapshot of the People: Age and Life Expectancy

Redlands' service area is home to a younger population, with a larger share of residents under 18 compared to the state. Adults ages 18–65 make up the majority, similar to the Inland Empire overall, while the share of older adults 65 and above is smaller than both state and regional averages. This points to a community that is growing, family-oriented, and full of up-and-coming generations. Life expectancy is 80.3 years—slightly higher than the Inland Empire but just below the California average—showing both progress and room for continued investment in health and well-being.

Life expectancy and population age breakdown compared to regional and state benchmarks:

80.3 years Life expectancy (*Inland Empire: 79.9 California: 81.7*)

Population Age Breakdown



Sources:
US Census, 2023, https://data.census.gov/
Institute for Health Metrics and Evaluation, 2019, https://www.healthdata.org/

Redlands Community Hospital

The Conditions Shaping Their Lives: Income, Poverty, Unemployment

The Redlands Community Hospital service area has a median household income of $84,100, which is lower than both the Inland Empire and California overall. About 14% of residents live below the poverty line, a higher share than seen at the regional and state levels. The unemployment rate stands at 4.8%, on par with the Inland Empire and slightly better than the state. Together, these measures show a community where employment is relatively steady, but lower incomes and higher poverty create financial strain for many families, underscoring ongoing gaps in economic stability that influence health and well-being.

Median household income, poverty level, and unemployment rate compared to regional and state benchmarks:

$84.1k Median Household income
(Inland Empire: $91.5k
California: $86.6k)

14% Residents living below the poverty level
(Inland Empire: 12.2%
California: 12%)

4.8% Unemployment rate
(Inland Empire: 4.8% California: 5%)

Sources:
US Census, 2023, https://data.census.gov/
US Bureau of Labor Statistics, 2023, https://www.bls.gov/lau/tables.htm#cntyaa

Progress Since the 2022 CHNA

The hospital has taken several steps to address its 2022 community health priorities: **cardiovascular disease and diabetes, mental and behavioral health, and basic needs for health and safety.** These efforts include community health education efforts, expanding access to care, and building partnerships to improve community health.

Cardiovascular Disease
Addressed this through community health education, wellness fairs, blood pressure screenings, CPR classes, and first-aid stations at community events such as the Redlands Bicycle Classic and Run Through Redlands.
Coming in **2026**—our new **Cardiology PCI Program** will expand heart care services providing patients access to advanced cardiac procedures right here in our community.

Diabetes
Supported access to primary care at its Redlands and Yucaipa Family Clinics, where diabetes screening, education, and management are provided for low-income and underserved populations. The hospital also engaged in community outreach programs and wellness events that emphasized healthy lifestyle education, weight management, and preventive care—all tied to reducing diabetes risk and complications.

Broader Health Initiatives
Access to Care: Expanded primary and prenatal care clinics, focusing on underserved communities, with grant funding sought to sustain programs.
Behavioral Health: Continued outpatient behavioral health programs and transportation support.
Community Engagement: Sponsored events such as blood drives, grief recovery classes, CPR classes, and health fairs to strengthen overall wellness.
Coalitions & Partnerships: Worked with schools, nonprofits, and coalitions to improve health policies and services.
Workforce Development: Trained new healthcare professionals (physicians, nurses, therapists) to ensure long-term capacity for treating conditions such as heart disease and diabetes.

Summary of Hospital Data: Burden of Disease

Mental Health and Substance Use indicators compared to state and regional benchmarks:

39.6 per 100k	People at risk for severe depression *(Inland Empire: 29.5 per 100k; California: 32.8 per 100k)*
39.3 per 100k	People at risk for severe depression *(Inland Empire: 29.5 per 100k; California: 32.8 per 100k)*

Cardiovascular and Diabetes Disease indicators compared to state and regional benchmarks:

23.2 per 100k	Number of deaths due to hypertensive heart disease *(Inland Empire: 24 per 100k; California: 15.7 per 100k)*
10.2%	Adults 20 or older told by a provider they have diabetes (excluding gestational) *(Inland Empire: 10.2%; California: 9.4%)*

Sources:
Mental Health America, 2024, https://mhanational.org/
CDC: Wonder, 2022, https://wonder.cdc.gov/
CDC: United States Diabetes Surveillance System, 2019, https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html
County Health Rankings, 2021, https://www.countyhealthrankings.org/
Institute for Health Metrics and Evaluation, 2019, https://www.healthdata.org/

Maternal and Infant Health indicators compared to state and regional benchmarks:

4.7 per 1,000	Deaths among infants less than 1 year of age *(Inland Empire: 5 per 1,000; California: 4.1 per 1,000)*
3.1 per 100k	Deaths due to maternal and neonatal disorders *(Inland Empire: 3.3 per 100k; California: 2.5 per 100k)*

Key Findings for Redlands Community Hospital

Mental Health and Substance Use
Suicidal ideation and severe depression are more common here than in California overall, showing a need for stronger mental health support.

Cardiovascular Disease and Diabetes
Heart disease deaths are higher than the state, and diabetes affects about 1 in 10 adults, underscoring ongoing health concerns.

Maternal and Infant Health
Infant and maternal deaths exceed state levels, pointing to continued challenges in maternal and infant health.

Burden of disease data tables are provided in Appendix B.

Summary of Hospital Data: Vital Conditions

Basic Needs for Health and Safety indicators compared to state and regional benchmarks:

277.1	Number of Mental Health Care Providers *(Inland Empire: 282.3 per 100k; California: 449.7 per 100k)*
63	Number of Dentists *(Inland Empire: 66.8 per 100k; California: 92.9 per 100k)*
35.2%	Percentage of Medicare enrollees who had an annual flu vaccination *(Inland Empire: 33.3%; California: 41.5%)*
87%	Percentage of the population age 19-65 who have health insurance *(Inland Empire: 88.3%; California: 90.2%)*

Sources:
County Health Rankings, 2023, https://www.countyhealthrankings.org/
County Health Rankings, 2022, https://www.countyhealthrankings.org/
County Health Rankings, 2021, https://www.countyhealthrankings.org/
US Census: American Community Survey, 2023, https://www.census.gov/programs-surveys/acs
CDC: Places, 2022, https://www.cdc.gov/places/index.html

Humane Housing indicators compared to state and regional benchmarks:

20.2%	Percentage of housing structures with 2+ units per structure *(Inland Empire: 18.1%; California: 31.8%)*
20%	Percentage of adults unable to pay mortgage, rent or utility bills in the past 12 months *(Inland Empire: 17.7%; California: 15.5%)*

Key Findings for Redlands Community Hospital

Basic Needs for Health and Safety
The service area has fewer mental health providers and dentists compared to the state, making it harder for residents to access care. Flu vaccination rates also fall below the California average, and fewer adults have health insurance compared to the region and state. These gaps highlight ongoing challenges in accessing routine and preventive care.

Humane Housing
Housing in the area includes fewer multi-family units than the state overall, while more adults report struggling to pay rent, mortgage, or utility bills. These patterns point to housing insecurity as a pressing issue for many families.

Vital conditions data tables are provided in Appendix C.

Health Disparities

Health disparities by race and ethnicity within the priority areas for hospitals are shown below. This information shows where races or ethnicities in the Redlands Community Hospital service area recorded worse results than the region. This is important because understanding which populations are most impacted helps hospitals and communities target resources, close equity gaps, and improve health outcomes where they are needed most.

Cardiovascular and Diabetes Disease

Indicator: Cardiovascular deaths

- ✓ Black
- ✓ White
- ✓ American Indian and Alaska Native

Indicator: Diabetes deaths

- ✓ Black
- ✓ White
- ✓ Native Hawaiian and Pacific Islander

Maternal and Infant Health

Indicator: Low birthweight

- ✓ Asian
- ✓ Black
- ✓ American Indian and Alaska Native

Indicator: Maternal and Neonatal Disorder Deaths

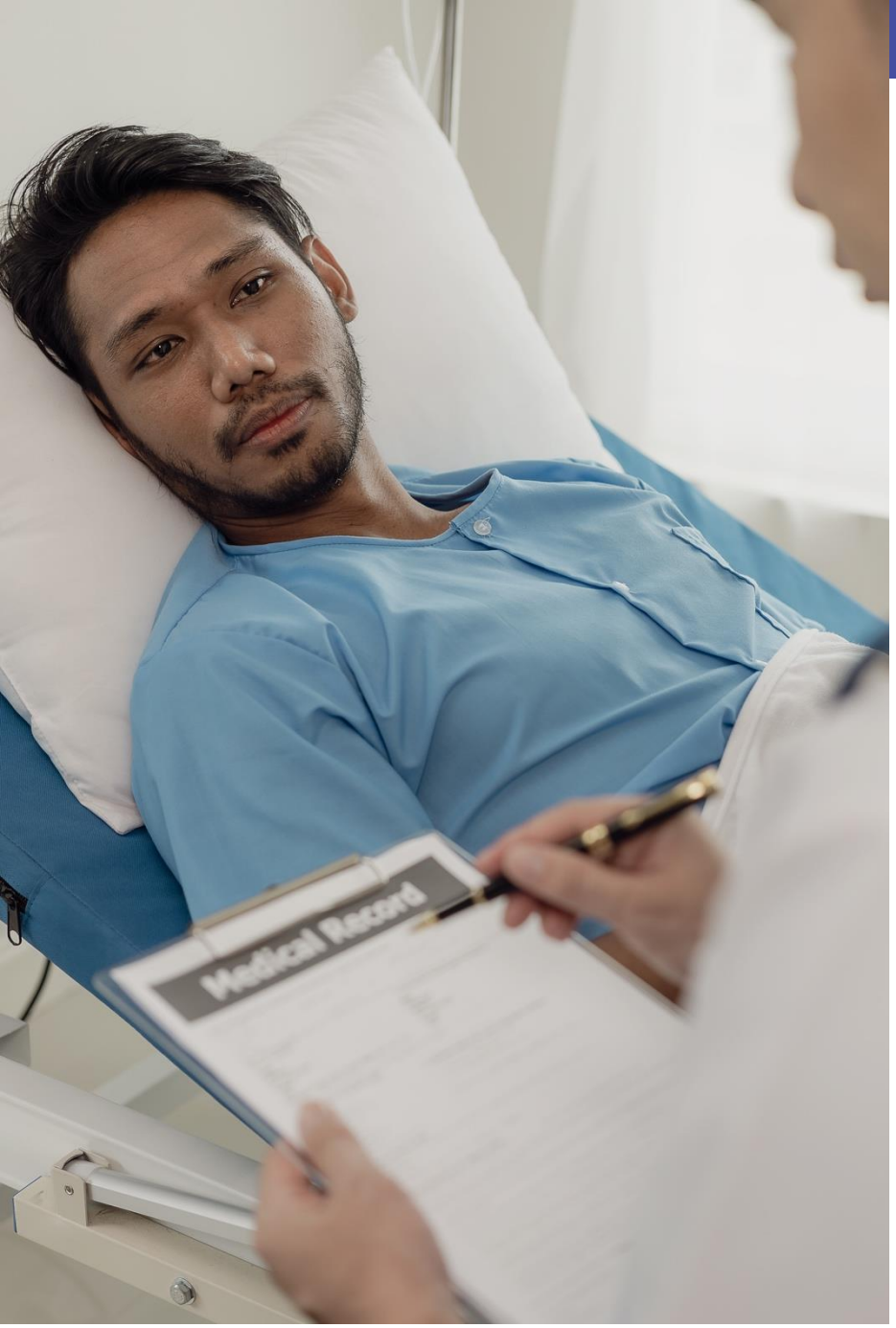
- ✓ Black
- ✓ Hispanic/Latinx

Basic Needs for Health and Safety

Indicator: Flu Vaccinations

- ✓ Asian
- ✓ Black
- ✓ Hispanic /Latinx
- ✓ American Indian and Alaska Native

Sources:
Institute for Health Metrics and Evaluation, 2019, https://www.healthdata.org/
CDC: Wonder, 2022, https://wonder.cdc.gov/
CDC: Places, 2022, https://www.cdc.gov/places/index.html
California Registry, 2017-2021, https://www.ccrcak.org



Redlands Community Hospital: Hospital Utilization Findings (2021-2024)

Prevention Quality Indicators (PQIs)	• Compared to state benchmarks, Redlands Community Hospital exceeds in PQI: • 01, 03, 07, 11, 14, 15, 16, 90, 91, 92, 93
Avoidable Emergency Department (ED) Visits	• Steady increase in overall avoidable ED rate (by payer and year)
ED Visits for Mental Health and Substance-Use Disorder	• Decline in ED volume for mental health disorders
30-Day Readmission Rates for Substance Use Disorder and Mental Health	• Increase in 30-day readmission rates for substance use and mental health disorders
Social Determinants of Health (SDOH) — ED	• Top 5 SDOH categories by volume in order of severity: housing, support, other psychosocial, environment, employment • Trends: • Decline in housing

Social Determinants of Health (SDOH) — Inpatient	• Top 5 SDOH categories by volume in order of severity: housing, environment, support, employment, other psychosocial
	• Trends:
	  • Decrease in housing
	  • Increase in environment

Hospital utilization charts are provided in Appendix D.

Sources

California Department of Health Care Access and Information, 2021-2024, https://hcai.ca.gov/data/data-and-reports/
Speedtrack, 2021-2024, https://speedtrack.com/healthcare/

Community Partner Matrix

Why Partnerships Matter

Partnerships are essential for turning local data into action. As the next step in developing the Community Health Improvement Plan (CHIP), these collaborations ensure that strategies are grounded in community strengths and aligned with real needs. Redlands Community Hospital has identified the following partners to work alongside in advancing health and well-being in its service area.

Partner Organization	Sector	Description of Services	Partnership	Priority
Central City Lutheran Mission	Homeless Shelter	• Shelter from 7pm to 7am • Emergency food, vouchers, clothing and assistance with obtaining ID's	Referrals for all patients	Humane Housing
Hospitality House (Salvation Army)	Homeless Shelter	Emergency and 90 day shelter	Referrals for all patients	Humane Housing
Time for Change	Homeless Shelter	Emergency shelter	Referrals for all patients	Humane Housing
Veronica's Home of Mercy	Homeless Shelter	Shelter for women and children	Referrals for all patients	Humane Housing
Liberty Ranch	Transitional and Permanent Housing	• $500 a month if on Social Security • $400 a month private pay	Referrals for all patients	Humane Housing

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Partner Organization	Sector	Description of Services	Partnership	Priority
Set Free	Transitional and Permanent Housing	Faith based substance abuse treatment and housing program for homeless individuals	Referrals for all patients	Humane Housing
Salvation Army Rehab Center San Bernardino	Transitional and Permanent Housing	Substance abuse and transitional housing program	Referrals for all patients	Humane Housing
Pacific Lifeline	Transitional and Permanent Housing	Transitional housing	Referrals for all patients	Humane Housing
The Stay	Transitional and Permanent Housing	Up to 90 day program for youth experiencing a mental health crisis; accept substance abuse but cannot be primary diagnosis	Referrals for all patients	Humane Housing
Operation Grace	Transitional and Permanent Housing	90 day transitional housing program. Approximately $260 per month for single women, $360 for families	Referrals for all patients	Humane Housing

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Partner Organization	Sector	Description of Services	Partnership	Priority
Light House Social Service Programs	Transitional and Permanent Housing	Chronically homeless persons with chronic health condition(s) for families, individuals, and unaccompanied youth	Referrals for all patients	Humane Housing
Step Up on Second Street INC	Transitional and Permanent Housing	Assistance with finding permanent housing	Referrals for all patients	Humane Housing
Veronica's Home of Mercy	Transitional and Permanent Housing	Transitional Housing program. Individual has to be eligible for government assistance	Referrals for all patients	Humane Housing
Central City Lutheran Mission	Food, clothing, laundry and showers	Food boxes provided on every 2nd and 3rd Friday of each month	Referrals for all patients	Basic Needs for Health and Safety
Family Service Association of Redlands	Food, clothing, laundry and showers	Offers food boxes, surplus food, emergency food and a nutritional support program	Referrals for all patients	Basic Needs for Health and Safety

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Partner Organization	Sector	Description of Services	Partnership	Priority
Community Action Partnership of San Bernardino	Food, clothing, laundry and showers	Call Monday –Friday 8am-5pm for locations near you, or refer to website: CAPSBC.org	Referrals for all patients	Basic Needs for Health and Safety
Helping Hands Pantry	Food, clothing, laundry and showers	Food distribution available Monday – Friday 8:30 – 11:30am; Sat 8-10am; Sun 8-11am	Referrals for all patients	Basic Needs for Health and Safety
Mary's Mercy Center	Food, clothing, laundry and showers	Showers for Women: Mon & Wed 8-10am; for Men: Tues & Thurs 7:30-9:30am Lunch served Mon-Thurs & Sat-Sun 11:30am-1:30pm	Referrals for all patients	Basic Needs for Health and Safety
The Rock Church	Food, clothing, laundry and showers	Food boxes distributed every Tues & Thurs from 8-10am. Starting Jan 7th distribution on Sat. only from 8:30-10:30am	Referrals for all patients	Basic Needs for Health and Safety
San Bernardino City Mission	Food, clothing, laundry and showers	Food boxes available	Referrals for all patients	Basic Needs for Health and Safety

Community Partner Matrix

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Partner Organization	Sector	Description of Services	Partnership	Priority
Catholic Charities	Food, clothing, laundry and showers	Food distribution available Monday, Wednesday, Friday 1:00-3:00pm	Referrals for all patients	Basic Needs for Health and Safety
Yucaipa Seventh Day Adventist Church	Food, clothing, laundry and showers	Emergency food for individuals and families Clothing available Wed 12-2pm	Referrals for all patients	Basic Needs for Health and Safety
Social Security Administration	Social security, disability and financial assistance	Assistance applying for retirement, Medicare disability benefits, and Social Security card. Open Mon, Tues, Thurs & Fri from 9am-4pm; Wed 9am-12pm	Referrals for all patients	Basic Needs for Health and Safety
Transitional Assistance Department (TAD)	Social security, disability and financial assistance	Offices open from 8:30am-4:30pm Assistance with: Calfresh, MediCal insurance, childcare reimbursement, and general relief	Referrals for all patients	Basic Needs for Health and Safety
San Bernardino Health Center	Medical and Dental Resources	Primary care, immunizations, reproductive health, HIV services outpatient medical treatment	Referrals for all patients	Basic Needs for Health and Safety

Community Partner Matrix

Why Partnerships Matter

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Partner Organization	Sector	Description of Services	Partnership	Priority
New Hope Free Clinic (Blessing Center)	Medical and Dental Resources	Free medical and dental care available by appointment only: Dental: Tuesdays 6-9pm Medical: Saturdays 9am-12pm	Referrals for all patients	Basic Needs for Health and Safety
SAC Health System Medical Clinic	Medical and Dental Resources	Outpatient medical treatment for low income medi-cal and noninsured patients	Referrals for all patients	Basic Needs for Health and Safety
SAC Health Clinic (Frazee)	Medical and Dental Resources	Outpatient medical treatment for low income medi-cal and noninsured patients	Referrals for all patients	Basic Needs for Health and Safety
SAC Health Clinic (Norton)	Medical and Dental Resources	Outpatient medical treatment for low income medi-cal and noninsured patients	Referrals for all patients	Basic Needs for Health and Safety
Yucaipa Family Clinic	Medical and Dental Resources	Primary care, outpatient medical treatment for low income medi-cal and noninsured patients	Referrals for all patients	Basic Needs for Health and Safety

Community Partner Matrix

Why Partnerships Matter

Partnerships are essential for turning local data into action. As the next step in developing the Community Health Improvement Plan (CHIP), these collaborations ensure that strategies are grounded in community strengths and aligned with real needs. Redlands Community Hospital has identified the following partners to work alongside in advancing health and well-being in its service area.

Partner Organization	Sector	Description of Services	Partnership	Priority
Redlands Family Clinic	Medical and Dental Resources	Primary care, outpatient medical treatment for low income medi-cal and noninsured patients	Referrals for all patients	Basic Needs for Health and Safety
McKee Clinic	Medical and Dental Resources	Outpatient medical treatment for low income medi-cal and noninsured patients	Referrals for all patients	Basic Needs for Health and Safety
Redlands Community Hospital Out Patient Behavioral Medline Program	Mental Health Resources	Outpatient partial hospitalization and intensive outpatient programs. Comprehensive evaluation by a psychiatrist. Symptom medical management. Groups and activity therapy. No-cost transportation may be available.	Referrals for all patients	Mental Health and Substance Use
Windsor Center	Mental Health Resources	23-hour crisis stabilization unit for individuals experiencing a mental health crisis but do not meet criteria for a 5150 hold. Psychiatry and nursing staff available; assistance with housing	Referrals for all patients	Mental Health and Substance Use

Community Partner Matrix

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Partnerships are essential for turning local data into action. As the next step in developing the Community Health Improvement Plan (CHIP), these collaborations ensure that strategies are grounded in community strengths and aligned with real needs. Redlands Community Hospital has identified the following partners to work alongside in advancing health and well-being in its service area.

Partner Organization	Sector	Description of Services	Partnership	Priority
Mesa Counseling Center	Mental Health Resources	Psychiatric and counseling services. Mesa Quik Clinic Walk In's also available Monday – Friday 8am-8pm for psychiatric assessment and medication prescription	Referrals for all patients	Mental Health and Substance Use
Phoenix Clinic	Mental Health Resources	Psychiatric and counseling services. Walk-in's for psychiatric assessment are available Mon-Thurs 8-10am on a first come, first serve basis	Referrals for all patients	Mental Health and Substance Use
South Coast Community Services	Mental Health Resources	Individual and group therapy offered Psychiatry services also available	Referrals for all patients	Mental Health and Substance Use

Through these partnerships, Redlands Community Hospital and community organizations are addressing core needs such housing, access to basic needs and social services, and mental health.

CHIP Next Steps: Call to Action

The Community Health Improvement Plan (CHIP) is more than a document—it is a call to action. Building on the findings of the CHNA, the CHIP creates a roadmap for hospitals and partners to move from data to impact.

This work requires collaboration across hospitals, communities, and systems to align priorities, share resources, and address the root causes of health inequities. By working together, partners can create stronger, more resilient communities where every person has the opportunity to thrive.

Now is the time to transform shared vision into collective action. Through the CHIP, hospitals can help lead the way in building lasting change and healthier futures for the Inland Empire.

Appendices

A: Inland Empire Behavioral Health Collaborative Partners
B: Burden of Disease Data Tables
C: Vital Conditions Data Tables
D: Hospital Utilization Charts
E: Other Inland Empire CHNA/CHA Findings
F: Well-Being Survey Findings
G: Prioritization Methods and Results

Appendix A: Inland Empire Behavioral Health Collaborative (IEBHC) Partners

Inland Empire Behavioral Health Collaborative (IEBHC): Partners

Arrowhead Regional Medical Center
Ballard Rehabilitation Hospital
Barstow Community Hospital
Bear Valley Community Hospital
Canyon Ridge Hospital
Cedar House
Chino Valley Hospital/Montclair Hospital
Coachella Valley Behavioral Health
Community Hospital of San Bernardino
Corona Regional Medical Center
Desert Regional Medical Center
Desert Valley Hospital
Doctors Hospital of Riverside
Eisenhower Health
Encompass Health
Encompass Health Rehabilitation Hospital of Murrieta
Encompass Health, Murrieta
Harris Koenig & Associates
HC2 Strategies
Hi- Desert Medical Center
Hospital Association of Southern California
IE Pathways to Housing Network
Inland Empire Health Plan
Inland Valley/Rancho Springs Hospitals
JFK Memorial Hospital
Kaiser Permanente Fontana Medical Center
Kaiser Permanente Foundation
Kaiser Permanente Moreno Valley Medical Center
Kaiser Permanente Ontario Vineyard Medical Center
Kaiser Permanente Riverside Medical Center
Kaiser Permanente, San Bernardino County Area
Kindred Hospital - Ontario
Kindred Hospital - Rancho
Kindred Hospital - Rancho Cucamonga

Inland Empire Behavioral Health Collaborative (IEBHC): Partners

Kindred Hospital - Riverside

Loma Linda University

Loma Linda University Health

Loma Linda University Hospital

Manifest Medex

Molina Healthcare California Health Plan

Montclair Hospital Medical Center

Pacific Grove Hospital

Palo Verde Hospital

Pomona Valley Hospital Medical Center

Prime Healthcare

Prime Healthcare Services Foundation

Providence Southern CA

Providence St. Mary's Medical Center

Redlands Community Hospital

Rehabilitation Hospital of Southern California

Rehabilitation Hospital of Southern CA

Riverside Community Health Foundation

Riverside Community Hospital

Riverside University Health Hospital

Riverside University Health System – Medical

RUHS - Public Health
Public Health Dept.

San Antonio Regional Hospital

San Bernardino County Department of Behavioral Health
Public Health Dept.

San Bernardino County Department of Public Health
Public Health Dept.

San Bernardino County Superintendent of Schools

San Bernardino Mountains Community Hospital

San Gorgonio Memorial Hospital

Southwest HealthCare - Inland Valley Hospital

Southwest Healthcare Inland Valley Hospital

Southwest Healthcare Rancho Springs Hospital

Inland Empire Behavioral Health Collaborative (IEBHC): Partners

Southwest Healthcare Temecula Valley Hospital

Southwest Inland Valley

Southwest Rancho Springs

St. Bernardine Medical Center

Temecula Valley Hospital

Totally Kids Rehabilitation Hospital

UHS Canyon Ridge Hospital

VA Loma Linda Healthcare System

West Valley HPN-Regional

Appendix B: Burden of Disease Data Tables

Burden of Disease

Maternal and Infant Health

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Early Pre-natal Care (2019)								
Percent of births for which prenatal care began in the first trimester								
85.5%	84.4%	84.7%	84.2%	86.0%	84.5%	84.4%	84.7%	85.6%
Low Birthweight (2022)								
Percentage of live births with low birthweight (less than 2,500 grams)								
7.0%	7.4%	7.1%	7.8%	7.4%	7.3%	7.4%	7.1%	7.5%
Teen Births (2022)								
Number of births per 1,000 females aged 15-19 years								
12.4	15.3	13.5	17.3	12.1	14.6	15.3	13.5	13.0
Pre-term Births (2019)								
Percent of births occurring before the 37th week of pregnancy								
9.1%	9.6%	9.1%	10.0%	9.5%	9.4%	9.6%	9.1%	9.6%
Infant Deaths (2021)								
Number of deaths among infants (less than one year of age) per 1,000 live births								
4.1	5.0	4.3	5.7	4.0	4.7	5.0	4.3	4.3
Maternal and Neonatal Disorder Deaths (2019)								
Number of deaths due to maternal and neonatal disorders per 100,000 women								
2.5	3.3	2.7	4.0	2.3	3.1	3.3	2.7	2.6

Sources:
- CDC: Wonder (https://wonder.cdc.gov/)
- County Health Rankings (https://www.countyhealthrankings.org/)
- Institute for Health Metrics and Evaluation (https://www.healthdata.org/)

Burden of Disease

Race & Ethnicity Breakdown: Low Birthweight

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Overall (2022)								
Percentage of live births with low birthweight (less than 2,500 grams)								
7.0%	7.4%	7.1%	7.8%	7.4%	7.3%	7.4%	7.1%	7.5%
Asian and Asian American, Non-Hispanic								
-	8.0%	8.3%	7.6%	7.7%	8.1%	8.0%	8.3%	7.7%
Black and African American, Non-Hispanic								
-	12.8%	12.3%	13.2%	12.1%	12.6%	12.8%	12.3%	12.3%
Hispanic and Latinx								
-	6.9%	6.6%	7.2%	7.1%	6.7%	6.9%	6.6%	7.1%
American Indian and Alaska Native, Non-Hispanic								
-	9.3%	7.2%	11.5%	8.7%	8.5%	9.3%	7.2%	9.4%
White, Non-Hispanic								
-	6.4%	6.0%	6.8%	6.1%	6.2%	6.4%	6.0%	6.2%
Native Hawaiian and Pacific Islander								
-	5.7%	5.7%	5.7%	6.7%	5.7%	5.7%	5.7%	6.5%

Sources:
- CDC: Wonder (https://wonder.cdc.gov/)
- County Health Rankings (https://www.countyhealthrankings.org/)
- Institute for Health Metrics and Evaluation (https://www.healthdata.org/)
- US Census (https://data.census.gov/)

Burden of Disease

Race & Ethnicity Breakdown: Maternal and Neonatal Disorder Deaths

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Overall (2019) *Number of deaths due to maternal and neonatal disorders per 100,000 women*								
2.5	3.3	2.7	4.0	2.3	3.1	3.3	2.7	2.6
Black and African American, Non-Hispanic								
-	8.1	5.6	10.3	4.9	7.2	8.1	5.6	5.8
Hispanic and Latinx								
-	3.6	3.2	4.0	2.6	3.5	3.6	3.2	2.9
American Indian and Alaska Native, Non-Hispanic								
-	2.5	2.3	2.6	2.1	2.4	2.5	2.3	2.2
White, Non-Hispanic								
-	2.0	1.6	2.5	1.4	1.8	2.0	1.6	1.6
Asian American Pacific Islander, Non-Hispanic								
-	2.3	1.9	2.7	1.4	2.1	2.3	1.9	1.5

Sources:
- CDC: Wonder (https://wonder.cdc.gov/)
- County Health Rankings (https://www.countyhealthrankings.org/)
- Institute for Health Metrics and Evaluation (https://www.healthdata.org/)
- US Census (https://data.census.gov/)

Burden of Disease

Mental and Behavioral Health

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Substance Use Disorder Deaths (2019)								
Number of deaths due to substance use disorders (including alcohol use disorders, and opioid use and other drug use disorders) per 100,000 population								
17.2	19.2	20.9	17.2	12.6	19.9	19.2	20.9	13.4
Self-harm and Interpersonal Violence Deaths (2019)								
Number of deaths due to self-harm, interpersonal violence, conflict and terrorism, and police conflict and executions per 100,000 population								
17.0	19.2	18.3	20.2	15.3	18.8	19.2	18.3	16.1
Frequent Mental Distress (2022)								
Percentage of adults aged 18 years and older who report 14 or more days of poor mental health per month								
16.7%	17.7%	17.4%	18.1%	17.4%	18.6%	16.8%	17.1%	16.7%
Suicidal Ideation (2024)								
Number of people reporting frequent suicidal ideation per 100,000 population								
35.0	39.9	39.0	41.0	36.0	39.6	39.9	39.0	36.9
Severe Depression (2024)								
Number of people at risk for severe depression per 100,000 population								
32.8	39.5	39.0	40.0	33.0	39.3	39.5	39.0	34.3

Sources:
- CDC: Places (https://www.cdc.gov/places/index.html)
- Mental Health America (https://mhanational.org/)
- Institute for Health Metrics and Evaluation (https://www.healthdata.org/)

Burden of Disease

Diabetes and Kidney Disease

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Diabetes and Kidney Disease Deaths (2019)								
Number of deaths due to diabetes and kidney diseases (including Diabetes mellitus, chronic kidney diseases, acute glomerulonephritis) per 100,000 population								
51.1	52.8	46.6	**59.7**	**57.1**	50.2	52.8	46.6	**57.6**
Renal Failure Deaths (2022)								
Number of deaths due to renal failure per 100,000 population								
10.9	11.9	11.1	12.8	**14.8**	11.6	11.9	11.1	**14.4**
Diabetes Deaths (2022)								
Number of deaths due to Type 2 diabetes per 100,000 population								
21.1	**24.8**	**18.3**	**32.1**	**27.1**	22.1	**24.8**	**18.3**	**28.0**
Diagnosed Diabetes (2019)								
Percentage of adults aged 20 years and older who report ever being told by a healthcare provider that they have diabetes (excludes gestational diabetes)								
9.4%	**10.2%**	**10.2%**	**10.2%**	9.5%	**10.2%**	**10.2%**	**10.2%**	9.6%

Sources:
- CDC: Wonder (https://wonder.cdc.gov/)
- CDC: United States Diabetes Surveillance System (https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html)
- Institute for Health Metrics and Evaluation (https://www.healthdata.org/)

Burden of Disease

Race & Ethnicity Breakdown: Diabetes Deaths

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Overall (2022) *Number of deaths due to Type 2 diabetes per 100,000 population*								
21.1	24.8	18.3	32.1	27.1	22.1	24.8	18.3	28.0
Asian and Asian American, Non-Hispanic								
-	22.0	18.7	25.3	28.8	20.7	22.0	18.7	28.4
Black and African American, Non-Hispanic								
-	43.4	31.9	53.4	51.5	39.0	43.4	31.9	51.8
Hispanic and Latinx								
-	19.7	14.7	24.9	23.0	17.7	19.7	14.7	23.4
American Indian and Alaska Native, Non-Hispanic								
-	-	-	-	44.1	-	-	-	44.1
White, Non-Hispanic								
-	30.5	21.6	43.2	27.4	26.6	30.5	21.6	30.3
Native Hawaiian and Pacific Islander								
-	76.4	-	76.4	65.8	76.4	76.4	-	68.3

Sources:
- CDC: Wonder (https://wonder.cdc.gov/)
- CDC: United States Diabetes Surveillance System (https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html)
- Institute for Health Metrics and Evaluation (https://www.healthdata.org/)
- US Census (https://data.census.gov/)

Burden of Disease

Respiratory Disease

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Chronic Respiratory Disease Deaths (2019)								
Number of deaths due to chronic respiratory diseases (including COPD, Pneumoconiosis, asthma, interstitial lung disease and pulmonary sarcoidosis, and other chronic respiratory diseases) per 100,000								
45.1	53.0	53.7	52.3	39.3	53.3	53.0	53.7	41.6
COPD (2022)								
Percentage of adults aged 18 years and older who report ever being told by a healthcare provider that they have chronic obstructive pulmonary disease (COPD), emphysema or chronic bronchitis								
5.5%	6.1%	**6.3%**	5.9%	5.0%	6.2%	4.9%	**7.1%**	4.9%
Current Asthma (2022)								
Percentage of adults aged 18 years and older who report having asthma								
9.9%	**10.5%**	**10.3%**	**10.7%**	9.9%	**10.8%**	10.0%	**10.4%**	9.7%

Sources:
- CDC: Places (https://www.cdc.gov/places/index.html)
- Institute for Health Metrics and Evaluation (https://www.healthdata.org/)

Burden of Disease

Cardiovascular Disease

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Stroke Deaths (2022)								
Number of deaths due to strokes (includes transient cerebral ischaemic attacks and related syndromes, central retinal artery occlusion, subarachnoid haemorrhage, intracerebral haemorrhage, other								
44.8	41.6	43.9	**39.1**	39.5	42.6	41.6	43.9	39.4
Heart Attack Deaths (2022)								
Number of deaths due acute myocardial infarction per 100,000 population								
25.3	27.4	28.7	25.9	25.4	27.9	27.4	28.7	25.5
Cardiovascular Deaths (2019)								
Number of cardiovascular disease deaths (including heart and valve diseases, stroke, hypertension, and other cardiovascular diseases) per 100,000 population								
215.4	228.5	242.1	213.4	213.9	234.1	228.5	242.1	213.8
Heart Disease (2022)								
Percentage of adults aged 18 years and older who report ever being told by a healthcare provider that they have angina or coronary heart disease								
-	6.1%	6.3%	5.8%	5.3%	6.0%	5.1%	**7.1%**	5.2%
High Blood Pressure (2021)								
Percentage of adults aged 18 years and older who report ever being told by a healthcare provider that they have high blood pressure (excludes high blood pressure occurring only during pregnancy and								
28.3%	29.9%	29.3%	**30.5%**	28.3%	30.1%	28.2%	**31.8%**	28.4%
Hypertension Deaths (2022)								
Number of deaths due to hypertensive heart disease per 100,000 population								
15.7	**24.0**	**22.2**	**26.0**	14.3	**23.2**	**24.0**	**22.2**	16.4

Sources:
- CDC: Places (https://www.cdc.gov/places/index.html)
- CDC: Wonder (https://wonder.cdc.gov/)
- Institute for Health Metrics and Evaluation (https://www.healthdata.org/)

Burden of Disease

Race & Ethnicity Breakdown: Stroke Deaths

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Overall (2022)								
Number of deaths due to strokes (includes transient cerebral ischaemic attacks and related syndromes, central retinal artery occlusion, subarachnoid haemorrhage, intracerebral haemorrhage, other								
44.8	41.6	43.9	39.1	39.5	42.6	41.6	43.9	39.4
Asian and Asian American, Non-Hispanic								
-	40.4	42.0	38.9	44.0	41.1	40.4	42.0	43.5
Black and African American, Non-Hispanic								
-	57.2	55.4	58.8	67.1	56.5	57.2	55.4	65.6
Hispanic and Latinx								
-	21.9	21.1	22.8	24.3	21.6	21.9	21.1	24.0
American Indian and Alaska Native, Non-Hispanic								
-	39.7	39.7	-	44.1	39.7	39.7	39.7	44.1
White, Non-Hispanic								
-	74.7	79.1	68.4	59.4	76.6	74.7	79.1	61.1
Native Hawaiian and Pacific Islander								
-	-	-	-	38.8	-	-	-	38.8

Sources:
- CDC: Places (https://www.cdc.gov/places/index.html)
- CDC: Wonder (https://wonder.cdc.gov/)
- Institute for Health Metrics and Evaluation (https://www.healthdata.org/)
- US Census (https://data.census.gov/)

Burden of Disease

Race & Ethnicity breakdown: Heart Attack Deaths

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Overall (2022) *Number of deaths due acute myocardial infarction per 100,000 population*								
25.3	27.4	28.7	25.9	25.4	27.9	27.4	28.7	25.5
Asian and Asian American, Non-Hispanic								
-	21.0	20.2	21.8	28.6	20.7	21.0	20.2	27.9
Black and African American, Non-Hispanic								
-	35.7	34.8	36.4	41.1	35.3	35.7	34.8	40.2
Hispanic and Latinx								
-	13.8	14.0	13.5	14.6	13.9	13.8	14.0	14.4
American Indian and Alaska Native, Non-Hispanic								
-	-	-	-	31.2	-	-	-	31.2
White, Non-Hispanic								
-	51.8	52.7	50.6	40.3	52.2	51.8	52.7	42.2
Native Hawaiian and Pacific Islander								
-	-	-	-	41.5	-	-	-	41.5

Sources:
- CDC: Places (https://www.cdc.gov/places/index.html)
- CDC: Wonder (https://wonder.cdc.gov/)
- Institute for Health Metrics and Evaluation (https://www.healthdata.org/)
- US Census (https://data.census.gov/)

Burden of Disease

Race & Ethnicity Breakdown: Cardiovascular Deaths

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Overall (2019)								
Number of cardiovascular disease deaths (including heart and valve diseases, stroke, hypertension, and other cardiovascular diseases) per 100,000 population								
215.4	228.5	242.1	213.4	213.9	234.1	228.5	242.1	213.8
Black and African American, Non-Hispanic								
-	267.6	263.6	271.2	366.6	266.1	267.6	263.6	349.4
Hispanic and Latinx								
-	96.0	93.0	99.1	109.2	94.8	96.0	93.0	107.3
American Indian and Alaska Native, Non-Hispanic								
-	284.3	274.3	295.5	412.0	280.2	284.3	274.3	389.3
White, Non-Hispanic								
-	452.8	467.8	432.0	366.1	459.4	452.8	467.8	378.5
Asian American Pacific Islander, Non-Hispanic								
-	148.3	148.8	147.7	189.5	148.5	148.3	148.8	185.5

Sources:
- CDC: Places (https://www.cdc.gov/places/index.html)
- CDC: Wonder (https://wonder.cdc.gov/)
- Institute for Health Metrics and Evaluation (https://www.healthdata.org/)
- US Census (https://data.census.gov/)

Burden of Disease

Race & Ethnicity Breakdown: Hypertension Deaths

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Overall (2022) *Number of deaths due to hypertensive heart disease per 100,000 population*								
15.7	24.0	22.2	26.0	14.3	23.2	24.0	22.2	16.4
Asian and Asian American, Non-Hispanic								
-	12.2	10.7	13.6	10.4	11.6	12.2	10.7	10.7
Black and African American, Non-Hispanic								
-	38.4	29.4	46.2	33.7	34.9	38.4	29.4	36.0
Hispanic and Latinx								
-	10.3	8.9	11.8	7.1	9.7	10.3	8.9	8.0
American Indian and Alaska Native, Non-Hispanic								
-	-	-	-	22.6	-	-	-	22.6
White, Non-Hispanic								
-	48.3	44.4	53.8	25.1	46.6	48.3	44.4	30.4

Sources:
- CDC: Places (https://www.cdc.gov/places/index.html)
- CDC: Wonder (https://wonder.cdc.gov/)
- Institute for Health Metrics and Evaluation (https://www.healthdata.org/)
- US Census (https://data.census.gov/)

Burden of Disease

Injury and Violence

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Opioid Overdose Deaths (2019)								
Number of deaths for which opioids, including opium, heroin, methodone and other opioids and synthetic narcotics, were a contributing cause								
13.0	12.8	16.6	8.6	9.3	14.4	12.8	16.6	9.2
Injury Deaths (2021)								
Number of deaths due to injury per 100,000 population								
59.0	64.7	65.5	63.8	48.6	65.0	64.7	65.5	51.4
Drug Poisoning Deaths (2021)								
Number of deaths due to drug poisoning per 100,000 population								
22.0	23.7	26.8	20.2	18.8	25.0	23.7	26.8	19.1
Gun Deaths (2021)								
Number of deaths due to firearms per 100,000 population								
8.2	9.8	8.6	11.1	7.9	9.3	9.8	8.6	8.5
Interpersonal Violence Deaths (2021)								
Number of deaths due to homicide per 100,000 population								
5.2	5.7	4.6	7.0	6.3	5.2	5.7	4.6	6.4
Motor Vehicle Crash Deaths (2021)								
Number of deaths due to traffic collisions involving a motor vehicle per 100,000 population								
10.5	13.9	12.7	15.2	8.9	13.4	13.9	12.7	10.1

Sources:
- County Health Rankings (https://www.countyhealthrankings.org/)
- CDC: Wonder (https://wonder.cdc.gov/)

Burden of Disease

Race & Ethnicity Breakdown: Interpersonal Violence Deaths

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Overall (2021) *Number of deaths due to homicide per 100,000 population*								
5.2	5.7	4.6	7.0	6.3	5.2	5.7	4.6	6.4
Asian and Asian American								
-	1.8	1.2	2.5	1.6	1.6	1.8	1.2	1.7
Black and African American								
-	20.4	15.2	25.1	24.9	18.4	20.4	15.2	25.0
Hispanic and Latinx								
-	5.5	4.9	6.2	6.7	5.3	5.5	4.9	6.6
White								
-	3.5	2.9	4.5	2.6	3.2	3.5	2.9	2.9
Native Hawaiian and Other Pacific Islander, Non-Hispanic								
-	-	-	-	10.6	-	-	-	10.6

Sources:
- County Health Rankings (https://www.countyhealthrankings.org/)
- CDC: Wonder (https://wonder.cdc.gov/)
- US Census (https://data.census.gov/)

Burden of Disease

Cancer

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Diagnosed Cancer (2022)								
Percentage of adults aged 18 years and older who report ever being told by a healthcare provider that they have cancer (excludes skin cancer)								
6.7%	6.3%	6.9%	5.7%	5.4%	5.8%	5.4%	7.8%	5.1%
Cancer Deaths (2019)								
Number of deaths due to neoplasms (includes skin cancers) per 100,000 population								
162.5	158.6	164.0	152.6	152.4	160.9	158.6	164.0	152.4

* Please review the IP3 website for the Inland Empire and feel free to review the leading causes of cancer in your hospital's service area.

Sources:
- CDC: Places (https://www.cdc.gov/places/index.html)
- Institute for Health Metrics and Evaluation (https://www.healthdata.org/)

Burden of Disease

STIs/HIV

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Sexually Transmitted Infection Deaths (2019)								
Number of deaths due to HIV/AIDS and sexually transmitted infections per 100,000 population								
1.8	1.9	**2.1**	1.7	**2.2**	2.0	1.9	**2.1**	**2.2**
HIV/AIDS Deaths (2022)								
Number of deaths due to human immunodeficiency virus (HIV) disease per 100,000 population								
1.6	1.8	**1.9**	1.6	**2.0**	1.8	1.8	**1.9**	**1.9**
Chlamydia (2023)								
Number of new chlamydia cases per 100,000 population								
491.1	511.5	466.9	**562.1**	**602.3**	493.0	511.5	466.9	**594.9**
HIV Prevalence (2022)								
Number of HIV cases per 100,000 population								
416.4	408.7	**512.1**	**290.4**	**611.5**	451.7	408.7	**512.1**	**554.4**

Sources:
- CDC: National Center for HIV, Viral Hepatitis, STD, and Tuberculosis Prevention (https://www.cdc.gov/nchhstp/about/atlasplus.html)
- CDC: Wonder (https://wonder.cdc.gov)
- Institute for Health Metrics and Evaluation (https://www.healthdata.org/)

Appendix C: Vital Conditions Data Tables

Vital Conditions

Reliable Transportation

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Vehicle Access (2023)								
Percentage of occupied housing units with one or more vehicles available								
7.0%	4.4%	4.3%	4.6%	4.7%	5.1%	3.8%	4.5%	4.2%
Active Commuting (2023)								
Percentage of workers aged 16 years and older who commute to work via public transportation, bicycle, or walking								
6.3%	2.3%	2.1%	2.5%	3.4%	2.7%	2.4%	2.2%	2.5%
Motor Vehicle Crash Deaths (2021)								
Number of deaths due to traffic collisions involving a motor vehicle per 100,000 population								
10.5	13.9	12.7	15.2	8.9	13.4	13.9	12.7	10.1
Commute Time (2023)								
Mean travel time to work (in minutes) for workers aged 16 years and older who do not work from home								
29.0	33.2	33.8	32.5	31.4	31.9	32.6	33.8	32.4
Household Transportation Cost (2022)								
Annual household transportation costs in inflation-adjusted U.S. Dollars for a "typical household" (a household with a median household income that matches that of the region)								
$17,594.10	$18,964.70	$19,340.60	$18,537.70	$17,626.70	$18,287.20	$18,186.60	$19,702.20	$18,061.20
Reliable Transportation (2022)								
Percentage of adults aged 18 years and older who do not report that a lack of reliable transportation kept them from medical appointments, meetings, work, or getting things needed for daily living in the								
89.7%	88.3%	88.9%	87.6%	88.4%	86.8%	89.2%	89.3%	88.7%

Sources:
- US Census: American Community Survey (https://www.census.gov/programs-surveys/acs)
- Center for Neighborhood Technology (https://cnt.org/)
- County Health Rankings (https://www.countyhealthrankings.org/)
- CDC: Places (https://www.cdc.gov/places/index/html)
- US Census (https://data.census.gov/)

Vital Conditions

Lifelong Learning

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
On-time High School Graduation (2021)								
Percentage of students who graduate high school within 4 years of entering 9th grade								
87.7%	89.1%	90.4%	87.6%	86.4%	89.6%	89.1%	90.4%	86.7%
Adults With a High School Diploma (2023)								
Percentage of the population aged 25 years and older who are high school graduates or higher								
84.6%	82.7%	83.3%	82.1%	82.2%	80.0%	83.7%	85.0%	82.1%
Preschool Enrollment (2023)								
Percentage of the population aged 3-4 years who are enrolled in school								
47.1%	31.8%	32.3%	31.3%	42.5%	31.0%	36.8%	33.0%	43.2%
Childcare Centers (2022)								
Number of child care centers per 1,000 population under 5 years old								
6.5	4.0	3.8	4.2	6.2	3.9	4.0	3.8	5.8
Adult Literacy (2017) *								
Percentage of adults ages 16-74 years old who scored at or above Level 3 Literacy and can be considered proficient at working with information and ideas in text								
46.2%	37.4%	38.4%	36.4%	40.2%	37.8%	37.4%	38.4%	39.6%
Learning Rate (2022)								
Average grade-to-grade level improvement in test scores within each cohort for students in grades 3-8								
.04	-.02	-.03	-.02	.01	-.03	-.02	-.03	.00

*Dated adult literacy data

Sources:
- US Skills Map (https://nces.ed.gov/surveys/piaac/skillsmap/)
- US Census: American Community Survey (https://www.census.gov/programs-surveys/acs)
- County Health Rankings (https://www.countyhealthrankings.org/)
- The Educational Opportunity Project (https://edopportunity.org/)

Vital Conditions

Basic Needs for Health and Safety

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Population With Any Disability (2022) *Percentage of the civilian noninstitutionalized population with a disability*								
11.0%	11.5%	11.6%	11.4%	10.3%	11.6%	9.3%	**14.7%**	9.4%
Medical Professionals (2023) *Number of health diagnosing and treating practitioners per 1,000 population*								
18.0	15.8	15.6	16.1	18.0	15.6	19.1	18.1	18.1
Recent Primary Care Provider Visit (2022) *Percentage of adults aged 18 years and older who report having been to a doctor for a routine checkup in the past year*								
70.5%	69.7%	69.4%	70.1%	70.1%	69.4%	69.8%	70.8%	70.0%
Insured Adults (2023) *Percentage of the civilian noninstitutionalized population aged 19 to 65 years who have health insurance*								
90.2%	88.3%	88.4%	88.3%	88.8%	**87.0%**	89.5%	89.5%	88.4%
Low Food Access (2019) *Percentage of population with low food access, defined as living beyond 1 mile (urban) or 10 miles (rural) of supermarket*								
29.4%	37.6%	34.6%	40.5%	22.4%	31.8%	25.2%	33.4%	28.6%
Preventable Hospital Events (2021) *Number of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees*								
2203.9	2415.6	2175.0	**2687.0**	2462.0	2316.0	2415.6	2175.0	**2503.4**
Mental Health Care Providers (2023) *Number of mental health care providers per 100,000 population*								
449.7	**282.3**	**269.7**	**296.5**	445.9	**277.1**	**282.3**	**269.7**	418.4
Dentists (2022) *Number of dentists per 100,000 population*								
92.9	**66.8**	**57.7**	**77.0**	96.9	**63.0**	**66.8**	**57.7**	93.3
Flu Vaccination (2021) *Percentage of Medicare enrollees who had an annual flu vaccination*								
41.5%	**33.3%**	**38.0%**	**28.0%**	39.0%	**35.2%**	**33.3%**	**38.0%**	**37.0%**

Sources:
- County Health Rankings (https://www.countyhealthrankings.org/)
- US Census: American Community Survey (https://www.census.gov/programs-surveys/acs)
- County Health Rankings (https://www.countyhealthrankings.org/)
- CDC: Places (https://www.cdc.gov/places/index/html)

Vital Conditions

Race & Ethnicity Breakdown: Preventable Hospital Events

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Overall (2021)								
Number of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees								
2203.9	2415.6	2175.0	**2687.0**	2462.0	2316.0	2415.6	2175.0	**2503.4**
Asian and Asian American								
-	**1613.8**	**1394.0**	**1831.0**	**1557.0**	**1526.2**	**1613.8**	**1394.0**	**1587.9**
Black and African American								
-	**3976.0**	**3532.0**	**4372.0**	**4815.0**	**3804.6**	**3976.0**	**3532.0**	**4733.0**
Hispanic and Latinx								
-	**2589.7**	**2509.0**	**2674.0**	**2983.0**	**2557.0**	**2589.7**	**2509.0**	**2919.5**
American Indian and Alaska Native								
-	**2639.3**	**1916.0**	**3389.0**	**1337.0**	2346.9	**2639.3**	**1916.0**	**1838.3**
White								
-	2203.7	1970.0	**2538.0**	2095.0	2101.0	2203.7	1970.0	2175.2

Sources:
- County Health Rankings (https://www.countyhealthrankings.org/)
- US Census: American Community Survey (https://www.census.gov/programs-surveys/acs)
- USDA: Food Access Research Atlas (https://www.ers.usda.gov/data-products/food-access-research-atlas)
- County Health Rankings (https://www.countyhealthrankings.org/)
- CDC: Places (https://www.cdc.gov/places/index/html)

Vital Conditions

Race & Ethnicity Breakdown: Flu Vaccinations

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Overall (2021)								
Percentage of Medicare enrollees who had an annual flu vaccination								
41.5%	33.3%	38.0%	28.0%	39.0%	35.2%	33.3%	38.0%	37.0%
Asian and Asian American								
-	36.5%	36.0%	37.0%	48.0%	36.3%	36.5%	36.0%	46.8%
Black and African American								
-	22.4%	25.0%	20.0%	22.0%	23.4%	22.4%	25.0%	21.6%
Hispanic and Latinx								
-	23.5%	24.0%	23.0%	28.0%	23.7%	23.5%	24.0%	27.0%
American Indian and Alaska Native								
-	19.6%	23.0%	16.0%	30.0%	21.0%	19.6%	23.0%	26.6%
White								
-	37.5%	42.0%	31.0%	42.0%	39.5%	37.5%	42.0%	40.0%

Sources:
- County Health Rankings (https://www.countyhealthrankings.org/)
- US Census: American Community Survey (https://www.census.gov/programs-surveys/acs)
- USDA: Food Access Research Atlas (https://www.ers.usda.gov/data-products/food-access-research-atlas)
- County Health Rankings (https://www.countyhealthrankings.org/)
- CDC: Places (https://www.cdc.gov/places/index/html)

Vital Conditions

Humane Housing

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Subsidized Housing (2024)								
Estimated number of subsidized units per 10,000 population								
332.0	317.1	340.4	292.1	228.7	283.9	278.2	180.0	206.9
High Housing Costs (2022)								
Percentage of occupied housing units for which housing costs amount to 30% or more of household income								
39.9%	39.6%	39.5%	39.7%	42.2%	39.9%	40.2%	**34.6%**	42.1%
Not Overcrowded Gouseholds (2023)								
Percentage of occupied housing units with no more than one occupant per room								
91.8%	91.8%	92.4%	91.0%	89.9%	89.5%	91.0%	93.9%	90.5%
Housing Insecurity (2022)								
Percentage of adults aged 18 years and older who were not able to pay mortgage, rent, or utility bill in the past 12 months								
15.5%	17.7%	16.5%	**19.0%**	18.2%	**20.0%**	17.0%	15.7%	17.6%
Students Experiencing Homelessness (2021)								
Percentage of public-school students who were reported by local education agencies as being unhoused at any time during a school year								
4.0%	5.0%	3.6%	**6.5%**	3.8%	4.4%	5.0%	3.6%	4.3%
Multi-family Housing (2023)								
Percentage of housing structures with two or more housing units per structure								
31.8%	**18.1%**	**16.4%**	**19.9%**	28.8%	**20.2%**	23.4%	**6.8%**	25.8%

Sources:
- US Census: American Community Survey (https://www.census.gov/programs-surveys/acs)
- CDC: Places (https://www.cdc.gov/places/index/html)
- Urban Data Catalog (https://datacatalog.urban.org/)
- National Housing Preservation Database (https://preservationdatabase.org/)

Vital Conditions

Race & Ethnicity Breakdown: Students Experiencing Homelessness

State	Inland Empire	Riverside County	San Bernardino County	Montclair Hospital Medical Center	Redlands Community Hospital	San Antonio Regional Hospital	San Gorgonio Memorial Hospital	Chino Valley Medical Center
Overall (2021)								
Percentage of public-school students who were reported by local education agencies as being unhoused at any time during a school year								
4.0%	5.0%	3.6%	**6.5%**	3.8%	4.4%	5.0%	3.6%	4.3%
Black and African American, Non-Hispanic								
-	**9.3%**	**8.5%**	**10.1%**	**9.9%**	**9.0%**	**9.3%**	**8.5%**	**9.9%**
Hispanic and Latinx								
-	**73.4%**	**74.3%**	**72.6%**	**75.5%**	**73.8%**	**73.4%**	**74.3%**	**74.8%**
White, Non-Hispanic								
-	**9.9%**	**10.1%**	**9.6%**	**5.3%**	**10.0%**	**9.9%**	**10.1%**	**6.2%**
Other Races (Unspecified)								
-	**6.9%**	**6.5%**	**7.3%**	**7.3%**	**6.7%**	**6.9%**	**6.5%**	**7.3%**

Sources:
- US Census: American Community Survey (https://www.census.gov/programs-surveys/acs)
- CDC: Places (https://www.cdc.gov/places/index/html)
- Urban Data Catalog (https://datacatalog.urban.org/)
- National Housing Preservation Database (https://preservationdatabase.org/)

📌 2025 Point In Time Homeless Count

Region	Total Homeless	Year-over-Year Change	Unsheltered Change	Notes
San Bernardino County	3,821	↓ 10.2%	↓ 14.2%	Strongest decline
Riverside County	3,990	↑ 7%	↓ 19%	Growth slowed
LA County	~72,308	↓ 4%	↓ 7.9%	Modest progress
San Diego County	~9,905 (region)	↓ 7% (regionwide)	—	Region-level drop
California Overall	N/A (est. 275k unsheltered)	Mixed	—	Highest national burden

Sources

San Bernardino County: https://main.sbcounty.gov/2025/05/22/san-bernardino-countys-pitc-data-shows-decrease-in-homelessness/
Riverside County: https://media.rivcocob.org/proceeds/2025/p2025_05_20_files/03.25001.pdf
LA County: https://www.lahsa.org/news?article=1044-declining-homelessness-is-now-a-trend-in-los-angeles-county
San Diego County: https://www.rtfhsd.org/wp-content/uploads/2025/07/2025-San-Diego-Region-Breakdown_SH-Update-HDX-Final.docx.pdf

Appendix D: Hospital Utilization Charts

Hospital Utilization Data — Methods

Hospital Utilization Data

Hospital utilization data in this needs assessment focus on hospital inpatient and emergency department (ED) utilization, morbidities (health conditions), chronic conditions, and the social determinants affecting hospital use.

The 2021 –2024 hospital data were derived from California's Department of Health Care Access and Information (HCAI) and analyzed by SpeedTrack, an information guidance technology company.

The hospital data were stratified by the Inland Empire as a whole and by San Bernardino and Riverside counties. In addition, SpeedTrack pulled utilization data specific to each hospital service area.

The California hospital data for inpatient admissions — flagged for Prevention Quality Indicators (PQIs) and "Z" type diagnosis codes (International Classification of Diseases, Tenth Revision – ICD 10) — are important because they highlight the most common chronic conditions and social drivers of health in the designated regions.

Hospital Data

For this assessment we looked at the following indicators by region and per hospital:

- **14 Quality Prevention Indicators (chronic conditions) County level/Hospital level and State and National Benchmarks**
- **Avoidable Emergency Department visits**
- **Emergency Department visits for Mental Health and Substance-Use Disorder**
- **30-Day readmission rates for Mental Health and Substance-Use Disorder**
- **Social Determinants of Health for Inpatient and Emergency Department visits**

Hospital Utilization Data Methods – Hospital Prevention Quality Indicators (PQIs)

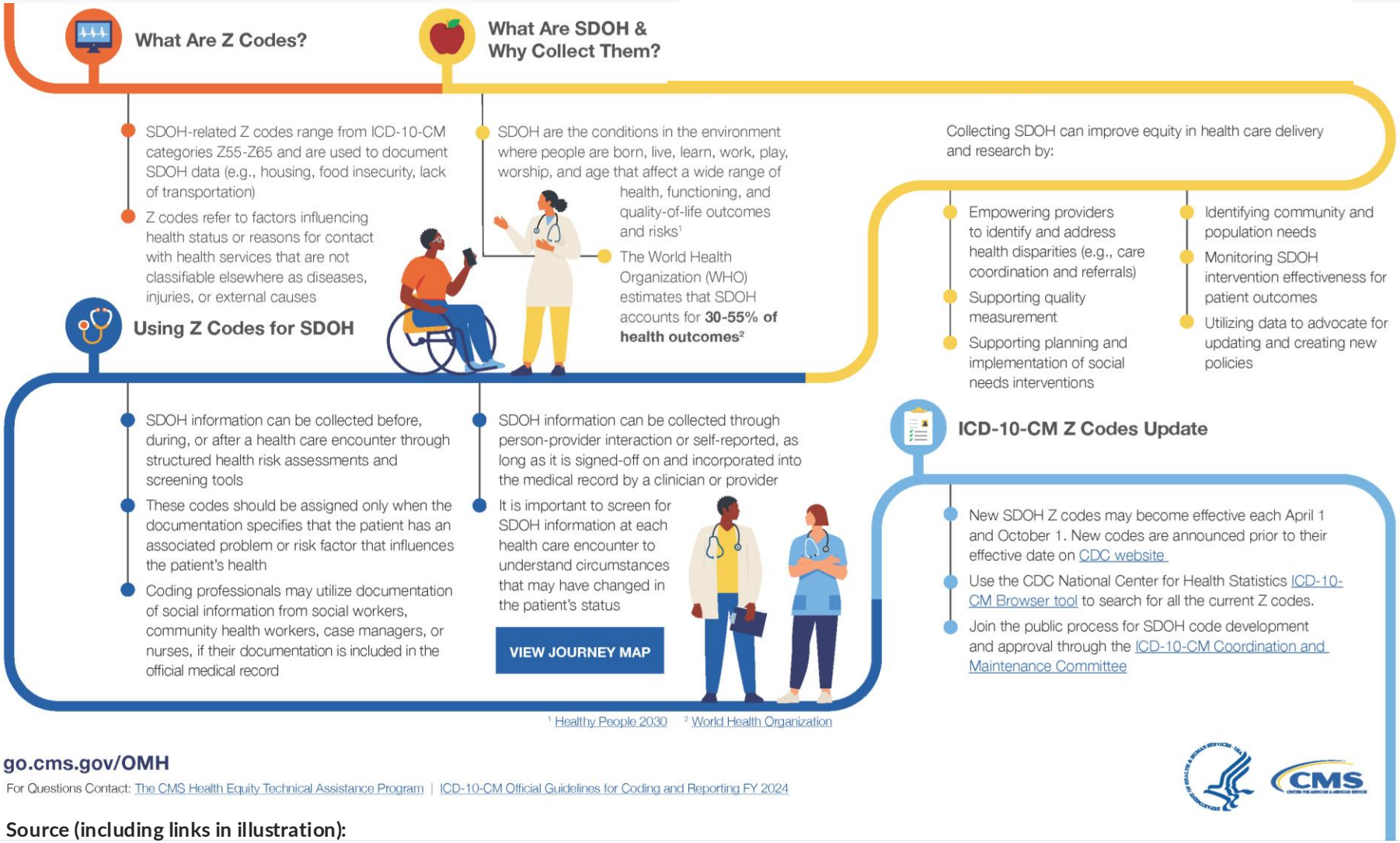
Prevention Quality Indicators (PQIs) help identify hospital inpatient admissions that might have been avoided if a patient had access to outpatient care, including follow-up after discharge. All California hospitals report PQIs to the state's Department of Healthcare Access and Information (HCAI). Hospitals across the nation use the PQI algorithms, which are set by the federal Agency for Healthcare Research and Quality (AHRQ). PQIs measure hospital inpatient admission rates for:

PQI 01 – diabetes, short-term complications
PQI 02 – perforated appendix
PQI 03 – diabetes, long-term complications
PQI 05 – COPD or asthma in older adults
PQI 07 - hypertension
PQI 08 – heart failure
PQI 09 – low birthweight
PQI 10 - dehydration
PQI 11 – community-acquired pneumonia
PQI 12 - urinary tract infections
PQI 14 - uncontrolled diabetes
PQI 15 – asthma in younger adults
PQI 16 – diabetes lower-extremity amputation
PQI 90 - overall composite
PQI 91 - acute composite
PQI 92 - chronic composite
PQI 93 - diabetes composite

PQI Number	Indicator Name	Units of Measure
PQI 01	Diabetes Short-Term Complications Admission Rate	Admissions per 100000 population (ages 18+)
PQI 02	Perforated Appendix Admission Rate	Admissions per 100000 population (ages 18+)
PQI 03	Diabetes Long-Term Complications Admission Rate	Admissions per 100000 population (ages 18+)
PQI 05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	Admissions per 100000 population (ages 40+)
PQI 07	Hypertension Admission Rate	Admissions per 100000 population (ages 18+)
PQI 08	Heart Failure Admission Rate	Admissions per 100000 population (ages 18+)
PQI 09	Low Birth Weight Rate	Percent of newborns
PQI 10	Dehydration Admission Rate	Admissions per 100000 population (ages 18+)
PQI 11	Community-Acquired Pneumonia Admission Rate	Admissions per 100000 population (ages 18+)
PQI 12	Urinary Tract Infection Admission Rate	Admissions per 100000 population (ages 18+)
PQI 14	Uncontrolled Diabetes Admission Rate	Admissions per 100000 population (ages 18+)
PQI 15	Asthma in Younger Adults Admission Rate	Admissions per 100000 population (ages 18–39)
PQI 16	Diabetes Lower-Extremity Amputation Rate	Admissions per 100000 population (ages 18+)
PQI 90	Overall Composite of All Prevention Quality Indicators	Composite rate per 100000 population (ages 18+)
PQI 91	Acute Composite(includes dehydration, UTI, bacterial pneumonia)	Composite rate per 100000 population (ages 18+)
PQI 92	Chronic Composite (includes diabetes, COPD, hypertension, heart failure)	Composite rate per 100000 population (ages 18+)
PQI 93	Diabetes Composite	Composite rate per 100000 population (ages 18+)

Hospital Utilization Data Methods – Z Codes for Social Determinants of Health

Hospitals track the social needs of their patients using "Z codes," which record non-medical factors that affect health. These include housing, employment, education, family support, and other conditions that shape well-being. Z codes can also point to unmet needs in the community and guide future health investments. Below is a detailed explanation of Z-codes from the Centers for Medicare and Medicaid Services.



Source (including links in illustration):
https://www.cms.gov/files/document/cms-2023-omh-z-code-resource.pdf

IMPROVING THE COLLECTION OF

Social Determinants of Health (SDOH) data with ICD-10-CM Z Codes

Exhibit 1. Recent SDOH Z Code Categories and New Codes

Z55 – Problems related to education and literacy
- Z55.5 – Less than a high school diploma (Added, Oct. 1, 2021)
- NEW Z55.6 – Problems related to health literacy

Z56 – Problems related to employment and unemployment

Z57 – Occupational exposure to risk factors

Z58 – Problems related to physical environment (Added, Oct. 1, 2021)
- Z58.6 – Inadequate drinking-water supply (Added, Oct. 1, 2021)
- NEW Z58.8 – Other problems related to physical environment
  - NEW Z58.81 – Basic services unavailable in physical environment
  - NEW Z58.89 – Other problems related to physical environment

Z59 – Problems related to housing and economic circumstances
- Z59.0 – Homelessness (Updated)
  - Z59.00 – Homelessness unspecified (Added, Oct. 1, 2021)
  - Z59.01 – Sheltered homelessness (Added, Oct. 1, 2021)
  - Z59.02 – Unsheltered homelessness (Added, Oct. 1, 2021)
- Z59.1 – Inadequate Housing (Updated)
  - NEW Z59.10 – Inadequate housing, unspecified
  - NEW Z59.11 – Inadequate housing environmental temperature
  - NEW Z59.12 – Inadequate housing utilities
  - NEW Z59.19 – Other inadequate housing
- Z59.4 – Lack of adequate food (Updated)
  - Z59.41 – Food insecurity (Added, Oct. 1, 2021)
  - Z59.48 – Other specified lack of adequate food (Added, Oct. 1, 2021)
- Z59.8 – Other problems related to housing and economic circumstances (Updated)
  - Z59.81 – Housing instability, housed (Added, Oct. 1, 2021)
    - Z59.811 – Housing instability, housed, with risk of homelessness (Added, Oct. 1, 2021)
    - Z59.812 – Housing instability, housed, homelessness in past 12 months (Added, Oct. 1, 2021)
    - Z59.819 – Housing instability, housed unspecified (Added, Oct. 1, 2021)
  - Z59.82 – Transportation insecurity (Added, Oct. 1, 2022)
  - Z59.86 – Financial insecurity (Added, Oct. 1, 2022)
  - Z59.87 – Material hardship due to limited financial resources, not elsewhere classified (Added, Oct. 1, 2022; Revised, April 1, 2023)
  - Z59.89 – Other problems related to housing and economic circumstances (Added, Oct. 1, 2021)

Z60 – Problems related to social environment

Z62 – Problems related to upbringing
- Z62.2 – Upbringing away from parents
  - NEW Z62.23 – Child in custody of non-parental relative (Added, Oct. 1, 2023)
  - NEW Z62.24 – Child in custody of non-relative guardian (Added, Oct. 1, 2023)
- Z62.8 – Other specified problems related to upbringing (Updated)
  - Z62.81 – Personal history of abuse in childhood
    - NEW Z62.814 – Personal history of child financial abuse
    - NEW Z62.815 – Personal history of intimate partner abuse in childhood
  - Z62.82 – Parent-child conflict
    - NEW Z62.823 – Parent-step child conflict (Added, Oct. 1, 2023)
  - Z62.83 – Non-parental relative or guardian-child conflict (Added Oct. 1, 2023)
    - NEW Z62.831 – Non-parental relative-child conflict (Added Oct. 1, 2023)
    - NEW Z62.832 – Non-relative guardian-child conflict (Added Oct. 1, 2023)
    - NEW Z62.833 – Group home staff-child conflict (Added Oct. 1, 2023)
  - Z62.89 – Other specified problems related to upbringing
    - NEW Z62.892 – Runaway [from current living environment] (Added Oct. 1, 2023)

Z63 – Other problems related to primary support group, including family circumstances

Z64 – Problems related to certain psychosocial circumstance

Z65 – Problems related to other psychosocial circumstances

go.cms.gov/OMH

Source (including links in illustration):
https://www.cms.gov/files/document/cms-2023-omh-z-code-resource.pdf

Hospital Utilization Data Methods – Avoidable ED Visits

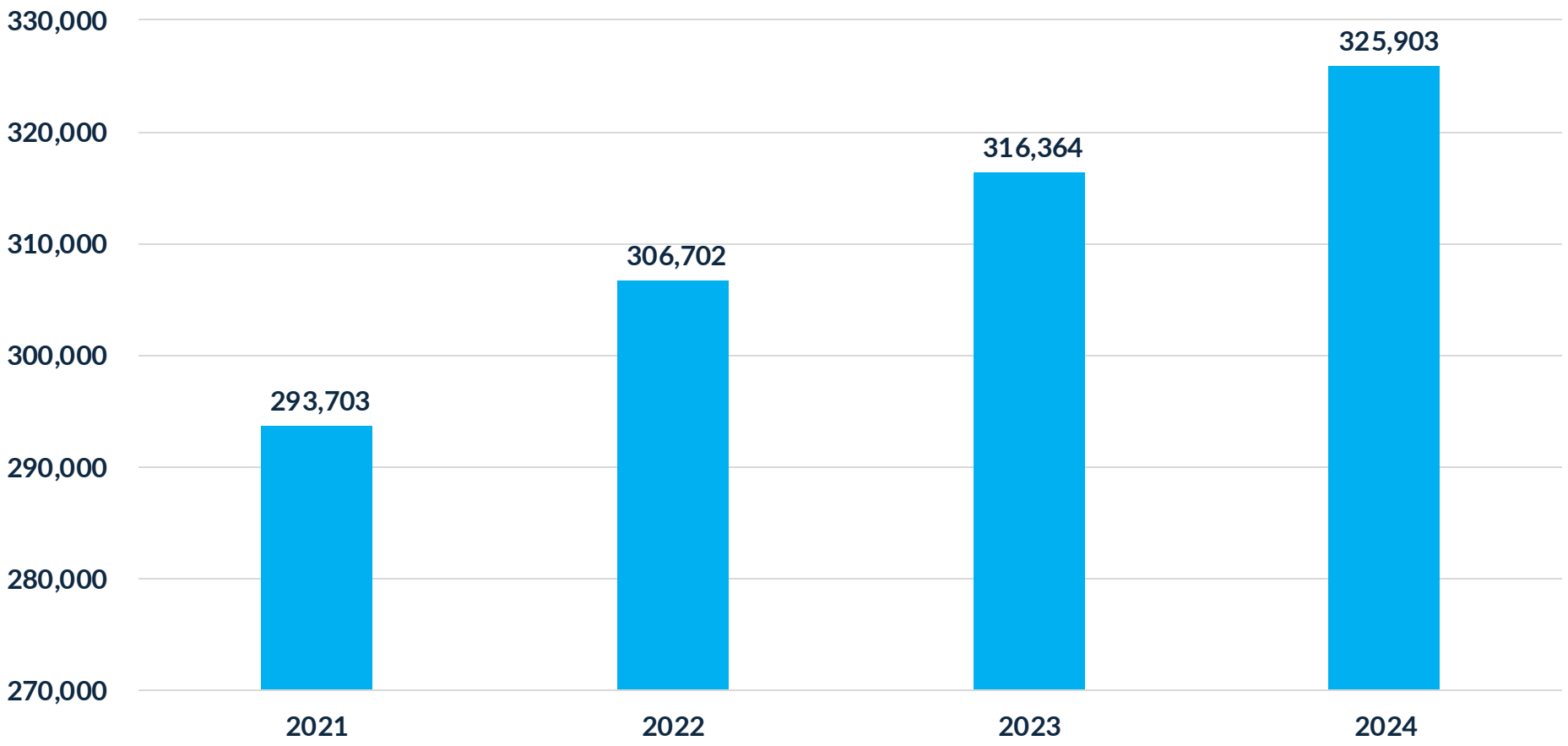
Avoidable Emergency Department Visits

Avoidable emergency department (ED) visits are defined as conditions managed in the ED that likely could have been treated in a primary care setting. When community members visit the ED instead of a primary care doctor, they miss the opportunity for coordinated and comprehensive treatment for their ongoing medical needs.

Avoidable ED visits were calculated using the New York University (NYU) Avoidable Emergency Department Algorithm, a widely used tool that classifies ED visits based on diagnosis codes. The algorithm estimates the proportion of visits that could have been managed in primary care or outpatient settings, providing insight into preventable use of emergency services and gaps in access to care.

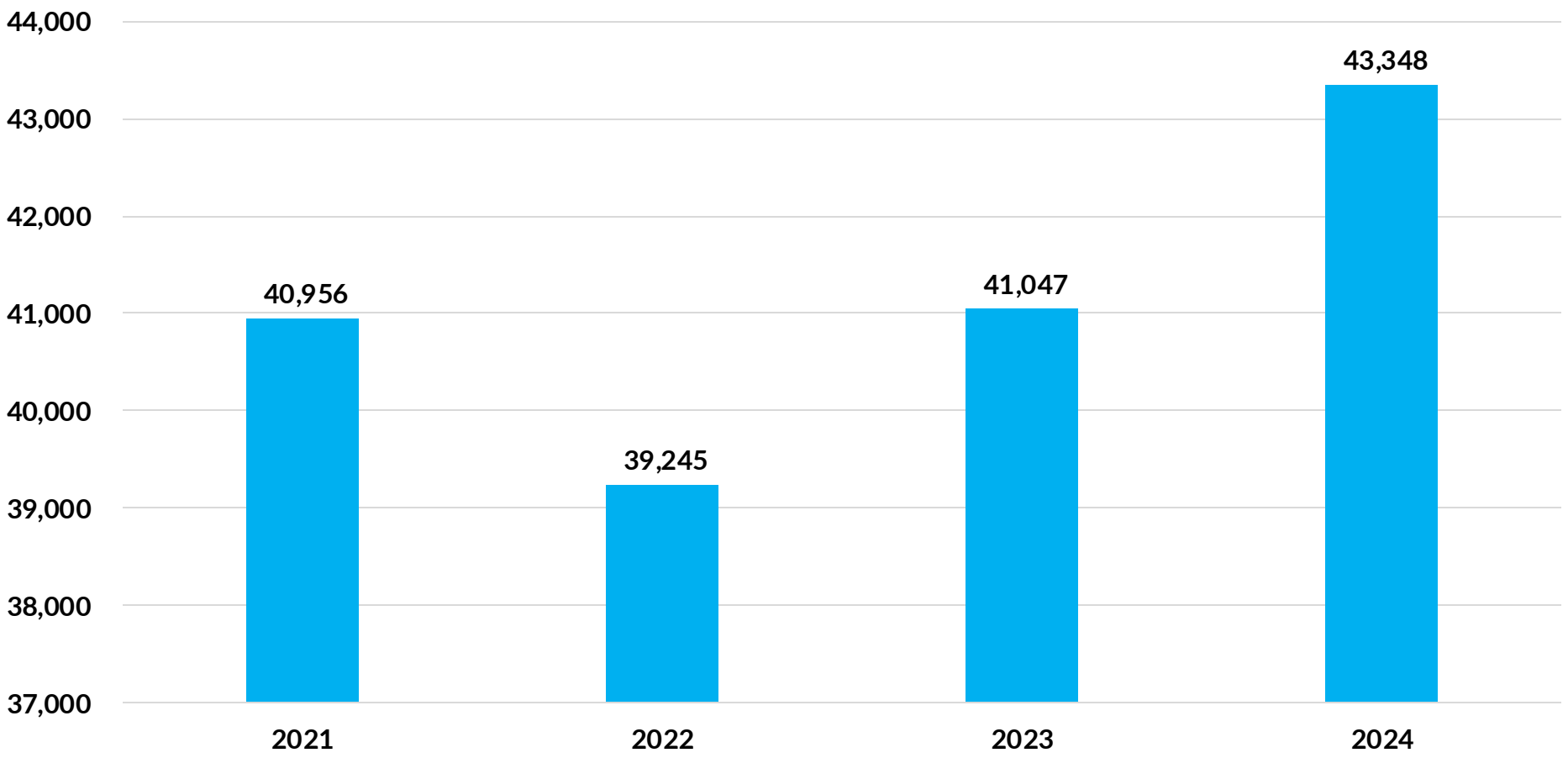
A detailed explanation of the NYU Algorithm, including methodology and limitations, is available in the full reference document here.

Inland Empire General Acute Inpatient Utilization Trend



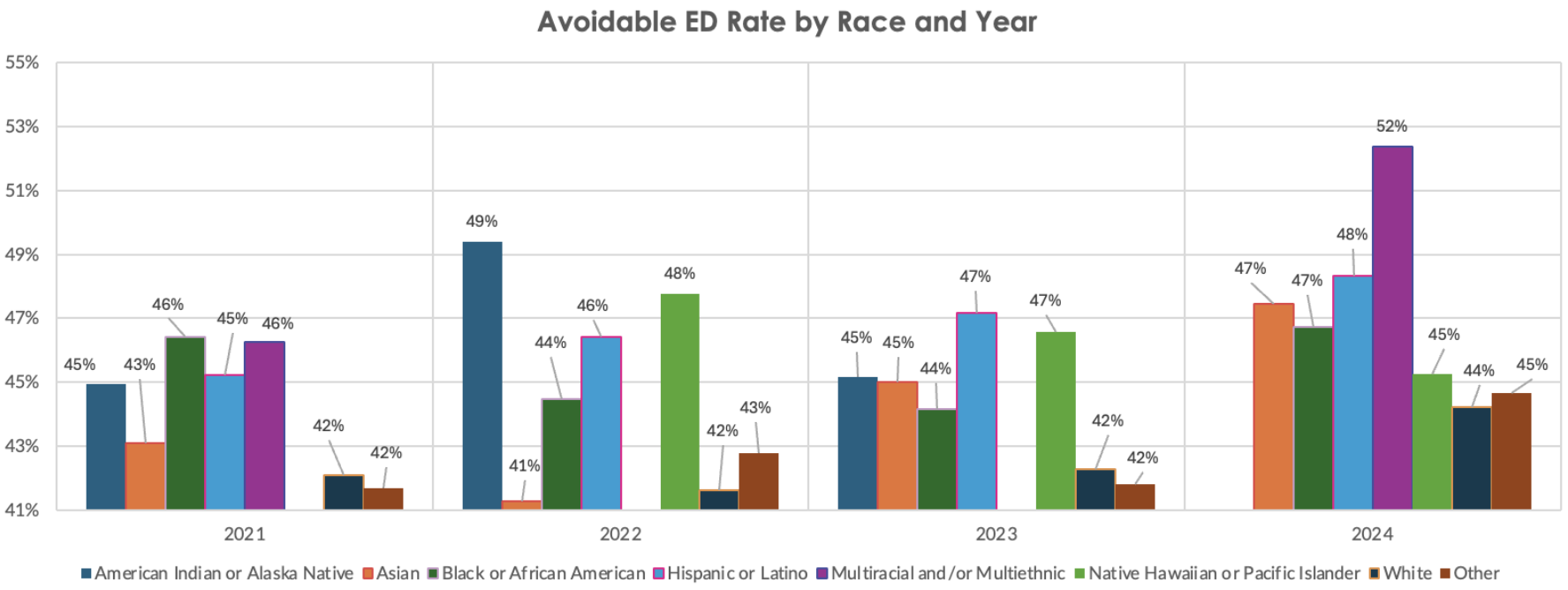
Source:
- California Department of Health Care Access and Information, (https://hcai.ca.gov/data/data-and-reports/)
- Speedtrack (https://speedtrack.com/healthcare/)

Inland Empire General Acute Inpatient Behavioral Health Utilization Trend



Source:
- California Department of Health Care Access and Information, (https://hcai.ca.gov/data/data-and-reports/)
- Speedtrack (https://speedtrack.com/healthcare/)

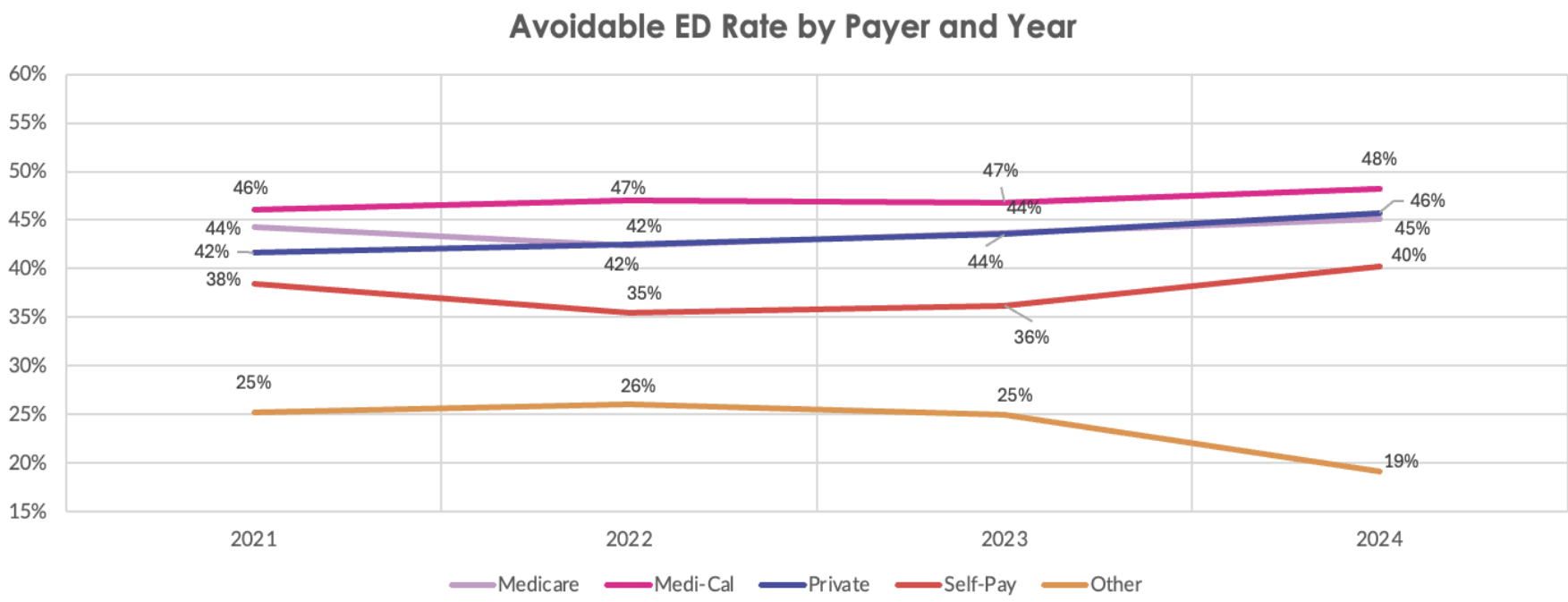
Redlands Community Hospital



Source:
- California Department of Health Care Access and Information (https://hcai.ca.gov/data/data-and-reports/)
- Speedtrack (https://speedtrack.com/healthcare/)

Avoidable ED visits refer to visits that are non-emergent or emergent but could have been treated by a primary care provider. Link to Box for a more detailed explanation:
https://hc2strategies.box.com/s/781ohnqs90nuy5c7b45re7m4io9bp8l8

Redlands Community Hospital



Source:
- California Department of Health Care Access and Information (https://hcai.ca.gov/data/data-and-reports/)
- Speedtrack (https://speedtrack.com/healthcare/)

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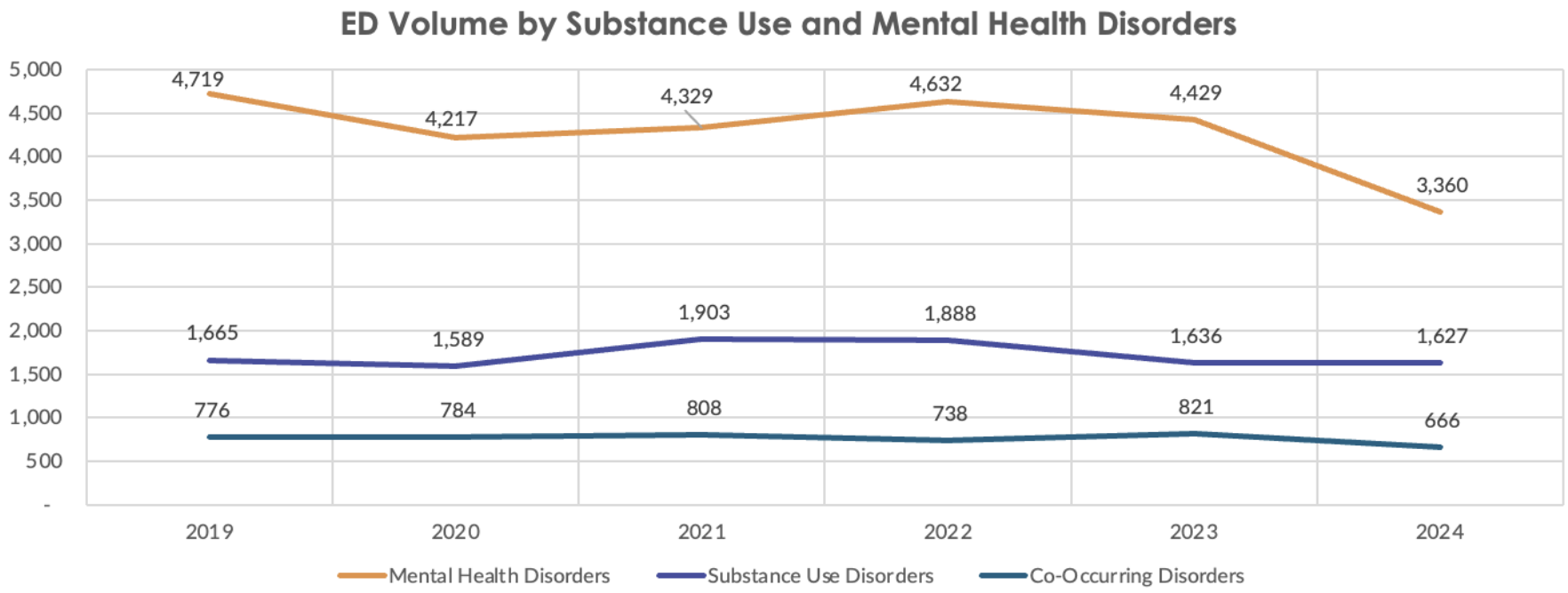
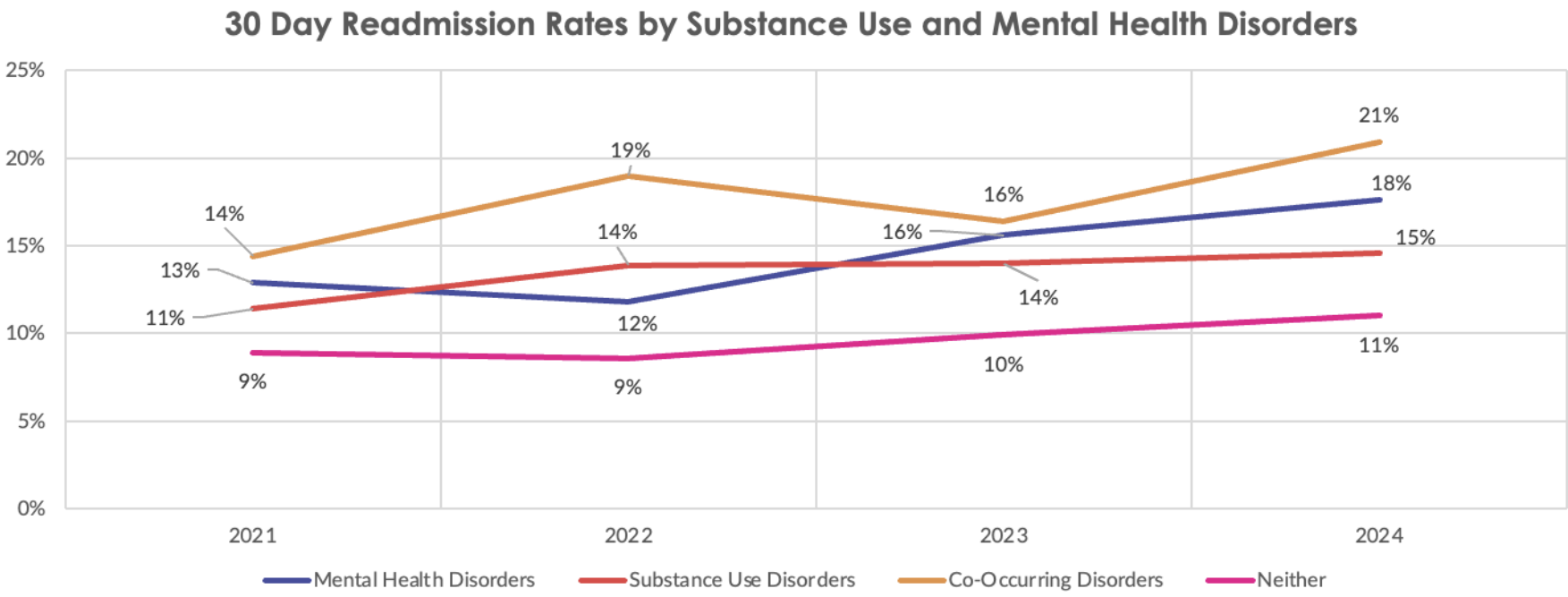
Redlands Community Hospital



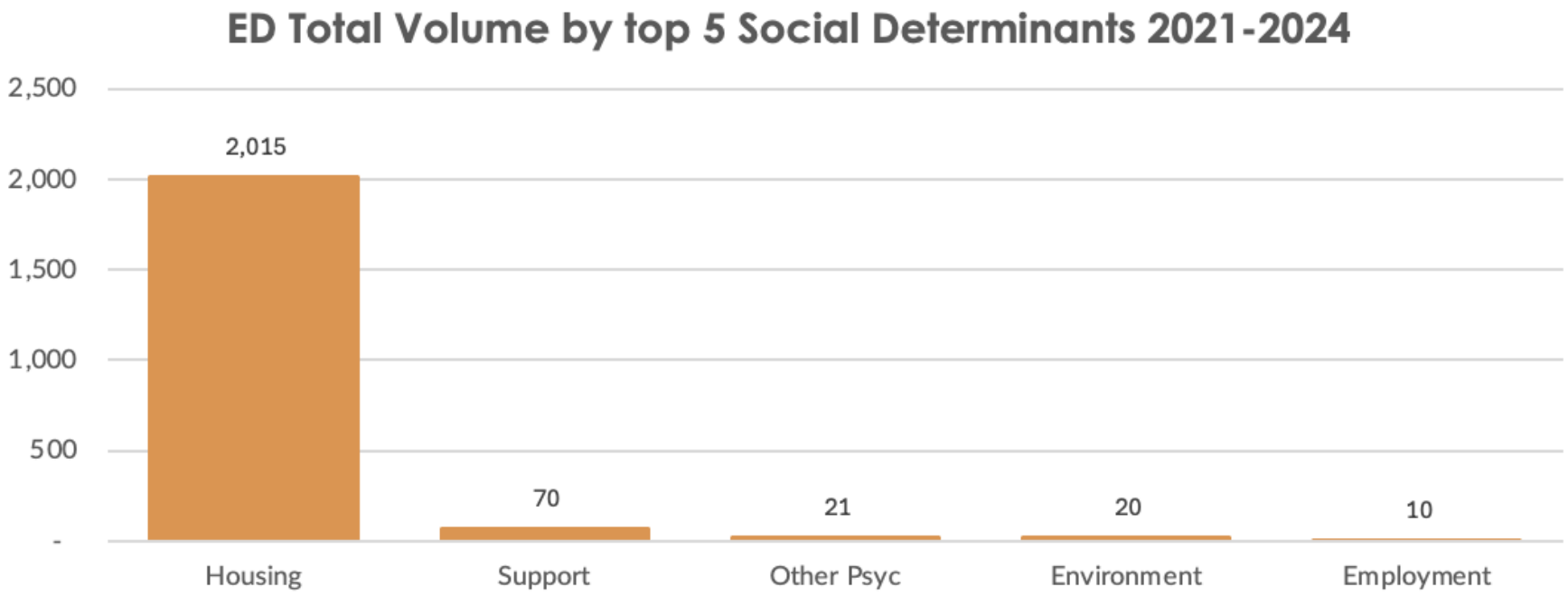
Source:
- California Department of Health Care Access and Information (https://hcai.ca.gov/data/data-and-reports/)
- Speedtrack (https://speedtrack.com/healthcare/)

Redlands Community Hospital



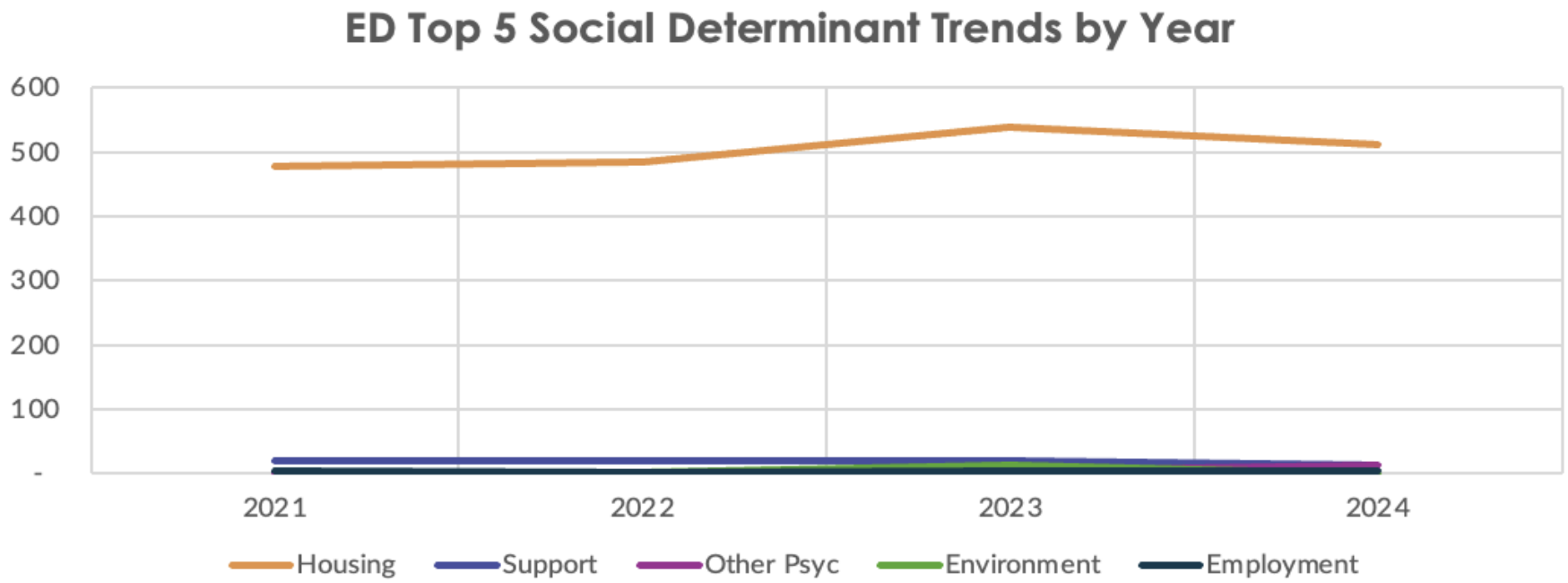
Source:
- California Department of Health Care Access and Information (https://hcai.ca.gov/data/data-and-reports/)
- Speedtrack (https://speedtrack.com/healthcare/)

Redlands Community Hospital



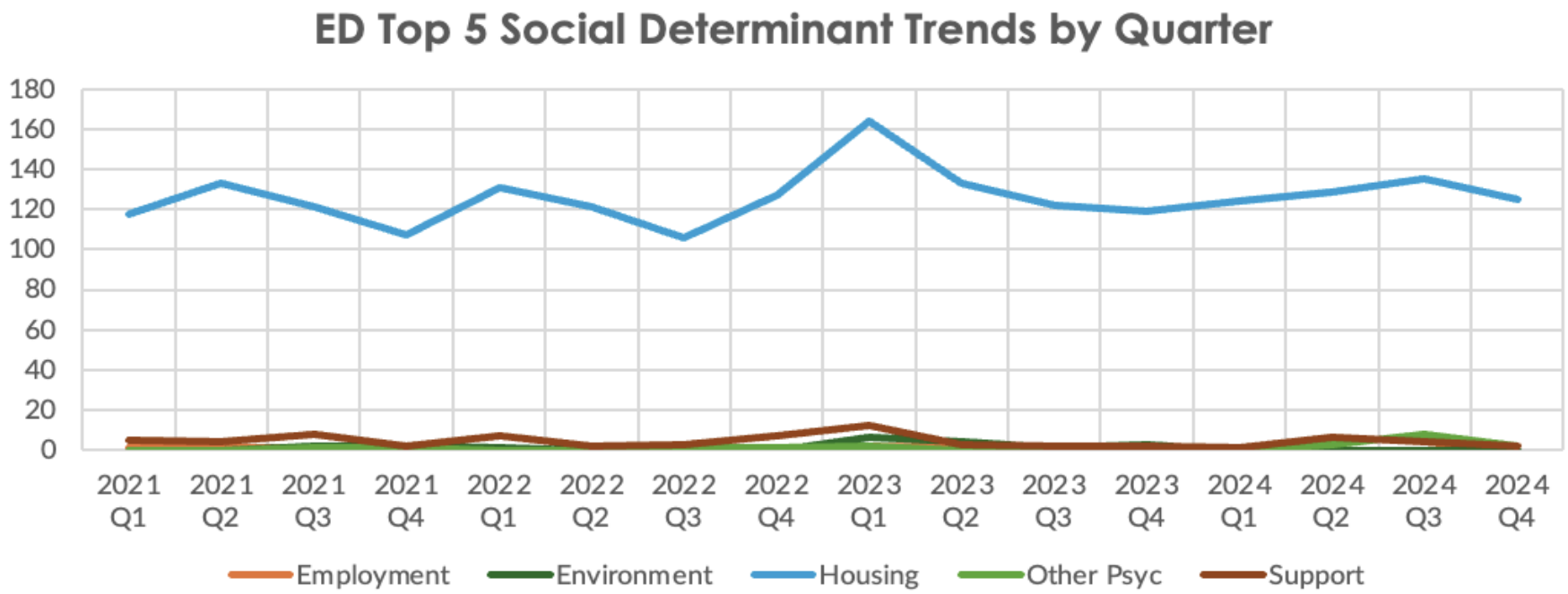
Source:
- California Department of Health Care Access and Information (https://hcai.ca.gov/data/data-and-reports/)
- Speedtrack (https://speedtrack.com/healthcare/)

Redlands Community Hospital



Source:
- California Department of Health Care Access and Information (https://hcai.ca.gov/data/data-and-reports/)
- Speedtrack (https://speedtrack.com/healthcare/)

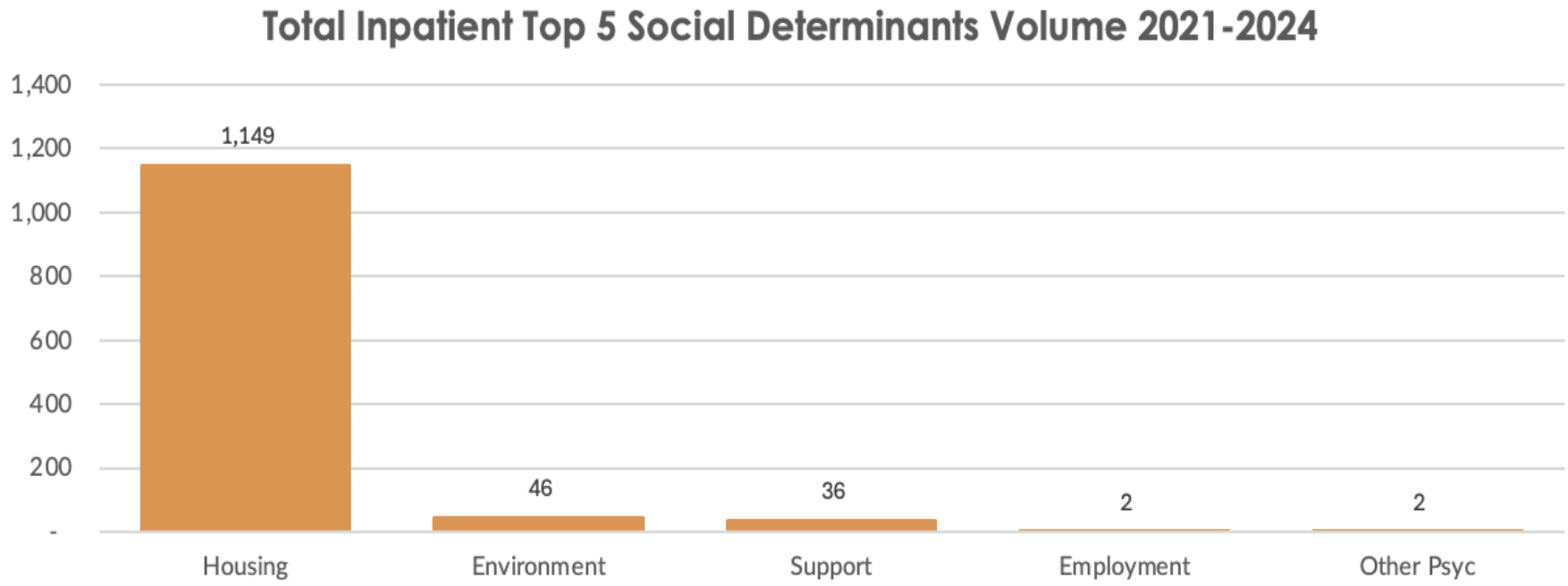
Redlands Community Hospital



Source:

- California Department of Health Care Access and Information (https://hcai.ca.gov/data/data-and-reports/)
- Speedtrack (https://speedtrack.com/healthcare/)

Redlands Community Hospital



Source:
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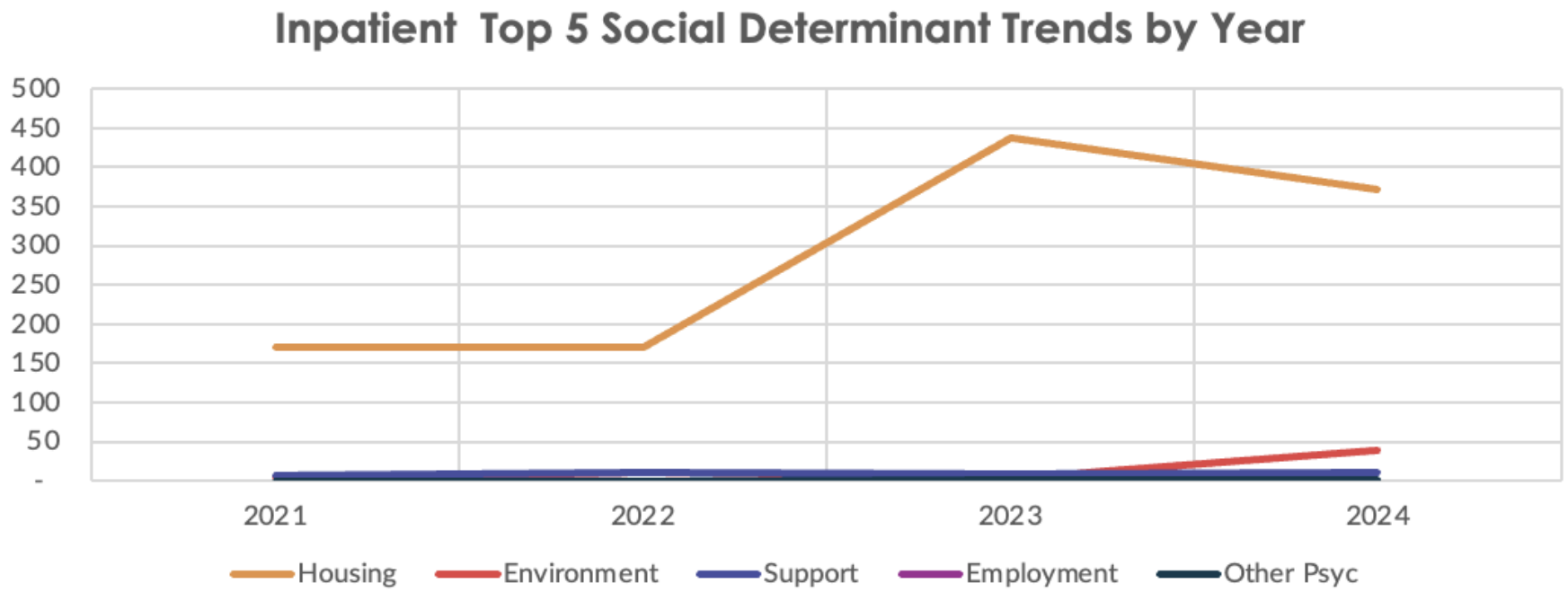
- Speedtrack (https://speedtrack.com/healthcare/)

Redlands Community Hospital



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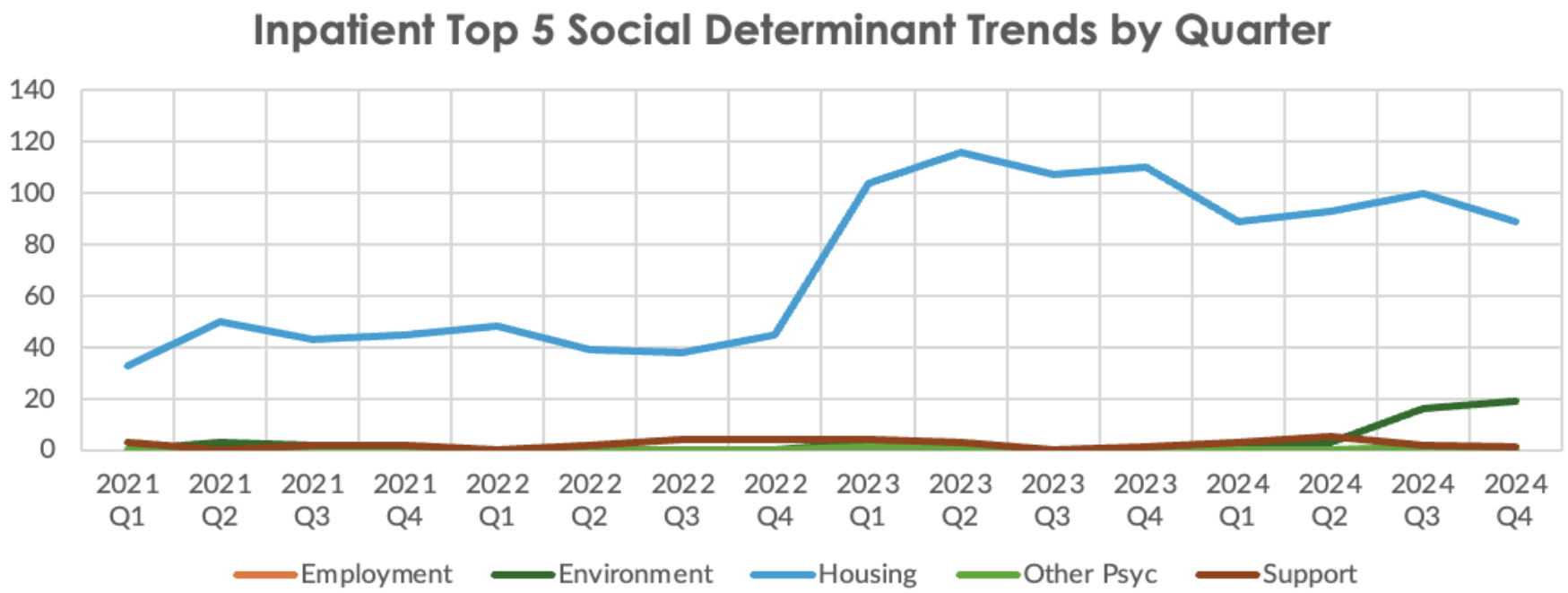
- Speedtrack (https://speedtrack.com/healthcare/)

Redlands Community Hospital



Source:
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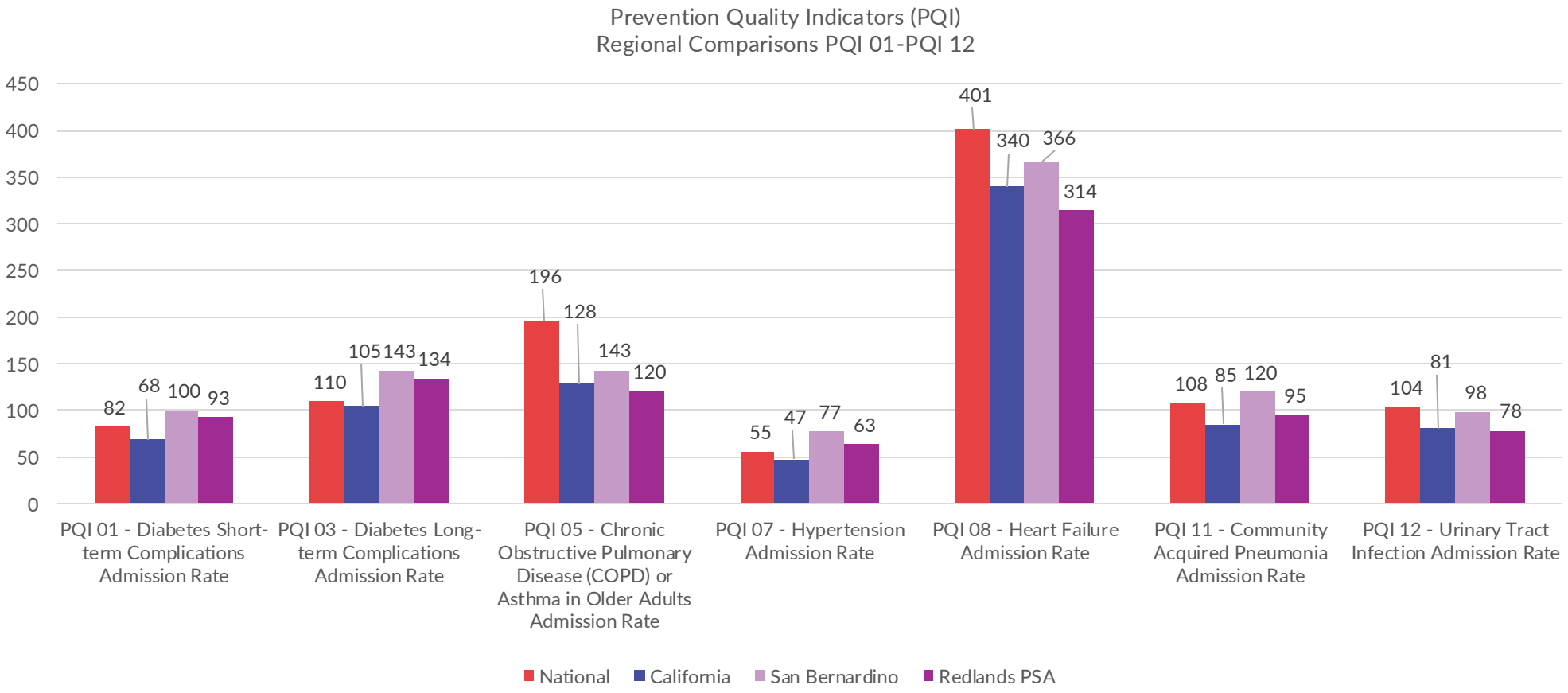
- Speedtrack (https://speedtrack.com/healthcare/)

Redlands Community Hospital



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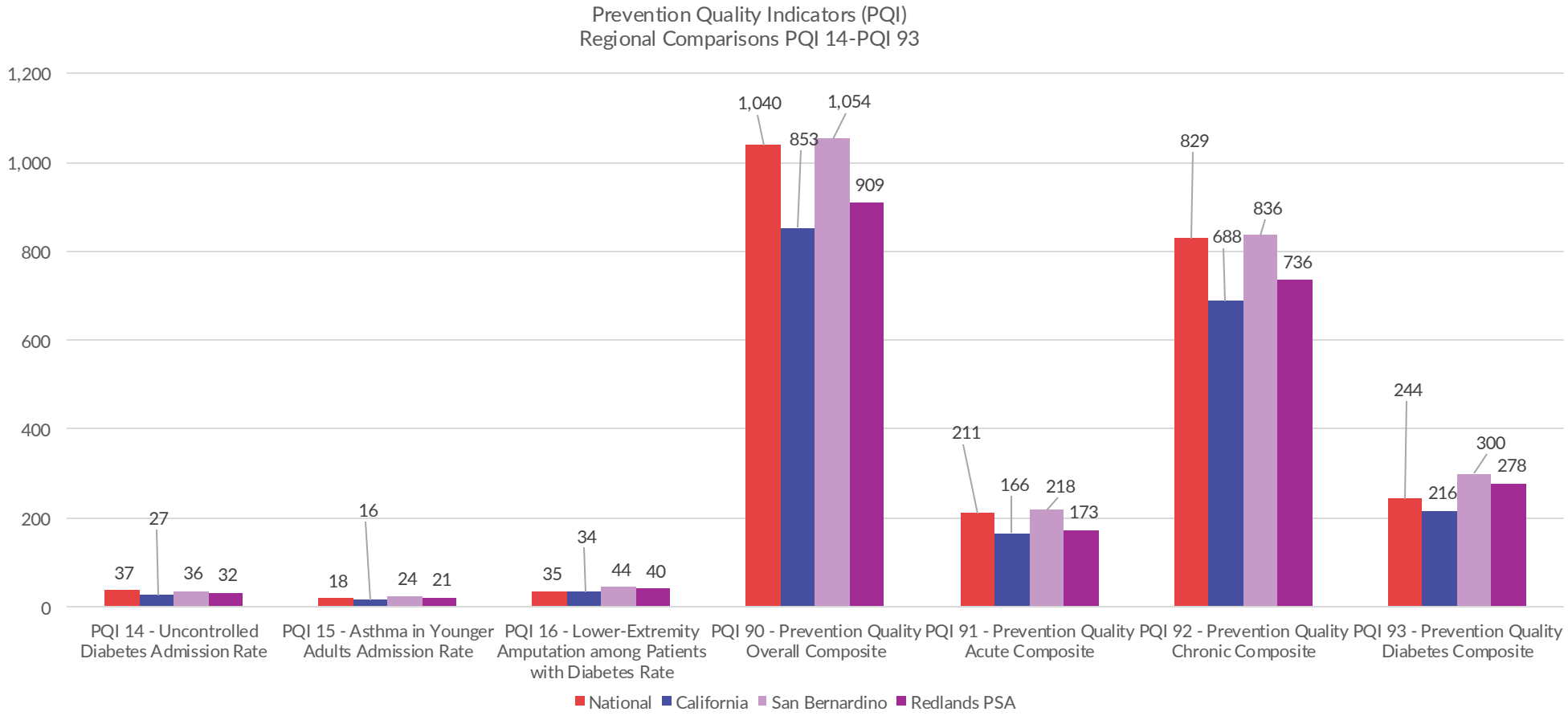
Redlands Community Hospital



Source:
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- Speedtrack (https://speedtrack.com/healthcare/)

Appendix E: Other Inland Empire CHNA/CHA Findings

Other CHA/CHNAs in the Inland Empire Priority Areas

Riverside University Health System Public Health	San Bernardino County CHA	Kaiser (Riverside)	Kaiser (Fontana, Ontario)	Dignity Health - St. Bernardine & Community Hospital of San Bernardino	Loma Linda University Health	St. Mary Medical Center, Apple Valley
Community Survey •RUHS and HARC •November 2022 – February 2023 •40,000 paper surveys were mailed across Riverside County •4,804 local adults, representing a 12% response rate •English and Spanish	**Community Survey** •County-wide community themes and strengths assessment (CTSA) survey • 6,210 community members engaged in the survey, which was available online and on paper in four languages: English, Spanish, Vietnamese, and Mandarin •November 2022 to January 2023	**Key Informant Interviews** •18 key informant interviews •These interviews included both individual and group formats. •April–August 2024	**Key Informant Interviews** •10 key informant interviews •Conducted in June 2024	**Focus Groups** •4 focus groups were conducted in January and February 2025, with a total of 62 community members participating. •2 of the groups were conducted in Spanish. One session was held virtually via Zoom, while the remaining groups were conducted in person. **Key Informant Interviews** •11 community stakeholders took part in a phone interview	**Focus Groups** •21 focus groups were conducted with 150 participants across a range of communities •Sessions were held in both English and Spanish **Key Informant Interviews** •16 in-depth interviews were conducted with regional leaders in public health, education, housing, transportation, behavioral health, nonprofit services, faith-based ministries and local government	**Community Survey** •471 surveys completed **Key Informant Interviews** •46 interviews were conducted from May to November 2023

Other CHA/CHNAs in the Inland Empire Priority Areas

Qualitative Data Themes Expressed in Surveys, Conversations & Key Informant Interviews	
CHA/CHNA	**Key Findings**
Riverside County	• Homelessness and high housing cost • Transportation • Gun violence and property crime • Obesity • Substance use • Poverty • Mental health problems • Health profession shortage • Delays in access to care • Lack of economic diversity and opportunity
San Bernardino County	• Behavioral health • Injury and violence • Chronic disease • Mental health • Poverty • Healthcare access and quality • Unsafe neighborhoods • Racism and discrimination

Kaiser Key Informants (Riverside)	• Lack of access
	  • Health services
	  • Food
	  • Internet
	  • Mental health and substance use treatment
	  • Anxiety, depression, ADHD and addiction
	• Housing affordability
	• Access to housing aid programs
	• Mental health and substance use
	• Support services for LGBTQ individuals
	• Shortages of workforce
	• Culturally competent care
	• Lack of bilingual providers
	• Maternal health

Kaiser Key Informants (San Bernardino)	• Meaningful work and health
	  • Poverty
	  • Need for workforce development
	• Thriving natural world
	  • Geographical disparities
	  • Air pollution
	  • Lack of walkability and green spaces
	  • Prioritize sustainable investment within the community
	• Access to care
	• Healthcare provider shortage
	• Maternal and Infant Health
	• Diabetes
	• Obesity
	• Sickle-cell anemia
	• Respiratory disease
	• Heart disease
	• Humane housing
	  • Affordable housing options for students
	• Belonging and civic muscle
	  • Need for culturally responsive services and care
	  • Inclusion of youth voices in programs and policies
	  • Cultural competency
	  • Support for LGBTQ+ spaces, and quality care without stigma
	• Reliable transportation
	• Basic needs for health and safety
	  • Poor food access
	• Mental and behavioral health
	  • High need for services
	  • The youth are struggling
	• Lifelong learning
	  • Low educational attainment limiting economic diversity

Loma Linda University	• Access to affordable culturally sensitive healthcare • Better mental health services including counseling and peer support • Need affordable housing options for families, seniors, and people in recovery • Safe, clean environments free from neighborhood violence and environmental hazards. • Lifelong learning • Thriving natural world • Belonging and civic muscle • Need for local job creation to reduce long commute times and improve quality of life. • Prevention, lifestyle and managing chronic conditions
Dignity Hospitals	• Access to healthcare services • Cancer and Diabetes • Awareness, education and preventative care needed • Mental health • Nutrition, physical activity and weight • Oral health • Potentially disabling condition • Respiratory disease • Heart disease and stroke • Housing • Sexual health • Substance abuse

Riverside County CHA

Riverside County CHA: Survey Reponses	
IDENTIFIED NEED	**COMMUNITY VOICES**
Racial Equity	• A quarter of participants said they had paid "a lot of attention" to issues of race and racial equity over the past three months. • Another quarter said they'd paid no attention at all. • Opinions were split on whether the amount of attention paid to racial issues in the U.S. was appropriate. • Majority of participants (63%) believe that it it "very important" to educate themselves about the history of racial inequality in the country.
Inflation	• Participants were also asked about how inflation had impacted them. Most described how inflation had affected their life (e.g., increased cost of goods and services without an increase in income). Several said that it had not affected them in any way. However, others said they were trying to fight back by working more (even coming out of retirement to go back to work) and budgeting/minimizing their spending. A common theme was how stressful living on a tight budget can be; some were forced to dip into their savings to make ends meet while others racked up credit card debt.
Great Resignation	• To assess the impact of the "Great Resignation" locally, participants were asked whether they voluntarily quit a job in 2021 or 2022; approximately 11% did, equating to 172,112 adults. The most common reasons for quitting included low pay, being disrespected at work, lacking opportunities for advancement, and lacking flexibility in scheduling.
Neighborhood Quality	• Participants were asked to rate the quality of their neighborhood as it pertained to several different domains. Overall, transportation and the economy have the lowest ratings overall; 15% rate the quality of transportation in their neighborhood as "poor" and 14% rate the quality of the economy in their neighborhood as "poor". In contrast, health/wellness, housing, and the environment are at excellent, with 16.5%, 14.2%, and 13.9%, respectively.
Most important health problems	• Participants were asked to select the five most important health problems that need to be fixed in their community from a list of options, and additional comments were available to write in. Results show that the most important health problems included **mental health, a shortage of healthcare professionals, and delays in access to healthcare.**
Social Issues	• To determine social issues, participants were asked to select the five most important social problems that need to be fixed in their community with an option to fill other concerns. Results show that the most important social problems included **homelessness, and high housing costs (purchase or rental).**

Riverside County CHA

Riverside County CHA: Survey Reponses	
INDENTIFIED NEED	**COMMUNITY VOICES**
General Health	• In general, participants rate their mental health slightly better than their physical health. Approximately 19% rated their physical health as "fair" or "poor", and 16% rated their mental health as "fair" or "poor."

San Bernardino County CHA

San Bernardino County CHA: Survey Responses	
IDENTIFIED NEED	**COMMUNITY VOICES**
Behavioral Health	• Drug overdose deaths as a leading contributor to premature death • Frequent mental distress is a corollary measure to poor mental health days. The percent of adults in San Bernardino County (18+ years) with poor self-reported mental health in the past year was 16.1% in 2021, a significant increase from 12.1% in 2017. In 2020, the average number of self-reported mentally unhealthy days in the past month in San Bernardino County was 4.6 days, higher than in California at 4.0 days. • 21% of the respondents reported having never had an appointment with a mental health professional and 11.0% reported difficulty remembering the last time they had an appointment with a mental health professional. • 35.6% of all CTSA Survey respondents and 52.7% of respondents who identify as a person of color indicated that access to mental health services is one the most important components of improving their health and well-being.
Injury and Violence Prevention	• 29.0% of all CTSA Survey respondents and 48.3% of respondents who identify as a person of color indicated that rape and sexual assault are among the most damaging to the health of their community. • 32.4% of all CTSA Survey respondents and 49.3% of respondents who identify as a person of color indicated that car accidents related to driver behaviors (texting, aggressive, distracted, or impaired driving) are among the most damaging to the health of their community.
Chronic Disease	• 31.6% of all CTSA Survey respondents and 51.0% of respondents who identify as a person of color indicated that chronic health conditions like diabetes, heart disease, and high blood pressure are among the most damaging to the health of their community. • 29.5% of all CTSA Survey respondents and 48.8% of respondents who identify as a person of color indicated that a lack of exercise is among the top five things that are the most damaging to the health of the people in their community.
Economic Stability	• Many residents struggle to afford basic needs • Survey respondents were asked to indicate how often they lack money for living essentials including rent/mortgage, utilities, food, cell phone or other phone, and gas or other transportation.
Healthcare Access and Quality	• Health insurance coverage disparities among Hispanic/Latino residents • Provider shortage • Reports of experiencing access to care. Top 4 most common barriers identified were: lack of evening and/or weekend hours of service, ineligible for services, high out-of-pocket costs/cost too much month, no appointment available or could not get an appointment in a reasonable amount of time • Commute time to doctors office and reliable transportation were also cited as a pressing barrier • A total of 992 reported having experienced rat least one case of racism or discrimination from a healthcare provider • 146 respondents who did not identify as POC reported having experience at least one case of racism or discrimination from a healthcare provider

San Bernardino County CHA

San Bernardino County CHA: Survey Responses	
IDENTIFIED NEED	**COMMUNITY VOICES**
Social and Community Context	• Unsafe neighborhoods: violent crime, aggravated assault/battery and homicide were higher in the County then in California • Higher percentage of respondents who identify as a person of color express feeling unsafe where they live • Juvenile arrest is nearly twice as high as the state
Racism and Discrimination	• Among the CTSA respondents, 81.0% indicate experiencing discrimination because of race, ethnicity, or skin color and 60.0% indicate that groups who are not white experience discrimination.
Mental Health	• 16.1% of adults in 2021 self-reported poor mental health during the past year. The rate has significantly increased since 2017 when it was at 12.1%. The average number of mentally unhealthy days in the past month in San Bernardino County was 4.6 days, higher than in California at 4.0 days • 35.6% of all CTSA Survey respondents and 52.7% of respondents who identify as a person of color indicated that access to mental health services is one the most important components of improving their health and well-being.
Cross cutting themes	• Structural racism

Kaiser Riverside CHA

Kaiser Riverside CHA: Key Informants	
IDENTIFIED NEED	**KEY INFORMANTS**
Basic Needs for Health and Safety	• Increase access to internet connection • Top health challenges are food scarcity, obesity, high blood pressure and poor nutrition • Mobile services • Lack of access to health food, care and education
Lifelong Learning	• Increased access to parenting classes. • Quality education
Humane Housing	• Increased access to affordable housing. • A top health issue is lack of housing and difficulty accessing available housing • Difficulties with housing • Utility assistance • Strict eligibility for housing aid programs
Mental and Behavioral Health	• Top health challenges includes mental health and substance use • Top mental health issues include anxiety, depression, ADHD, and addiction • Some root problems of mental health challenges are trauma, financial burdens, lack of early prevention and awareness and biological ADHD • Instability due to low behavioral health provider capacity • Shift focus to mental health and social emotional learning programs • Need for community-based psychoeducation and early intervention • Mobile mental health unites for clients lacking privacy or transport • One stop support center for LGBTQ+ individuals • Some challenges that impact addressing health needs include misconceptions about mental health
Meaningful Work and Wealth	• A top challenge preventing solutions is the job market's misalignment with housing wages • Unemployment • Instability due to systematic poverty and pandemic-related issues • Hiring from local communities • Assisting patients in finding jobs • There is a workforce shortage and high turnover rate • Expand workforce development • Need for better employment opportunities that pay a living wage • Need to address poverty • Areas most impacted by poverty include Hemet and Coachella Valley because they lack a strong base and education opportunities

Kaiser Riverside CHA

Kaiser Riverside CHA: Key Informants	
IDENTIFIED NEED	**KEY INFORMANTS**
Belonging and Civic Muscle	• Freedom from systematic discrimination and negative experiences with providers • Bias in healthcare • Cultural stigma • Involving youth in community planning • Investing in cultural responsive training, community informed engagement and design programs with the intent of focusing on how it can be for the community, not with. • Need for greater civic participation and public policy engagement, specifically from affected communities and youth
Resource Navigation and Awareness	• Family support is a large issue, not because of a lack of resources, but because people are unaware of how to access the resources. • Major of accessible resources and resource awareness • More care navigators and promotores • Better coordination of care between medical and mental health providers
Thriving Natural World	• Funding is a major issue with a lack of culturally and linguistically appropriate services • Recommends Kaiser should fund community partners who have a flexible investment model • Promote Kaiser's community services and invest in community education • Partner with county agencies, schools, colleges and funders • Focus on multi-year grants to support sustainability, infrastructure support and evaluation of funded initiatives • More funding for different purposes • Community reinvestment
Access to care	• Top health issues is access to quality care • Lack of bilingual providers • Need for more family and social programs that promote community safety • Vision health • Geographic access disparities • Cultural competent care • Creating clinics in underserved areas • Address long wait times and limited local access to care • More preventive care • Physician shortage in the area that has caused problems with access to care • High provider turnover

Kaiser Riverside CHA

Kaiser Riverside CHA: Key Informants	
IDENTIFIED NEED	**KEY INFORMANTS**
Maternal and Infant/Child Health	• Child health outcomes • Women's health • Lower childcare costs • Maternal health as a top health need
Reliable Transportation	• Agreement that transportation and community safety are important
Community Safety	• Emerging need is community safety
Cross cutting themes	• Focus on marginalized groups including LGBTQ individuals, low-income populations, system-impacted individuals, women, children, the elderly, unhoused people and those with limited English proficiency • Address inequities based on race, gender and socioeconomic status • Develop culturally responsive programs with community input • Build community trust between institutions and the community • Strengthen community infrastructure by promoting collaboration between institutions like schools, and invest/support sustainable community-led solutions • Improve access to basic needs like healthy food • Find sustainable funding and work towards more integrated systems to meet health needs effectively • Promote cultural humility within healthcare to tackle cultural stigma

Kaiser San Bernardino CHA

Kaiser San Bernardino CHA: Key Informants	
IDENTIFIED NEED	**KEY INFORMANTS**
Meaningful Work and Wealth	• Supports unemployed and underemployed residents • Poverty as a top health need • Workforce development for youth. More paid internships to support local hiring. • Investing in local workforce development • Economic decline • High desert's lack of economic drivers which forces residents to commute long distances for work • Increase involvement from the business community to invest in employee health and community wellness • Many queer youth struggle with employment due to limited affirming workplaces, lack of mentorship and financial hardships
Access to care	• Limited access to healthcare providers • Limited provider availability, lack of evening/weekend care, broadband issues, billing restrictions and stigma around mental health. Increasing clinic hours to evenings/weekends and enhancing tele-health options can help overcome barriers for working individuals who cannot afford to take a day off work. • Major provider shortages making it hard for patients to access care and get referrals. • High demand for healthcare professionals, mostly nurses and clinical staff. • Recommendations include support skills training and wraparound services • Increase investment in wraparound services and youth development • Make services more accessible • Students lack access to stable healthcare outside of school • Partner with trusted, community-rooted organizations for service delivery • Recommendations to expand tele-health and revising billing policies • Increasing mobile services in transit-poor neighborhoods • There is a regular lack of awareness or access to existing resources among community members, limiting their ability to benefit from available programs • Addressing health needs requires strong partnerships among health departments, hospitals, providers, community-based organizations and health plans to deliver care where people live and reduce access barrier. • Scaling up community health workers and patient navigators is key to educating residents, helping them navigate complex health and social services, and improving cultural responsiveness. • Enhanced coordination between primary care and behavioral health services is needed, including co-locations of services and integrated care models, to address comprehensive health needs effectively. • Provide support services like transportation, childcare and culturally appropriate programming is vital to reduce barriers to care and improve health outcomes.

Kaiser San Bernardino CHA

Kaiser San Bernardino CHA: Key Informants	
IDENTIFIED NEED	**KEY INFORMANTS**
Maternal and Infant Health	• Top health priority includes maternal and infant health • High Black infant mortality • Geographic isolation in the high desert and mountain areas limits access to quality maternal care, including specialized hospital services • LGBTQ+ community lacks visible, inclusive perinatal healthcare resources • Pregnant teens face inconsistent support and insufficient school-based resources across different regions • Black and Indigenous communities experience significant disparities in maternal and infant health outcomes. The Latinx community benefits from protective cultural factors. Expanding culturally reflective, community-based programs, including more midwives and inclusive partner support, can improve outcomes.
Health Problems	• Diabetes • Obesity • Sickle-cell anemia • Respiratory disease • Heart disease
Thriving Natural World	• Geographical equity; high desert and mountain areas face the greatest challenges • Healthiest community assets include Loma Linda, mountain areas like Big Bear and Wrightwood, offering recreational activities such as hiking and mountain biking, and overall large communities with parks and social support networks • Air pollution as a challenge • Lack of walkability and green space • Recommendations for funding trusted community-led programs and grassroots organizations • Sustainable, long-term funding for community organizations is needed to avoid overburdening volunteers and enabling lasting change • Current funding prioritizes short-term projects rather than long-term systemic change or community mobilization, which is necessary to address root causes of health disparities.
Humane Housing	• Housing insecurity, particularly in students remain a significant top health and social need.

Kaiser San Bernardino CHA

Kaiser San Bernardino CHA: Key Informants	
IDENTIFIED NEED	**KEY INFORMANTS**
Belonging and Civic Muscle	• Need for culturally responsive services, programs and organizations, as well as inclusion of youth voices • Invest in the youth • Involve youth in community planning • Mismatch between provider communication and patient expectations is a cultural competency need, along with a need for culturally matched staff and liaisons • Recommendations to increase culturally responsive care, recruit from underserved communities • Participants highlighted that health needs assessments often collect data but fail to translate into concrete policy changes, investments or equitable services in underserved neighborhoods. Recommendations include ensuring direct resource allocation based on CHNA findings. • Black and Caribbean communities, rural residents, older adults, women and transgender individuals face significant health disparities and mistrust in care • Need for geographical equity in the high desert and mountain areas • Empower the community to find their own solutions rather than relying on external programs • Invest in social justice mobilization and influence policymakers to create structural changes • COVID-19 worsened health disparities • Inequities affect mainly Latino populations and certain geographies • Need for culturally competent, affirming communication that treats LGBTQ youth as capable individuals with valid experiences. Professionals must listen actively and engage youth in meaningful conversations about their needs. • Support for LGBTQ+ youth varies widely across school districts. While some actively engage LGBTQ+ youth and host pride events, other remain resistance, reflecting ongoing cultural wars and inconsistent policy implementation. Key local resources include True Evolution, Desert AIDS Project, IE Prism Collective, Planned Parenthood, Clay Counseling Solutions, and others. Grassroots groups and social spaces like Bird Cage Café play vital roles in support and identity affirmation. • Simplifying and normalizing the collection of sexual orientation and gender identity data, ensuring culturally competent care, and increasing access to LGBTQ affirming services are key priorities to reduce health disparities.
Reliable Transportation	• Limited access to transportation
Basic Needs for Health and Safety	• Basic needs remain unmet for many families • Poor food access • Limited access to grocery stores • Recommendations for investment in food access initiatives tied to economic development • Recommendations include implementing zoning reforms to reduce fast food/liquor stores and require health retails • Poor air quality influenced by the Los Angeles basin

Kaiser San Bernardino CHA

Kaiser San Bernardino CHA: Key Informants	
IDENTIFIED NEED	**KEY INFORMANTS**
Mental and Behavioral Health	• Mental health is a number one concern, especially post COVID-19. • Behavioral challenges and lack of coping skills in students remain a top health and social need • High need for mental and behavioral health services • Youth are disconnected and unsure about their future. Barriers to this include lack of mentorship, transportation, and stable employment. Issues like homelessness, violence and social media have worsened youth mental health. • Recommend expanding school-based mental health and health access • LGBTQ+ youth face significant mental health challenges linked to stigma, lack of family support, and systemic barriers • Access to affirming mental health services and trust community organizations is essential
Lifelong Learning	• Teachers and staff are burnt-out and under-resourced. Schools need more social/emotional support staff. • COVID-19 deepened learning loss, trauma and disengagement. Parents also struggled to navigate learning and service systems. • Region has low educational attainment, limiting economic diversity and contributing to over-reliance on logistics and manufacturing jobs with low barriers to entry.
Cross cutting themes	• COVID-19 magnified existing inequalities, community fatigue, isolation, and burnout. • Build institutional trust with the community. Transparency and communication with the community is key. • Need for better inter-count cooperation • Prioritize relationship-building and equity-centered design • Uplift the voices of the youth in policy and program design within the community • Acknowledge health inequities rooted in systemic discrimination

Dignity Health Hospitals CHNA

Dignity Health Hospitals CHNA: Community Voices & Key Informant Interviews	
IDENTIFIED NEED	**COMMUNITY VOICES & KEY INFORMANTS**
Access to Health Care Services	• Contributing factors: long waits for appointments, fragmented healthcare system and the gap in the continuity of care. One major challenge when accessing healthcare services is not having the digital competency to find services, as well as the language barrier. Ability to pay is another barrier. • Access to care/services: there are limited resources in the community. Easy access and availability to mental health support • Social determinants of health: SDOH such as access to primary care, transportation, nutritional food insecurity, green space for physical activity, cultural and linguistically appropriate care and medical illiteracy • Cultural competence: digital competency to find services is an emerging challenge • Awareness/education: knowledge about resources for the community • Income/poverty: economic and social barriers • Health disparities • Vulnerable populations: senior care, Medicare plans do not cover a lot of their healthcare needs
Cancer	• Lifestyle: the risk of all individuals developing or being diagnosed with cancer continues to increase and with the impacts of COVID, certain lifestyle habits have changes or worsened, which may increase risk of being diagnosed with Cancer. • Prevention: many of the most prevalent cancers are preventable. Some has effective screening and prevention programs such as colorectal screening and HPV vaccinations of target groups. • Incidence/Prevalence: stats show that there are many people diagnosed with this terminal illness. • Awareness/Education: people need information about treatment and how to assist people with this disease.
Diabetes	• Diabetes ranked as a top concern • Contributing factors: education and access to care. Food insecurity, poor economic conditions, eating habits, nutrition literacy, lack of regular exercise, lack of access/affordability of medication, and lack of health literacy related to managing their condition. • Awareness/education: people need information about the treatment and how to assist people with this disease. • Access to care: lack of community resources to aid in its management and prevention. • Access to affordable healthy food • Affordable medications/supplies • Diabetes management

Dignity Health Hospitals CHNA

Dignity Health Hospitals CHNA: Community Voices & Key Informant Interviews	
IDENTIFIED NEED	**COMMUNITY VOICES & KEY INFORMANTS**
Mental Health	• Mental Health ranked as a top concern • Access to care/services: access to timely and affordable ongoing mental health services. Biggest challenge is finding mental health providers, especially in the adult population 55+ and accessing psychiatry services. • Homelessness: Mental health issues are a major source of homelessness. The issues range from the lack of proper treatment facilities and management for the homeless. • Contributing factors: Access to care. Social stigma associated with mental health and inadequate access to services or counseling. Lack of culturally and linguistically appropriate therapists. • Affordable care: major lack of resources available to truly meet the needs for those mentally ill. • LGBTQ Populations: lack of health, mental health and social services found in the LGBTQ+ community. • Denial/stigma: not accepting that you have a mental health problem makes the problem worse. • Awareness/Education: people need information about treatment and how to assist people with this disease. • Lack of providers: insufficient mental health professionals
Nutrition, Physical Activity and Weight	• Contributing factors: few parks and less knowledge about the role of nutrition, physical activity, and weight control • Awareness/education: nutritional education. Information about benefits and planning to engage people • Due to COVID-19: post COVID there was a rise in overweight cases, specifically among the youth • Built Environment: lack of space to exercise and access to fast food. • Nutrition: food insecurity, nutrition literacy, commitment to activity. • Access to affordable healthy food
Oral Health	• Oral health ranked as a top concern • Contributing factors: public benefit coverage is minimal, treatments are too costly for people to take on, lack of oral health education, years without treatment, social stigma • Affordable care/services: lack of resources to pay for dental coverage. For the socioeconomic level of the demographic we serve, access to high quality, low-cost oral health care is a major issue. Many of the dental clinics in the area are largely “Medi-Cal” mills and even in the FQHC world adult patients find it difficult to get the level of care that they need. • Awareness and education: lack of knowledge of importance of oral health to overall wellbeing and lack of dental insurance • Insurance coverage: dental care is not fully covered by Medi-Cal and is an expensive out of pocket cost. • Due to COVID-19: due to the pandemic, lack of ability to visit dentists and provider children with necessary checkups.

Dignity Health Hospitals CHNA

Dignity Health Hospitals CHNA: Community Voices & Key Informant Interviews	
IDENTIFIED NEED	**COMMUNITY VOICES & KEY INFORMANTS**
Potentially Disabling Conditions	• Diagnosis/treatment: disability is often overlooked and chronic pain is not often well-managed. • Contributing factors: limited support and care options available. • Awareness/education: people need information about treatment and how to assist people with this disease • Caregiving: lack of support for caregivers
Respiratory Disease (including COVID-19)	• Awareness/education: people need information about treatment and how to assist people with this disease • Co-Occurrences: allergies and asthma • Environmental contributors: the valley is home to multiple freeways and interchanges, air pollution is a problem in all LA. • Contributing factors: the community was disproportionately affected by the pandemic due to socioeconomic factors, the rate of infections were very high. • Vulnerable populations: beliefs, barriers and life circumstances within the community increased their risk of acquiring and suffering from COVID-19 • Awareness and education: people need information about treatment and how toa assist people with the disease. • Incidence/prevalence: COVID-19 is a top health challenge • Isolation: housing and safe places for people to stay posed a challenge in reducing the spread of the virus
Heart Disease and Stroke	• Awareness and education: lack of knowledge and information on lifestyle changes and habit that can prevent a heart attack and stroke. • Contributing factors: due to lack of access to healthy food and access to places of exercise, especially in this time of pandemic. • Incidence/Prevalence: both conditions remain top 10 causes of mortality and morbidity. • Diet: obesity and high cholesterol are prevalent because of poor diets.

Dignity Health Hospitals CHNA

Dignity Health Hospitals CHNA: Community Voices & Key Informant Interviews	
INDENTIFIED NEED	**COMMUNITY VOICES & KEY INFORMANTS**
Housing	• Mental health issues are a major source of homelessness. • Mental health issues have become an escalating problem since March 2020. The issues range form the lack of proper treatment facilities and management for those who were homeless in dire need of treatment to the need for the average person experiencing the stresses and mental health challenges of the isolation and upheaval of the last two years for someone with the proper training to talk to and validate their concerns.
Sexual Health	• Contributing factors: due to the practice of sexual activity at an early age and the lack of communication with people who to speak them with respect and true love. Need for health education and focusing on underlying social issues may be important. Could be better to strengthen contact tracing, treatment and follow-up control measures. • Awareness/education: information/education in accessing services. • Incidence/prevalence. HIV rates are still higher than they should be. PrEP uptake is low. Other STI transmission rates are high.
Substance Abuse	• Substance abuse ranked as a top concern. • Contributing factors: access to help and knowledge about how to assist people with this problem. The greatest barrier is lack of knowledge as to where to go for information for families dealing with these issues. Stigma as well. Services are not readily available. • Lifestyle: someone suffering from this condition has to be ready for treatment. • Access to care/services: timely and affordable access to treatment. Long wait lists, cost prohibitive service plans • Easy access: easy access to prescription medication and drugs • Social norms/community attitude: the community's norms and viers. • Prevention: mental health and substance use should be interconnected. More prevention measures should be in place. • Stress; due to increased stress in families, increased substance abuse is evident
Cross Cutting Themes	• Targeted intervention • Awareness and education • Focus on prevention • Access to more resources

Loma Linda CHNA

Loma Linda CHNA Primary Needs Expressed during Community Conversations & Key Informant Interviews		
IDENTIFIED NEED	**COMMUNITY CONVERSATIONS**	**KEY INFORMANTS**
Basic Needs for Health and Safety	• Access to affordable, culturally sensitive healthcare. • Better mental health services, including counseling and peer support. • Reliable, nutritious food sources (addressing food deserts and affordability). • Health education on prevention, lifestyle, and managing chronic conditions. • Safe, clean environments free from neighborhood violence and environmental hazards.	• Access to affordable, timely healthcare (especially mental health, behavioral health, and specialty care) • Greater health literacy and system navigation support, particularly for immigrant, refugee, and low-literacy populations • Reduction of stigma and cultural barriers, especially around mental health and domestic violence • Increased availability of food assistance, fresh foods, and safe drinking water • Enhanced local disaster preparedness (wildfires, extreme heat, flooding)
Humane Housing	• Affordable housing options for families, seniors, and people in recovery. • Safe, stable living conditions with landlord accountability (mold, pests, repairs). • More transitional housing and shelters for homeless individuals. • Programs to prevent displacement and gentrification. • Opportunities to repurpose vacant or abandoned properties for community use.	• More affordable housing, including family-friendly units and supportive housing • Streamlined zoning and permitting to speed affordable housing development • Anti-displacement protections and renter supports (e.g., rent stabilization, tenant rights) • Housing rehabilitation programs, especially for aging or unsafe manufactured/ mobile homes • Creative models like land trusts, ADUs, and rent-to-own pathways
Meaningful Work and Wealth	• Access to stable, well-paying jobs with advancement opportunities. • Job training, apprenticeships, and certification programs, especially for re-entry and immigrant populations. • Financial assistance and coaching to manage rising costs. • Reforms to address benefit cliffs that discourage earning slightly higher wages.	• Local job creation to reduce long commute times and improve quality of life • Access to safe, dignified, living-wage jobs (not just low-wage, precarious work) • Expansion of financial literacy and access to banking services in underserved communities • Support for small business development and workforce pathways, especially in healthcare and childcare • Addressing wage gaps and economic inequities affecting marginalized communities
Reliable Transportation	• Affordable, reliable public transit connecting neighborhoods, healthcare, and jobs. • Flexible, same-day transportation options (especially for medical needs). • Better information on transportation benefits available through insurance. • Infrastructure improvements to ensure safe walking and biking access.	• Affordable, safe, and reliable public transportation to connect people to jobs, healthcare, and services • Innovative solutions like employer shuttles or community-based transportation • Better integration of housing, jobs, and transit planning to reduce dependence on long commutes • Improved rural and unincorporated area mobility options

Loma Linda CHNA

Loma Linda CHNA: Community Conversations & Key Informant Interviews		
INDENTIFIED NEED	**COMMUNITY CONVERSATIONS**	**KEY INFORMANTS**
Lifelong Learning	• Workforce development and adult education (literacy, English, computer skills). • Youth development programs, including after-school activities and career pathways. • Health and life skills workshops focused on nutrition, mental health, and financial literacy. • Clear, accessible information on how to navigate healthcare and social systems.	• Early childhood development programs, including developmental screenings and preschool access • Trauma-informed schools and culturally competent teaching • Youth leadership, civic engagement, and mentorship programs • College readiness and financial aid navigation, especially for first-generation students • Workforce training and upskilling aligned with local employment opportunities
Thriving Natural World	• Cleaner air and water to reduce chronic health risks. • Access to green spaces, safe parks, and affordable recreational opportunities. • Community cleanup efforts to address illegal dumping and neighborhood blight. • Climate resilience strategies to handle extreme heat and environmental hazards.	• Environmental justice interventions to address air pollution, warehouse impacts, and extreme heat • Green infrastructure investments: shade trees, parks, cooling centers, and clean energy upgrades • Safe, clean drinking water access in agricultural and rural areas • Community education on climate risks and adaptation strategies • Policies to balance economic development (e.g., warehousing) with environmental health
Belonging and Civic Muscle	• Opportunities for meaningful civic engagement and advocacy. • Community spaces for dialogue, organizing, and building trust across groups. • Culturally affirming, inclusive spaces where all voices are heard. • Support for grassroots leaders, Promotoras, and peer advocates.	• Civic engagement training and leadership development for historically excluded groups • Building trust in institutions, including healthcare, schools, and government • Sustained cross-sector collaboratives with shared goals, funding, and metrics • Youth programs and safe community spaces to foster belonging and empowerment • Faith-based, cultural, and grassroots partnerships as bridges to hard-to-reach populations
Cross Cutting Themes	• • Address systemic inequities and structural racism shaping access to services. • Reduce language and information barriers, making systems easier to navigate. • Provide holistic, multi-sector solutions linking health, housing, work, and environment. • Build trust between communities and public systems by demonstrating accountability and cultural respect.	

Appendix F: Well-Being Survey Methods and Results

Well-Being Survey Methods

The Survey Instrument

The Well-Being Survey consisted of 19 questions, offered in both English and Spanish, and was designed to assess multiple dimensions of personal well-being among residents of Riverside and San Bernardino Counties. The Cantril ladder was used as a core measure of life evaluation.

Survey Components

- Life evaluation
- Health assessment (physical and mental)
- Psychosocial factors (e.g., sense of purpose)
- Demographic questions
- National comparison

Core survey questions were adapted from the Institute for Healthcare Improvement (IHI) and Gallup, allowing results to be compared against national well-being benchmarks.

Hospitals also requested supplemental questions. These covered community health issues, where people go for care, and barriers to accessing services.

Distribution and Reach

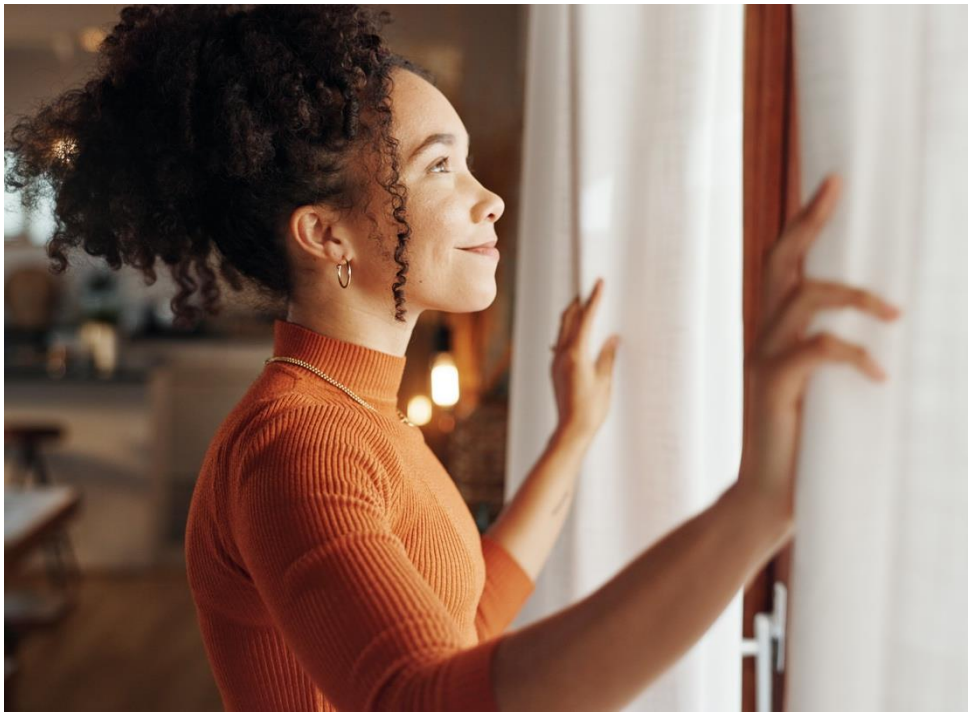
The survey was distributed from May to July 2025 in both paper and online formats, available in English and Spanish. To support outreach, hospitals received a comprehensive communication toolkit that included digital screensavers, flyers, social media posts, and newsletter articles. A total of 319 community members engaged in the survey.

Sources:
Institute for Healthcare Improvement Health and Well-being Measurement Approach and Assessment Guide
Understanding How Gallup Uses the Cantril Scale

Survey Analysis

After excluding responses outside the region, 291 surveys were retained for analysis. Data were cleaned, reverse-coded for consistency, and analyzed by demographics including region, age, race/ethnicity, household income, education, gender, and sexual orientation. Well-being measures included financial stability, health status, functional limitations, sense of purpose, belonging, social support, and emotional health. Answers to the additional questions added by the hospitals were compiled into one list.

Together, these insights were incorporated into the prioritization process to make sure the community's voice guided decisions.



Well-Being Survey Methodology

Process

- Region-wide health and well-being survey May-July 2025
- 319 community members engaged in the survey, which was available online and on paper in two languages: English or Spanish.
- 291 responses were analyzed after cleaning the data.
- Core questions are used by IHI and Gallup, which provides a national benchmark for thriving.

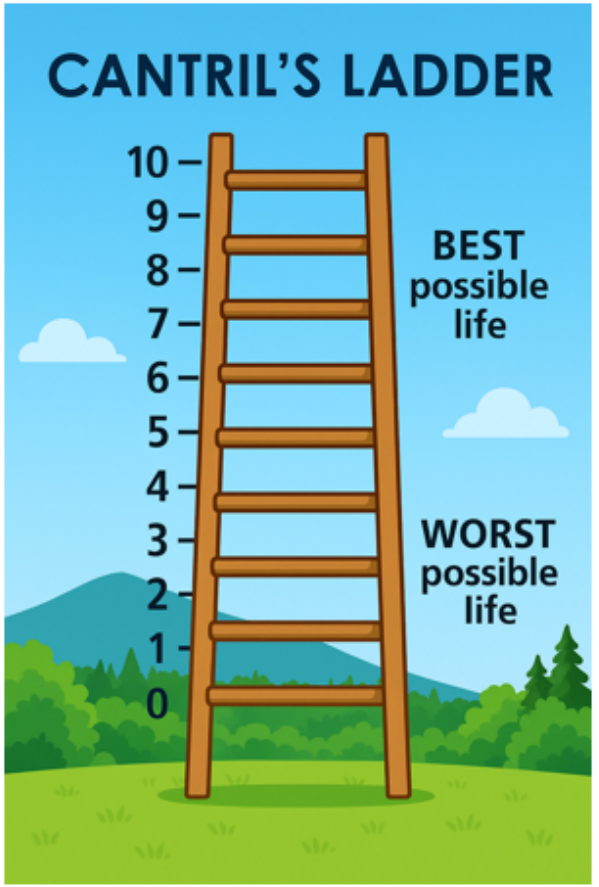
Definitions

Thriving: Well-being that is strong, consistent, and progressing. These respondents have positive views of their present life situation (7+) and positive views of the next five years (8+), using Cantril's Ladder ratings.

Struggling: Well-being that is moderate or inconsistent. These respondents have moderate views of their present life situation OR moderate OR negative views of their future. They are either struggling in the present or expect to struggle in the future.

Suffering: Well-being that is at high risk. These respondents have poor ratings of their current life situation (4 and below) AND negative views of the next five years (4 and below).

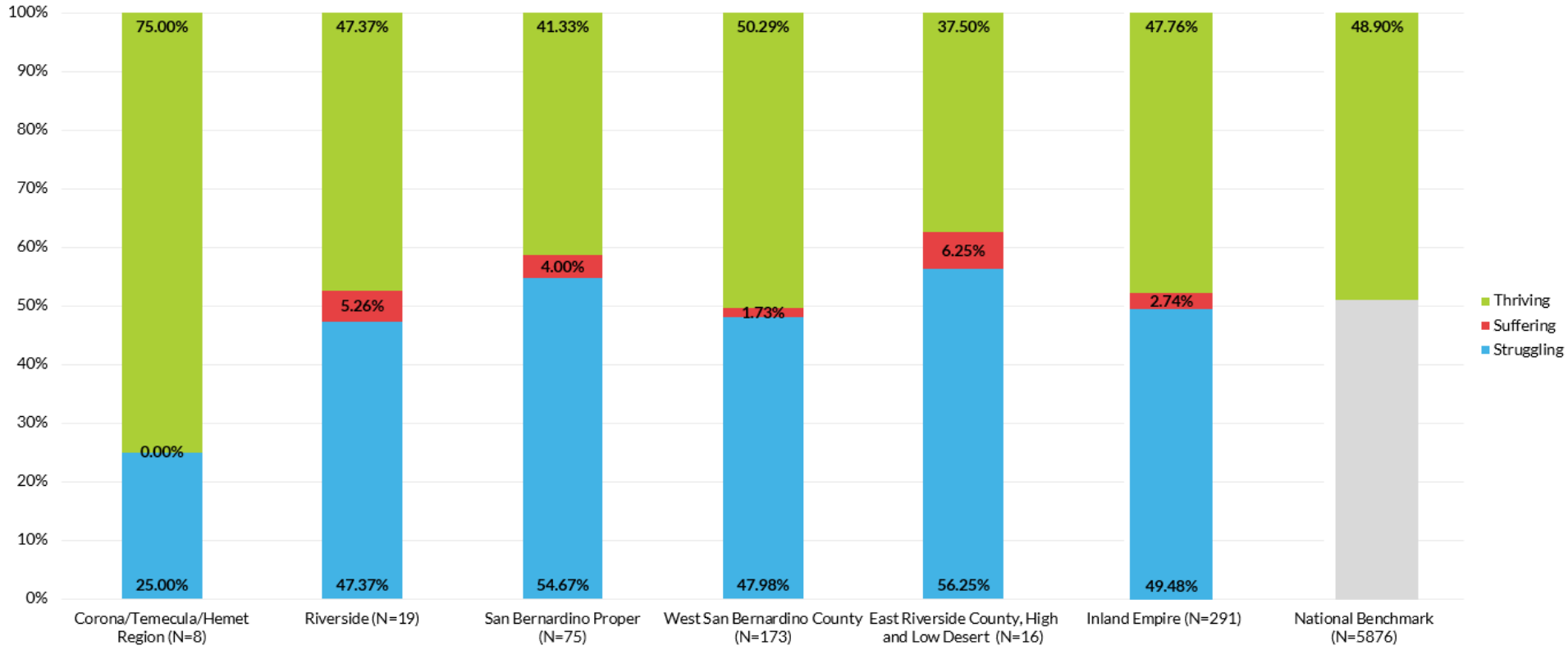
Understanding How Gallup Uses the Cantril Scale



HC² STRATEGIES

COMMUNITIES LIFTING COMMUNITIES®

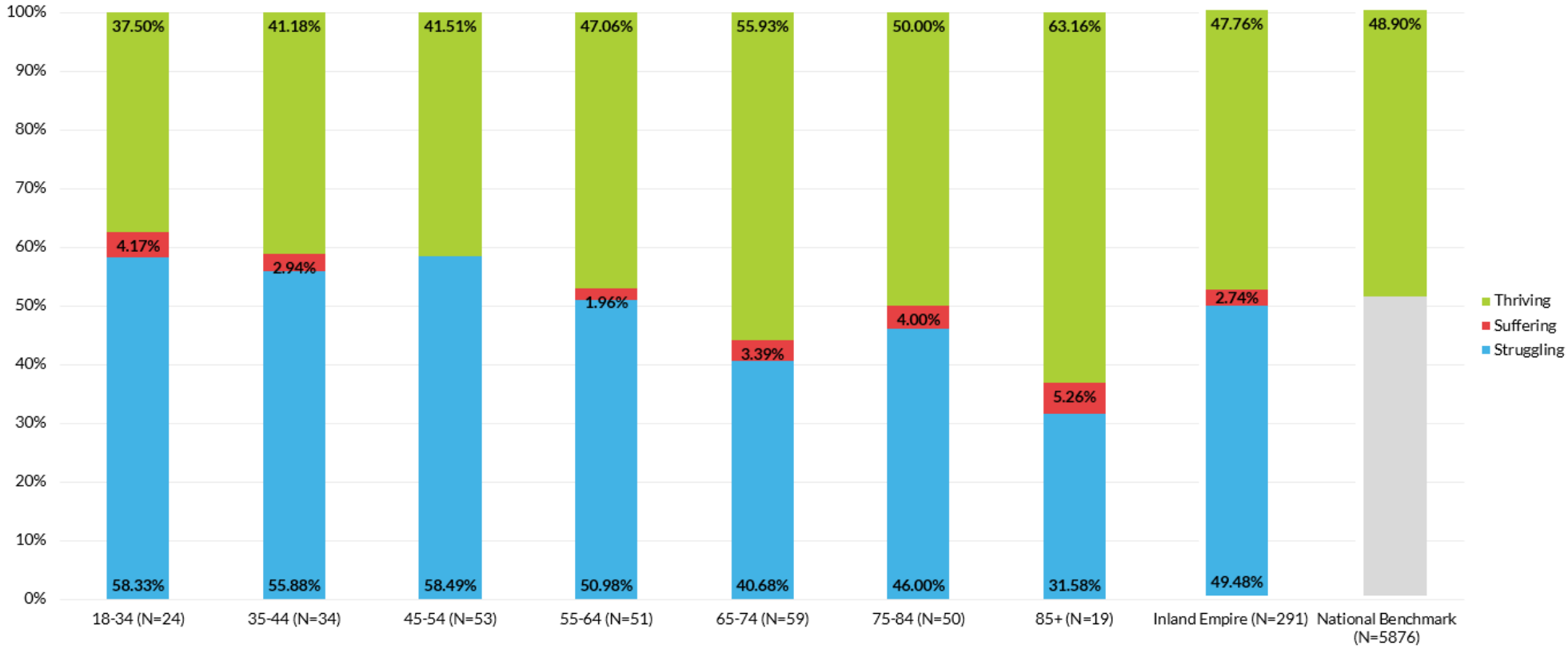
Thriving, Suffering, and Struggling by Region



Source for national benchmark:
https://news.gallup.com/poll/658778/americans-life-ratings-slump-five-year-low.aspx

Note: Only thriving data is publicly available for the national benchmark.

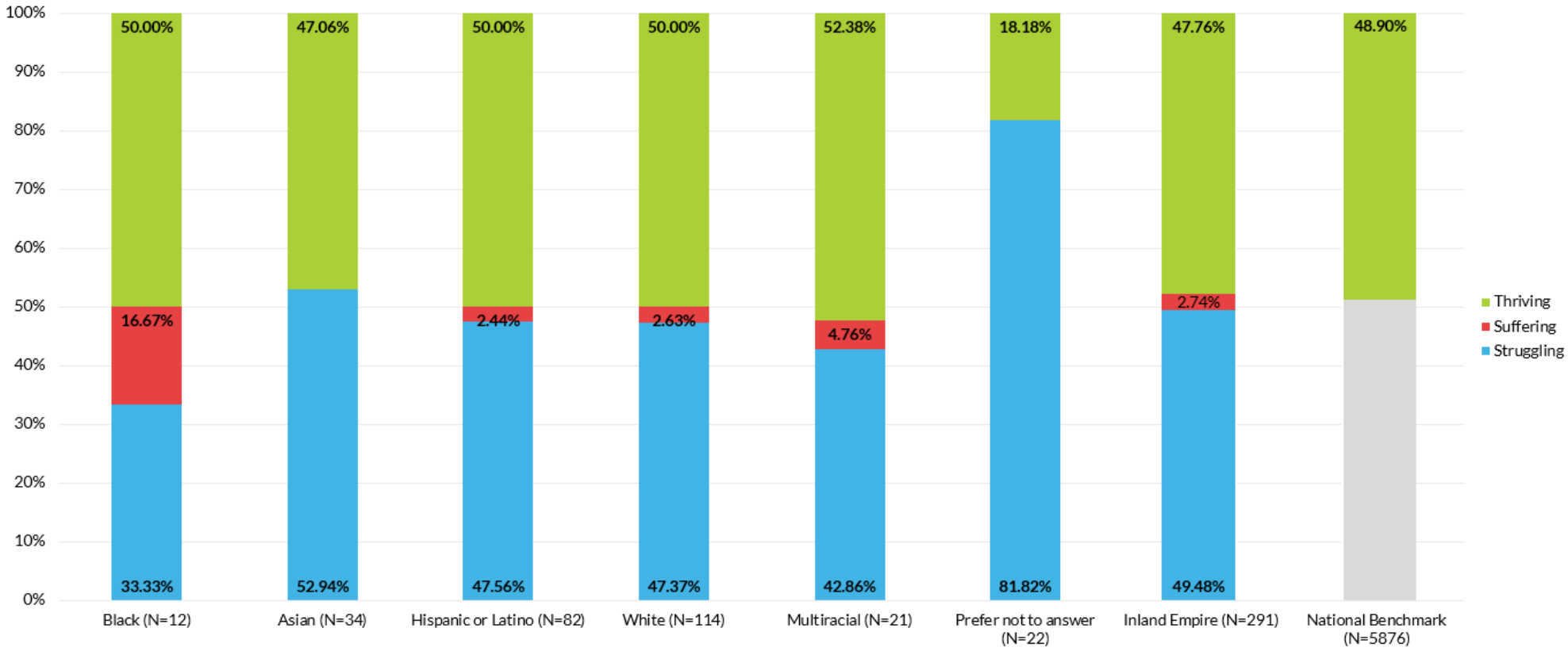
Thriving, Suffering, and Struggling by Age



Source for national benchmark: https://news.gallup.com/poll/658778/americans-life-ratings-slump-five-year-low.aspx

Note: Only thriving data is publicly available for the national benchmark.

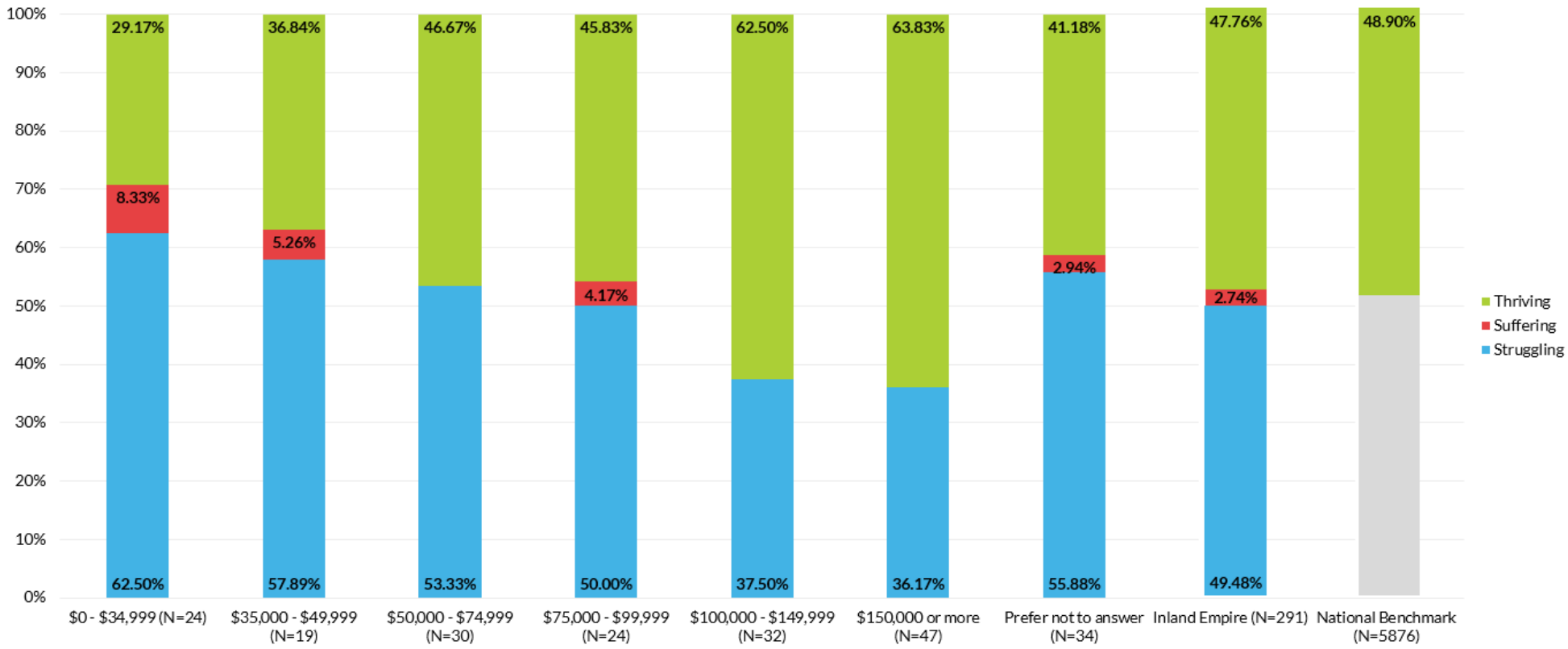
Thriving, Suffering, and Struggling by Race and Ethnicity



Source for national benchmark: https://news.gallup.com/poll/658778/americans-life-ratings-slump-five-year-low.aspx

Note: Only thriving data is publicly available for the national benchmark.

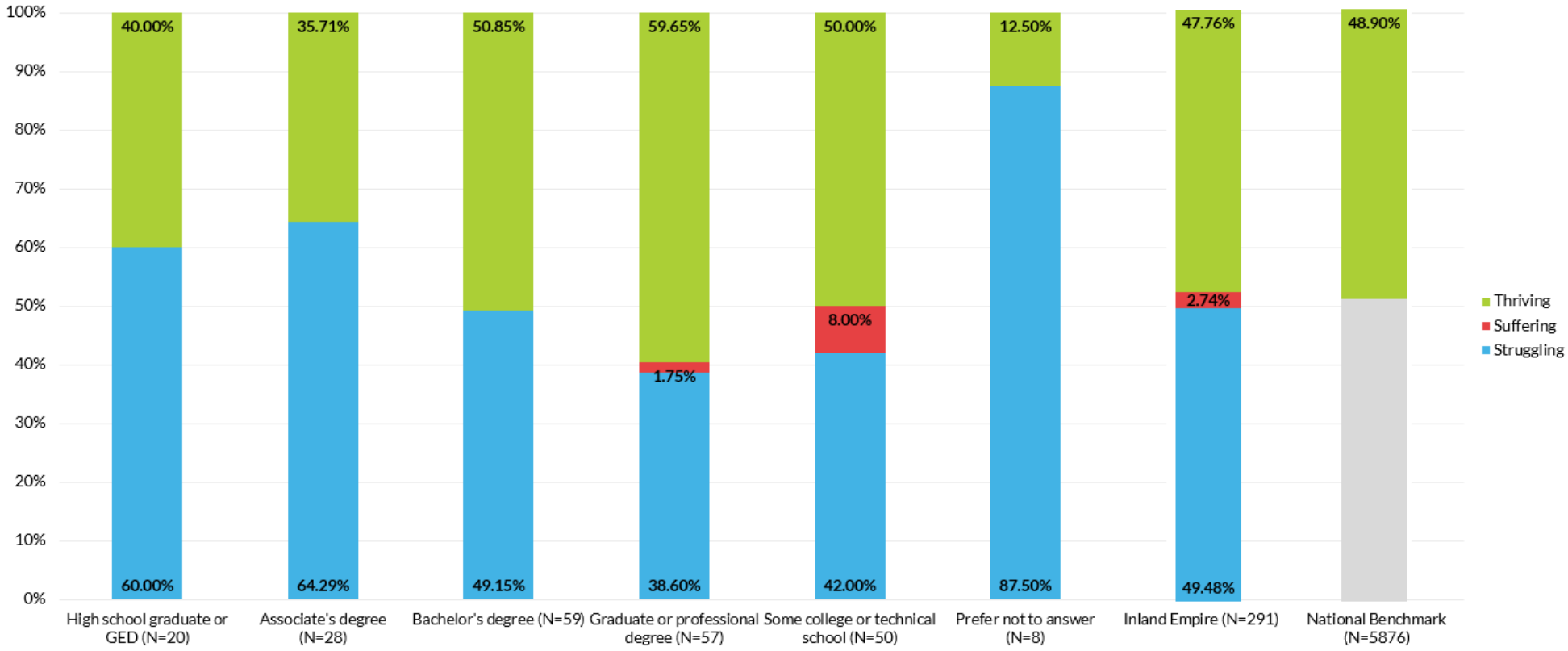
Thriving, Suffering, and Struggling by Household Income



Source for national benchmark: https://news.gallup.com/poll/658778/americans-life-ratings-slump-five-year-low.aspx

Note: Only thriving data is publicly available for the national benchmark.

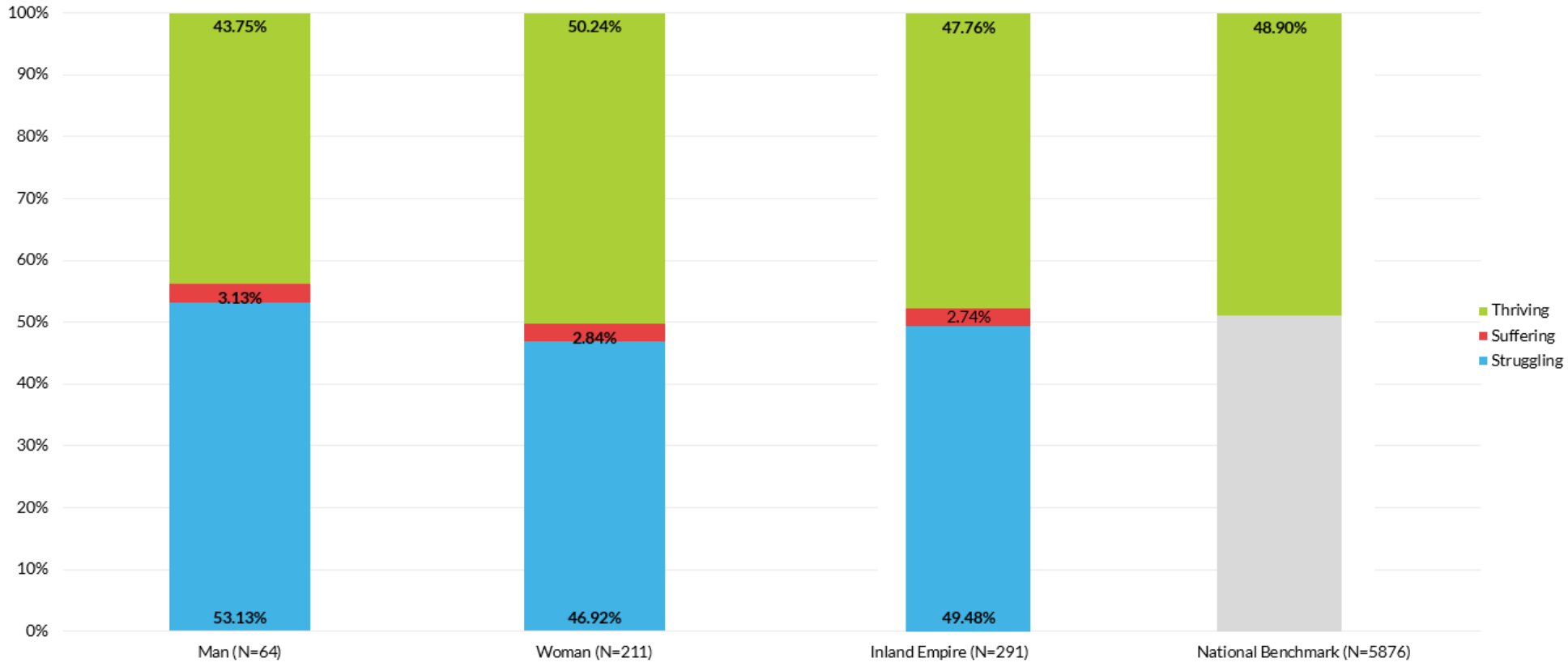
Thriving, Suffering, and Struggling by Educational Attainment



Source for national benchmark: https://news.gallup.com/poll/658778/americans-life-ratings-slump-five-year-low.aspx

Note: Only thriving data is publicly available for the national benchmark.

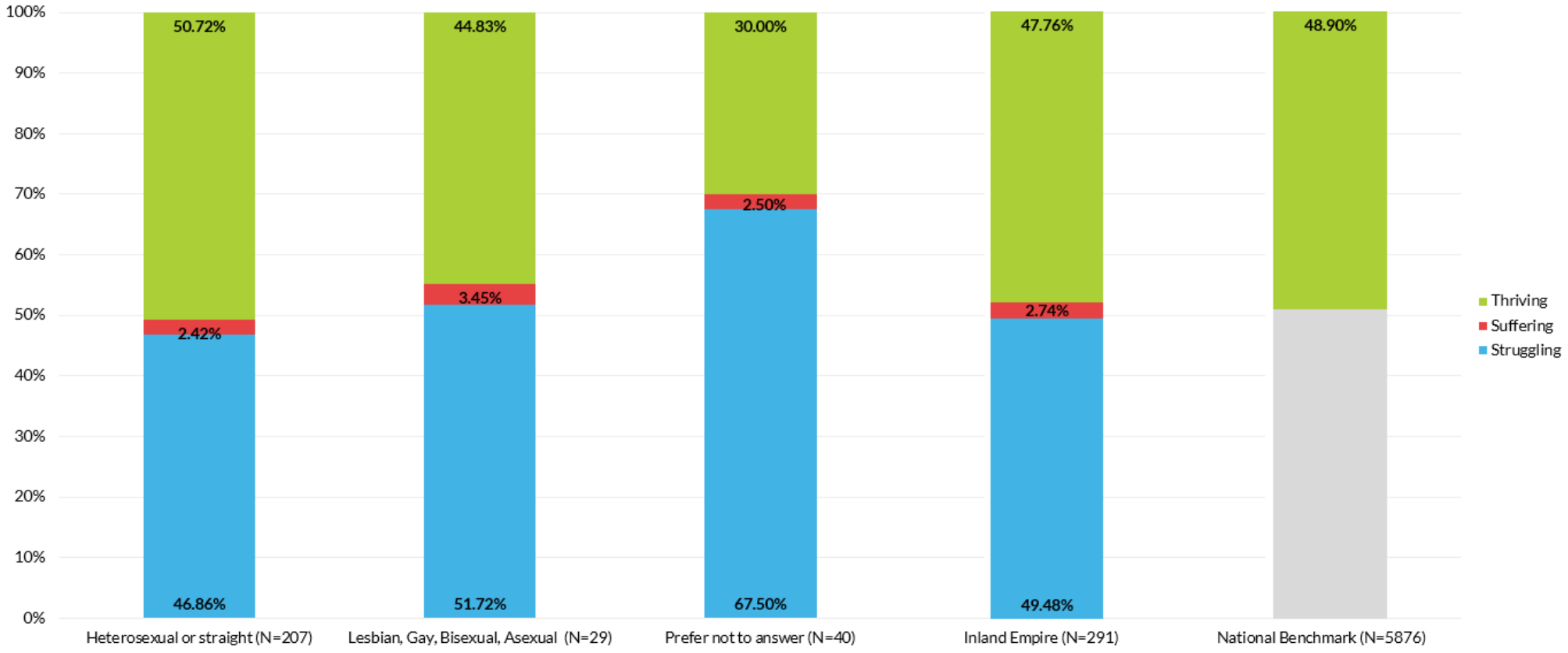
Thriving, Suffering, and Struggling by Gender



Source for national benchmark: https://news.gallup.com/poll/658778/americans-life-ratings-slump-five-year-low.aspx

Note: Only thriving data is publicly available for the national benchmark.

Thriving, Suffering, and Struggling by Sexual Orientation



Source for national benchmark:
https://news.gallup.com/poll/658778/americans-life-ratings-slump-five-year-low.aspx

Note: Only thriving data is publicly available for the national benchmark.

HC² STRATEGIES

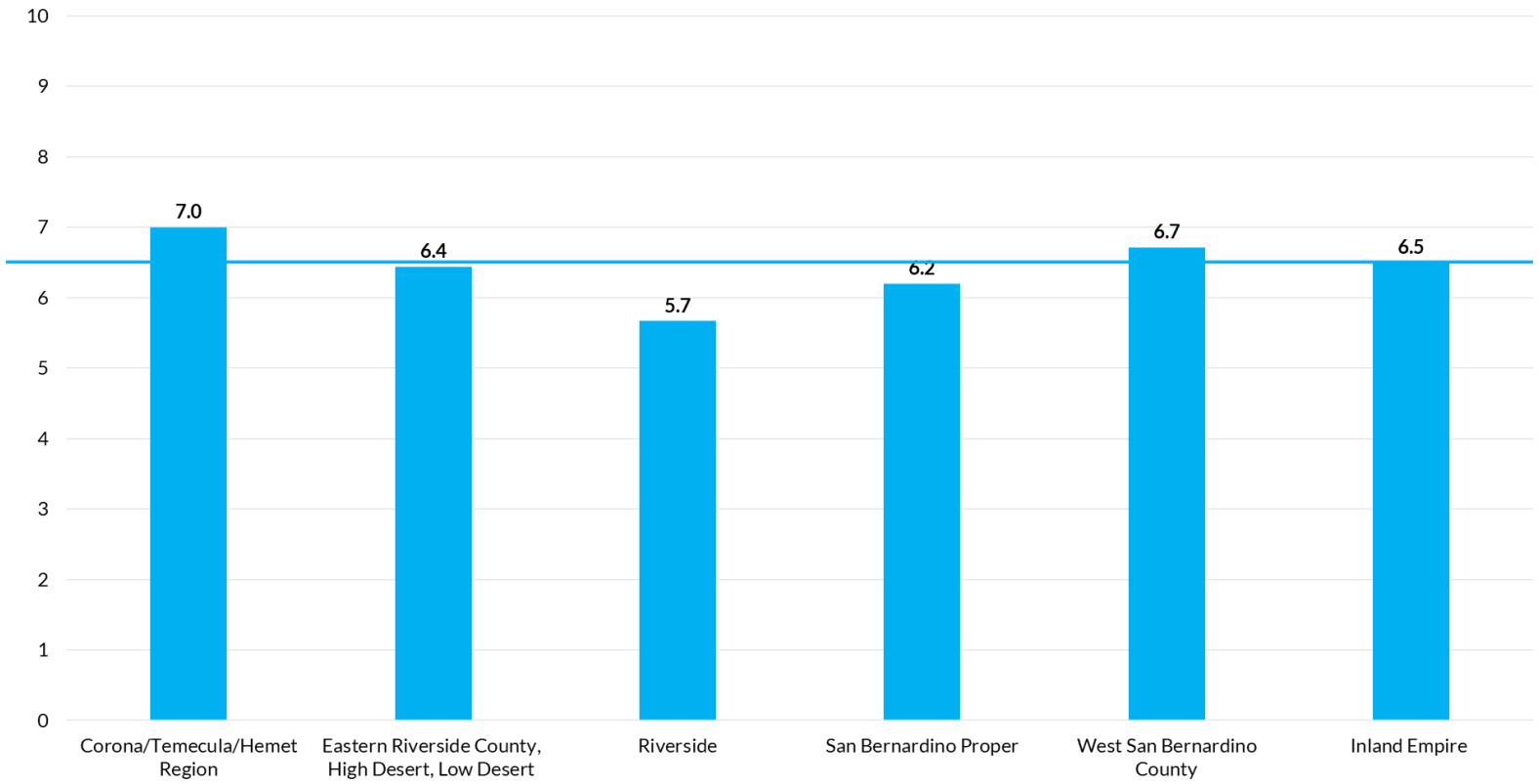
COMMUNITIES LIFTING COMMUNITIES®

Financial Well-Being by Demographic Data

Question: Now imagine the top of the ladder represents the best possible financial situation for you, and the bottom of the ladder represents the worst possible financial situation for you. Please indicate where on the ladder you stand right now.

- Region
- Age
- Race/ethnicity
- Household income
- Educational attainment
- Gender
- Sexual orientation

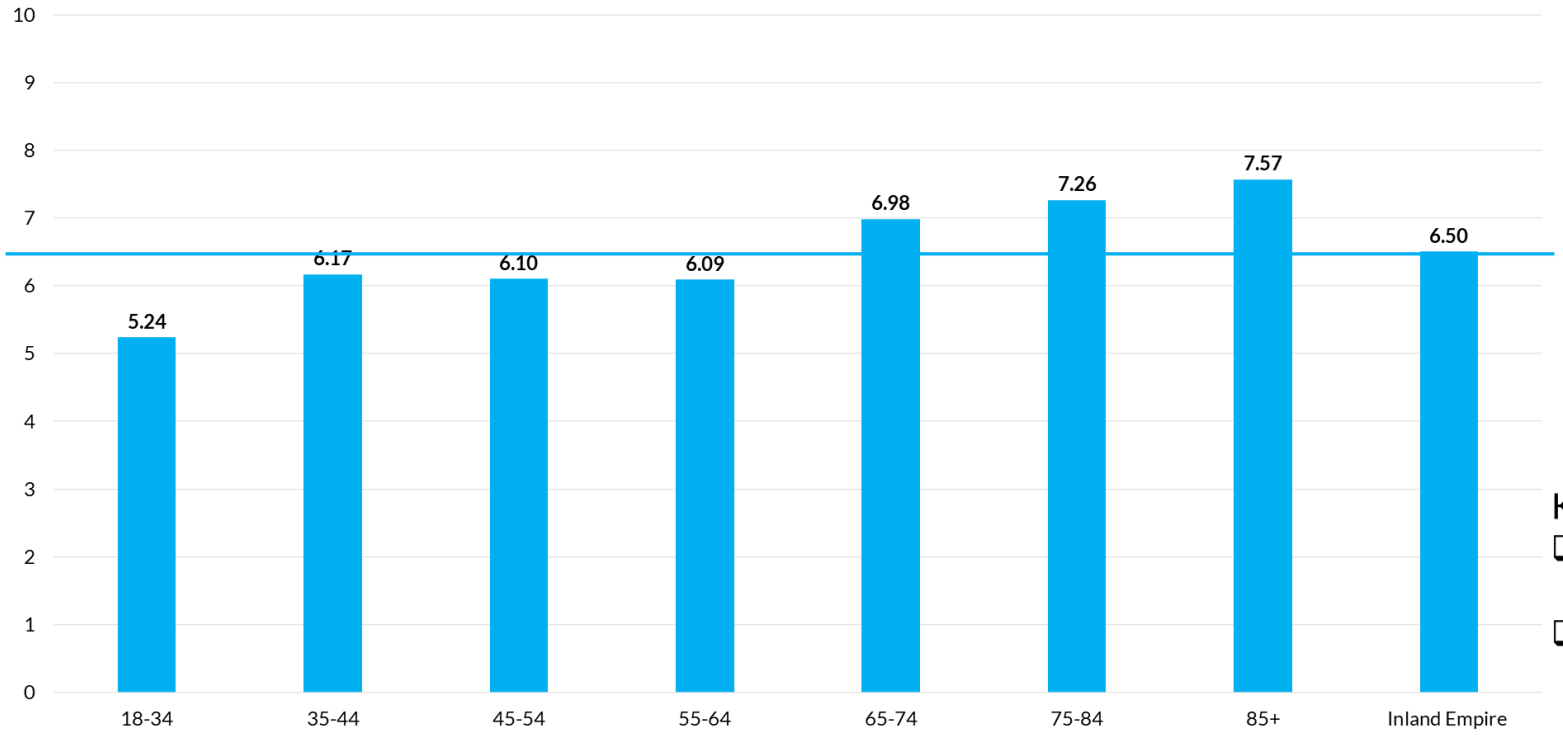
Financial Well-Being by Region



Key:

- 0 – Worst possible
- 10 – Best possible

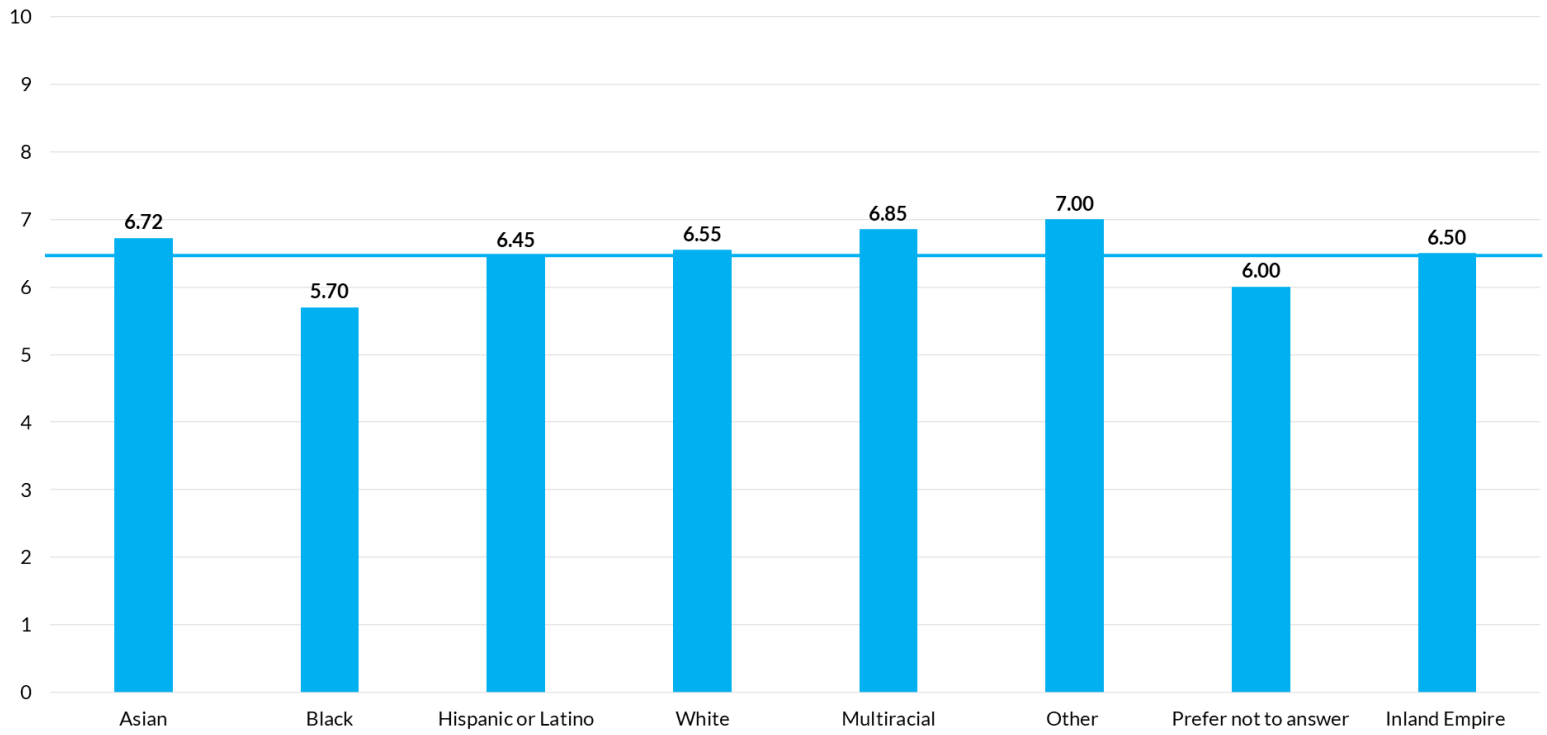
Financial Well-Being by Age



Key:

- ❑ 0 – Worst possible
- ❑ 10 – Best possible

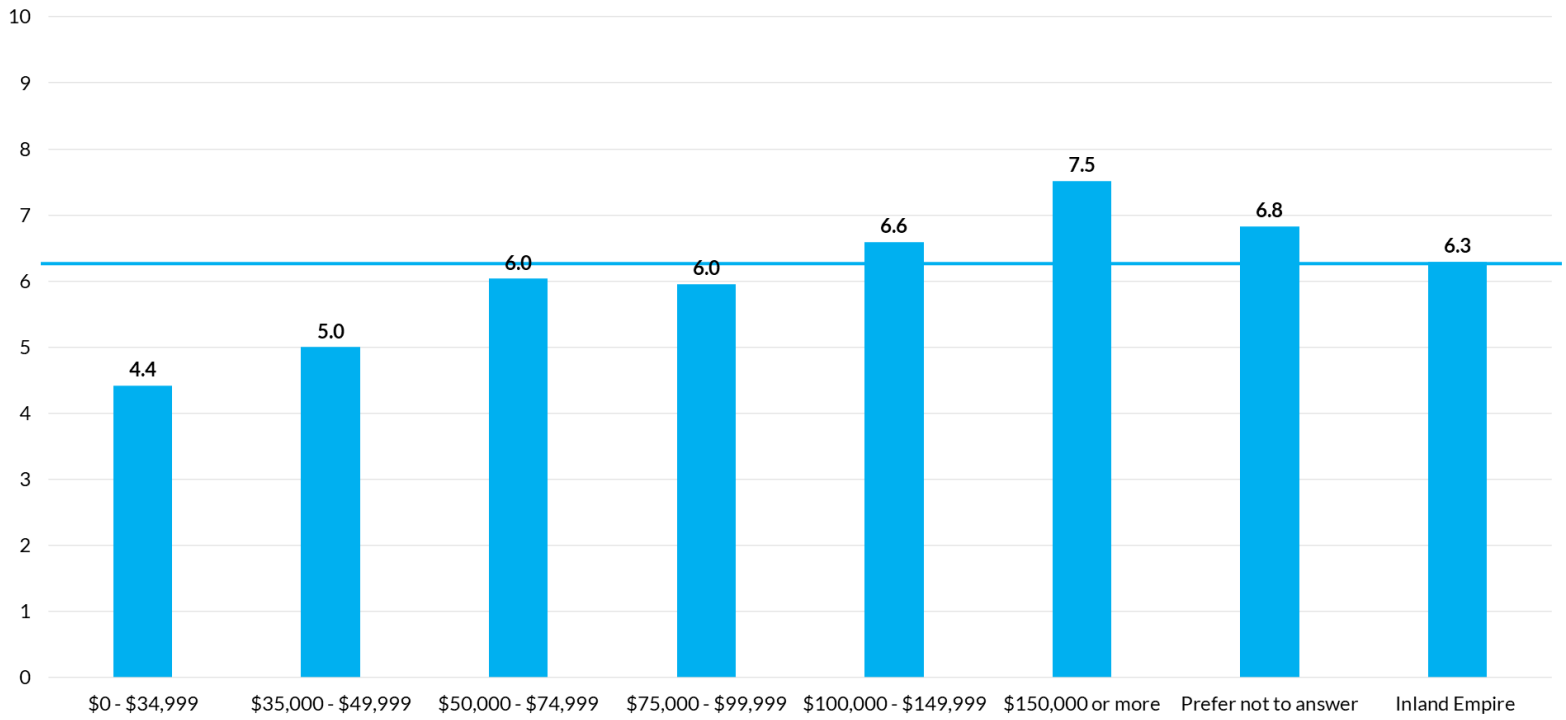
Financial Well-Being by Race/Ethnicity



Key:

- 0 – Worst possible
- 10 – Best possible

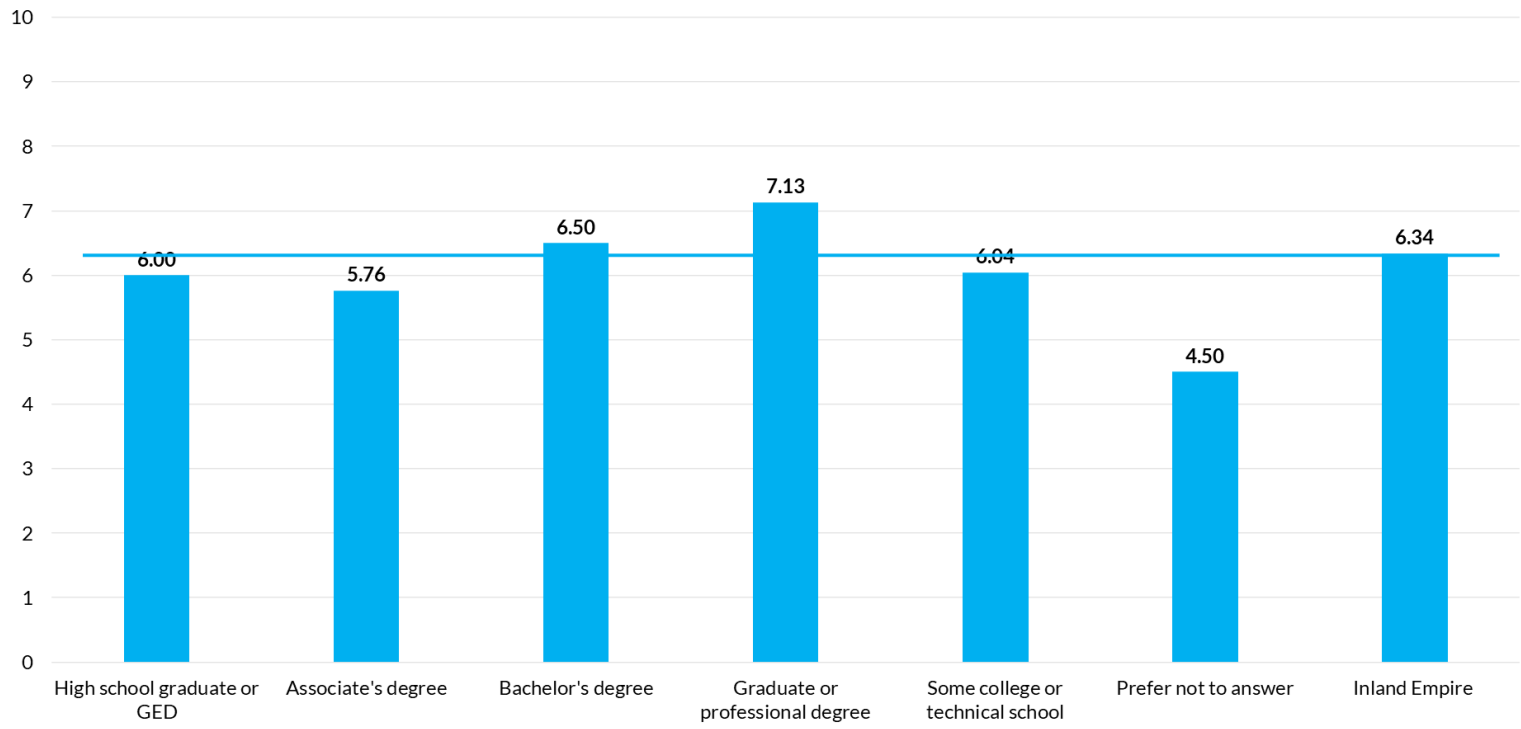
Financial Well-Being by Household Income



Key:

- 0 – Worst possible
- 10 – Best possible

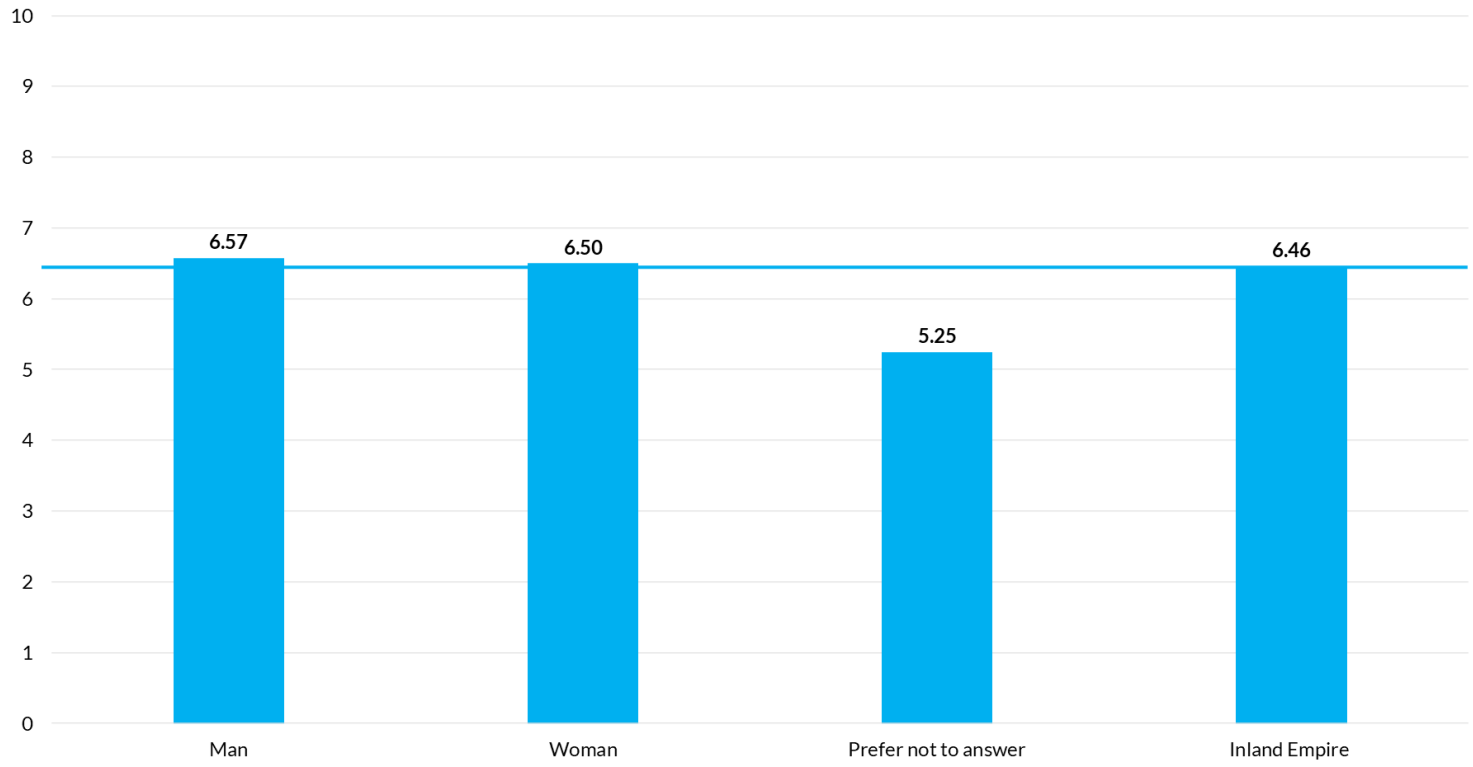
Financial Well-Being by Educational Attainment



Key:

- 0 – Worst possible
- 10 – Best possible

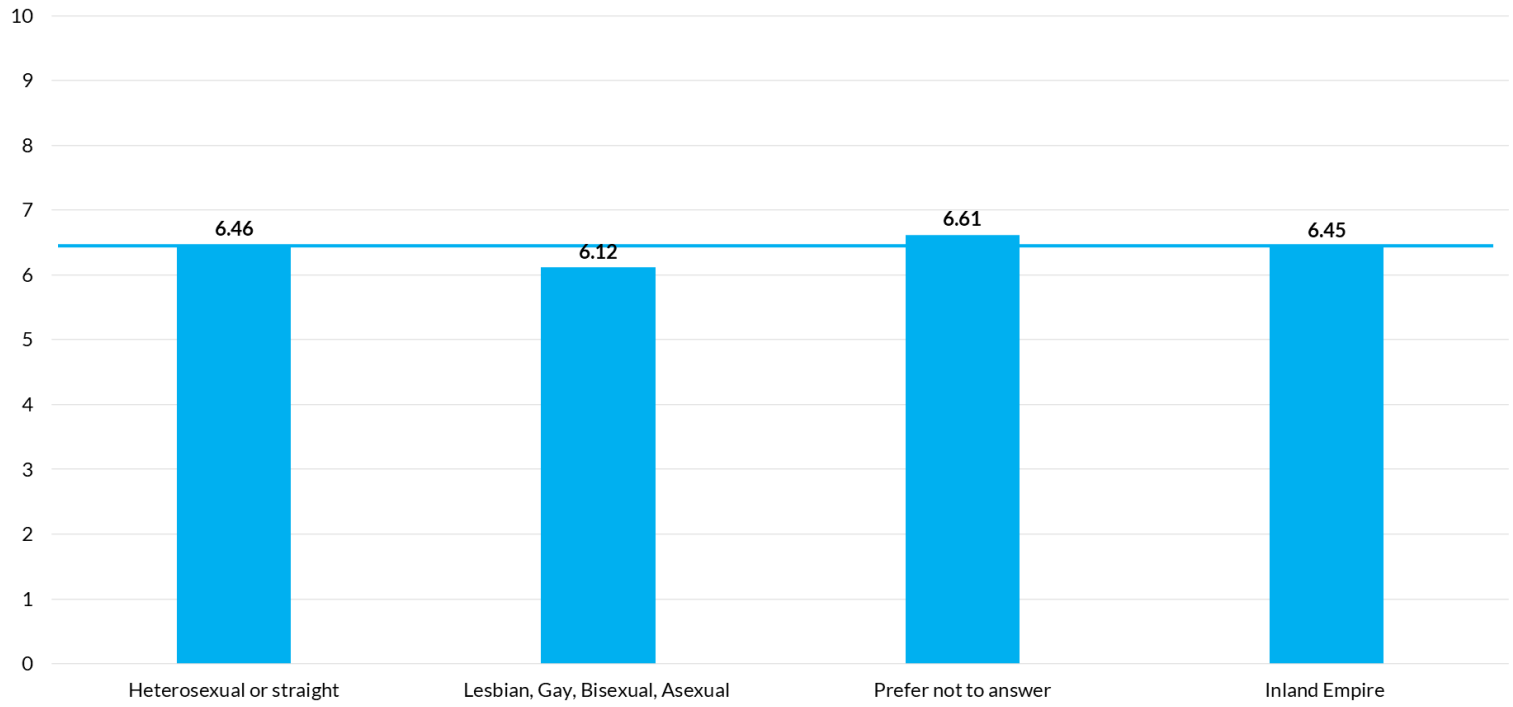
Financial Well-Being by Gender



Key:

- ❑ 0 – Worst possible
- ❑ 10 – Best possible

Financial Well-Being by Sexual Orientation



Key:

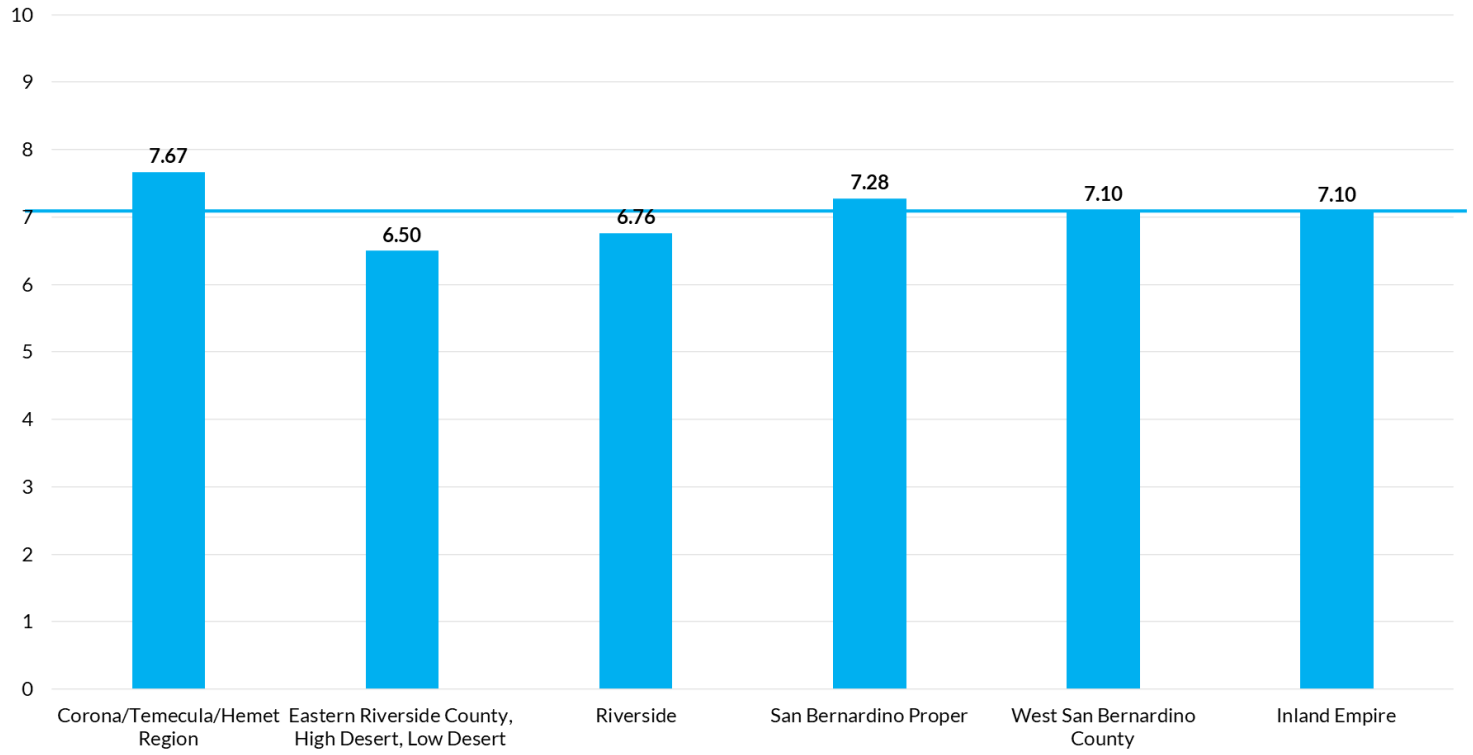
- ❑ 0 – Worst possible
- ❑ 10 – Best possible

Physical Health by Demographic Data

Question: In general, how would you rate your physical health?

- Region
- Age
- Race/ethnicity
- Household income
- Educational attainment
- Gender
- Sexual orientation

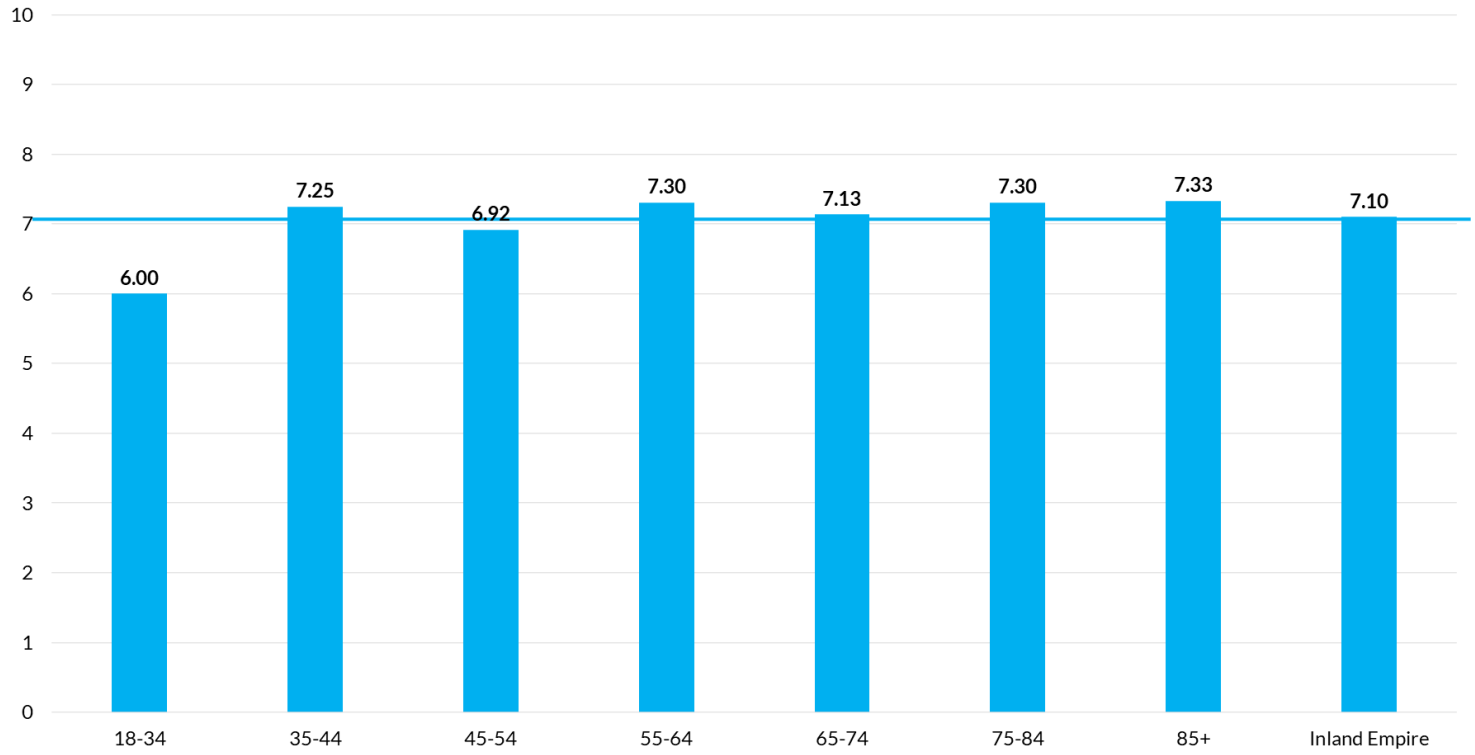
Physical Health by Region



Key:

- ❑ 0 – Poor
- ❑ 10 – Excellent

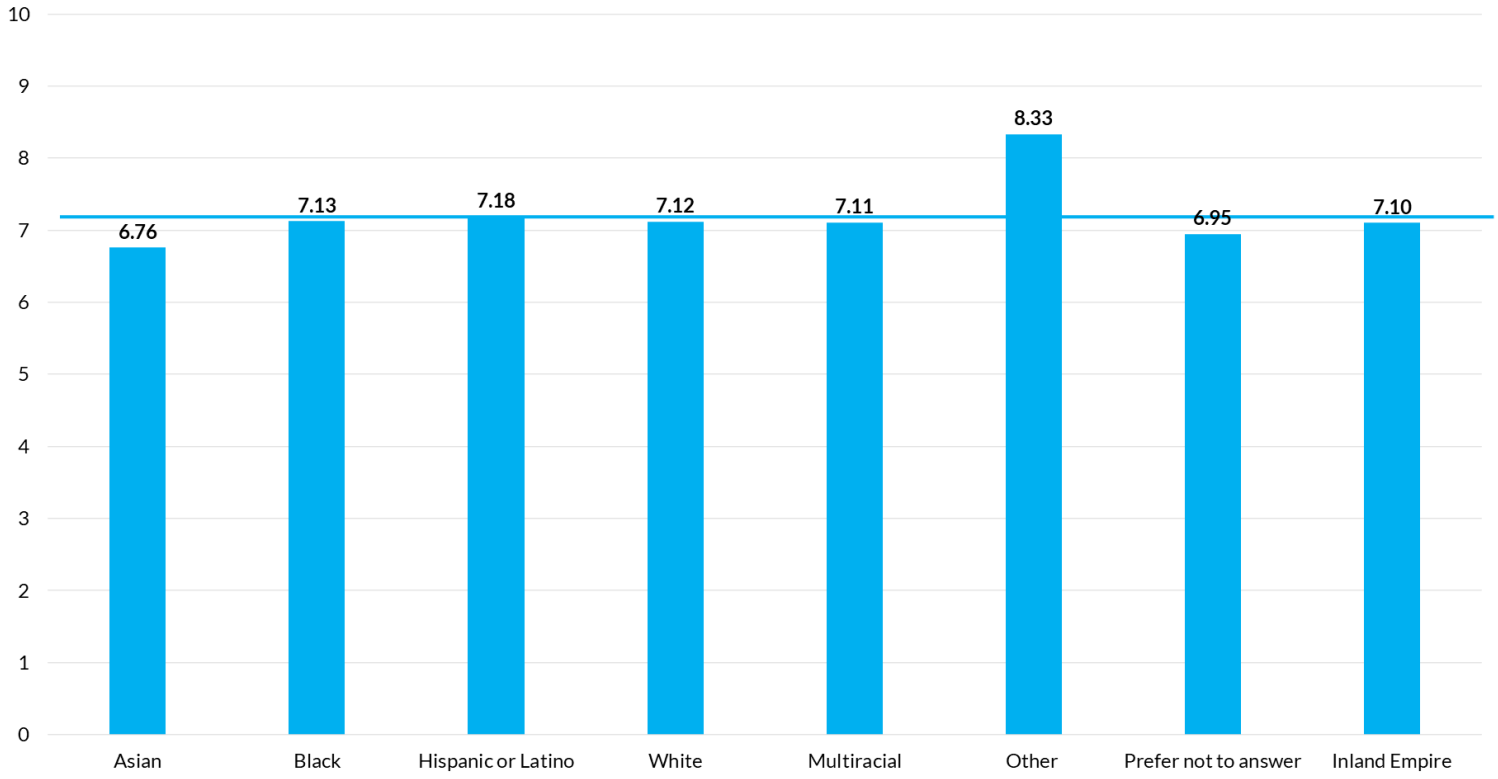
Physical Health by Age



Key:

- 0 – Poor
- 10 – Excellent

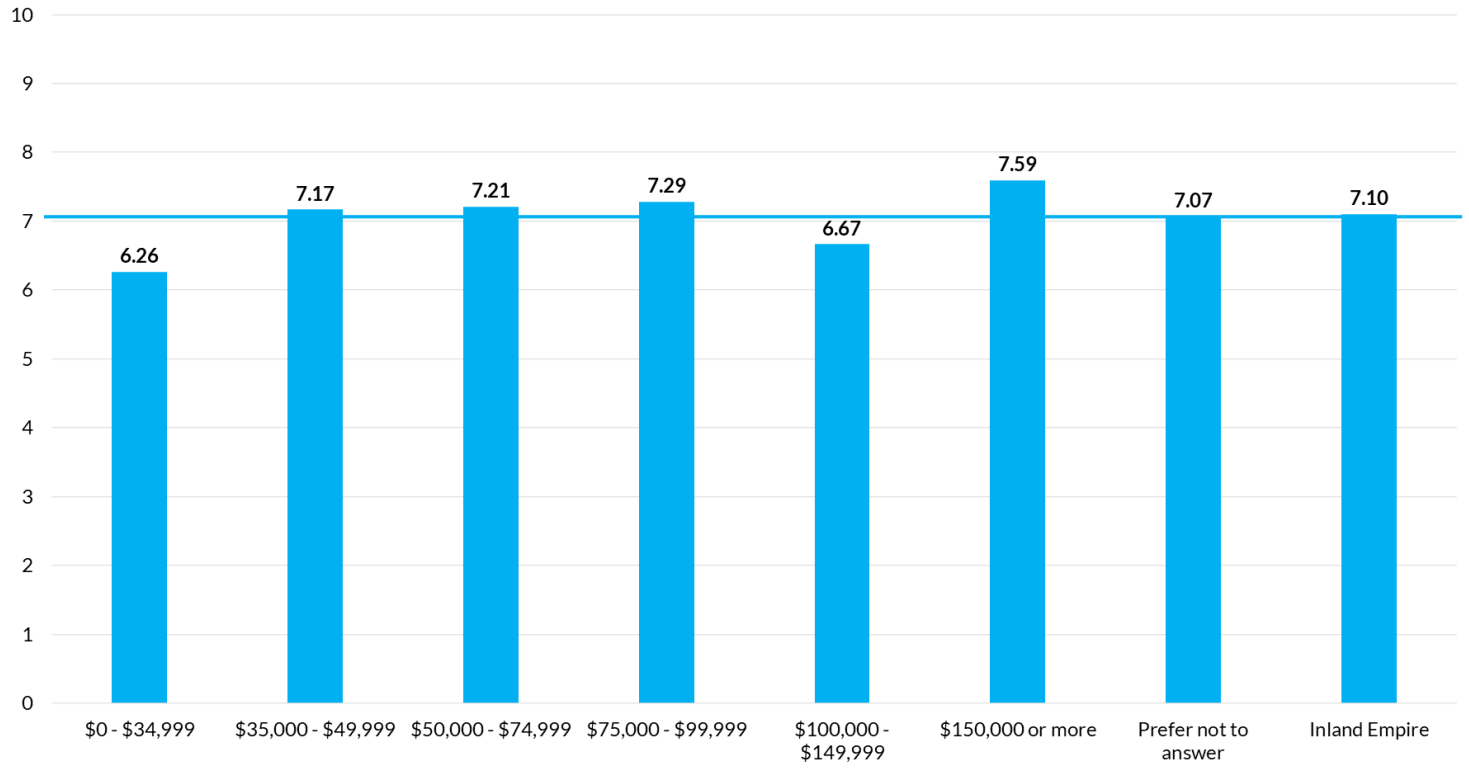
Physical Health by Race/Ethnicity



Key:

- ❑ 0 – Poor
- ❑ 10 – Excellent

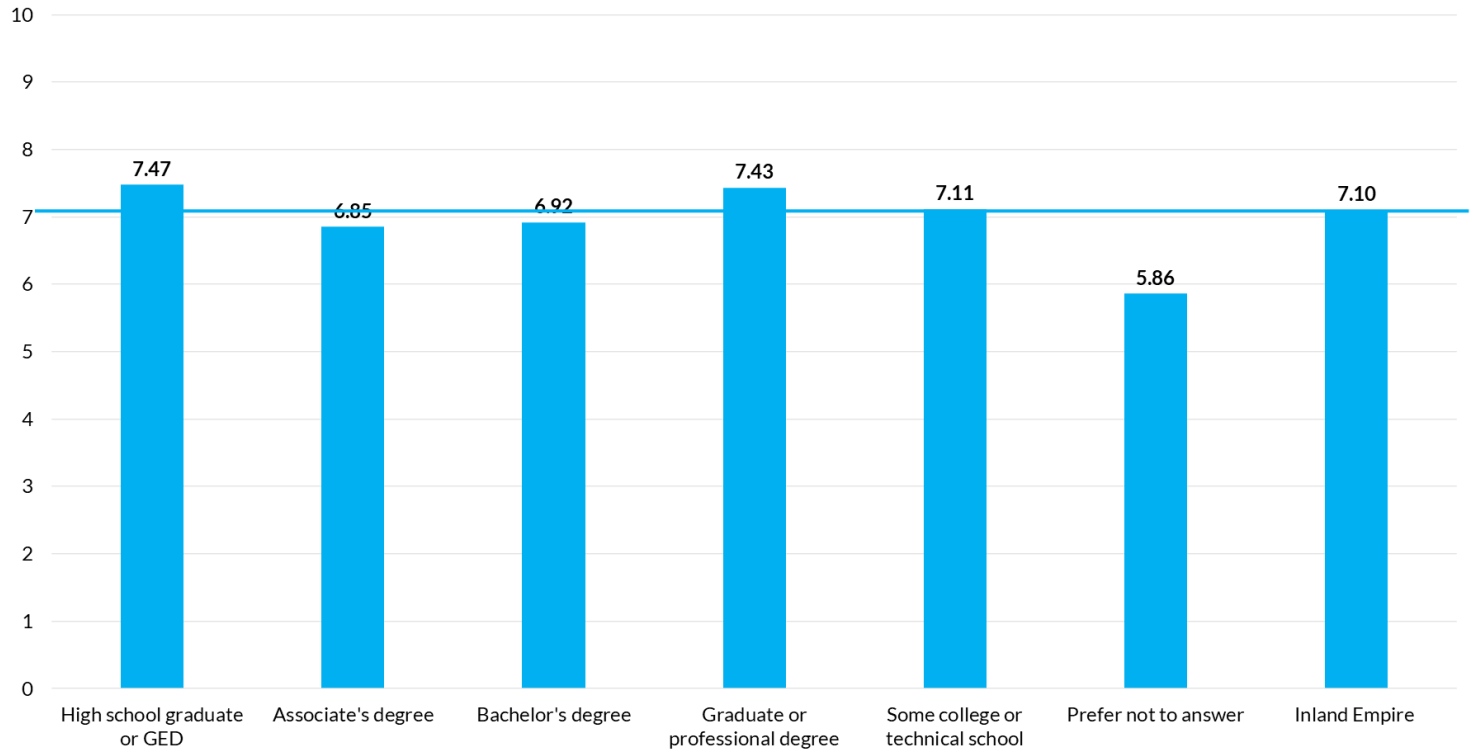
Physical Health by Household Income



Key:

- ❑ 0 – Poor
- ❑ 10 – Excellent

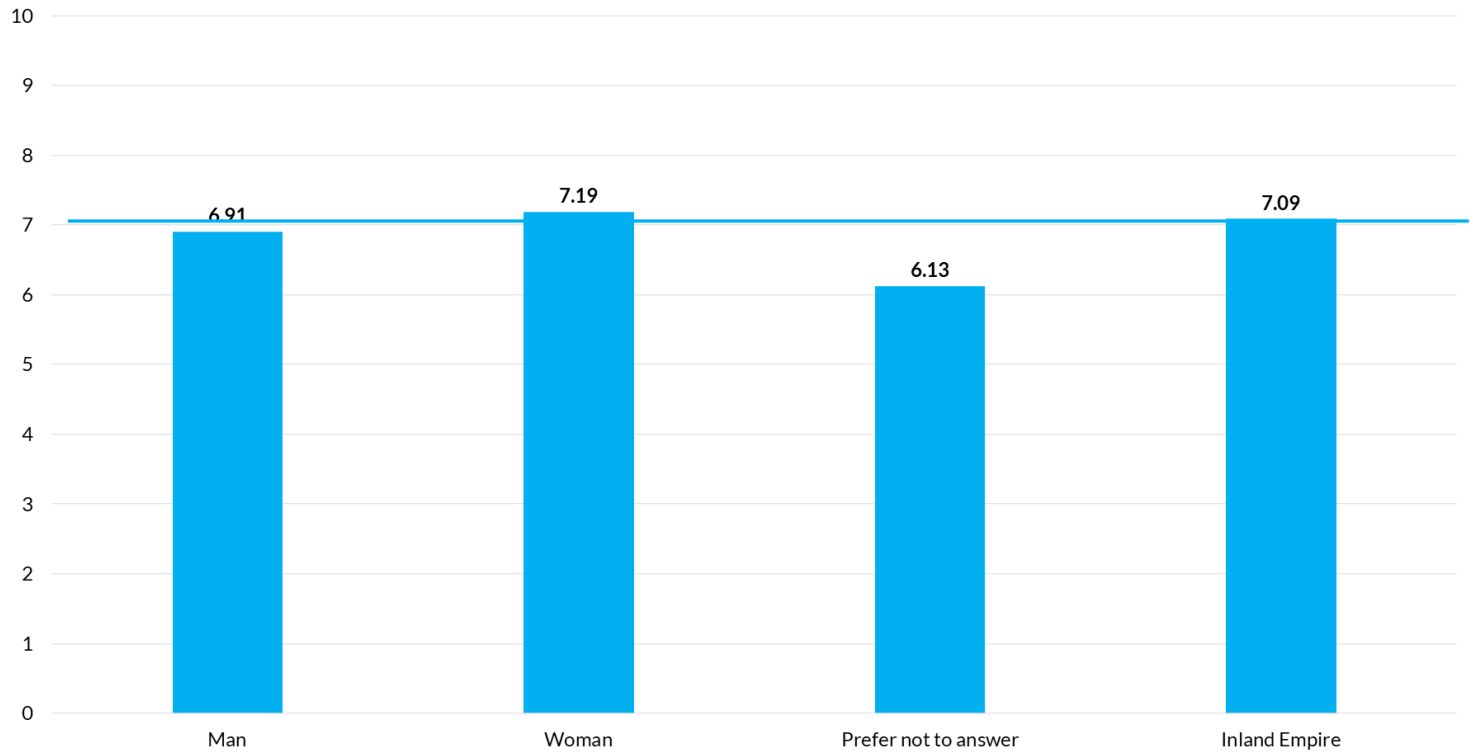
Physical Health by Educational Attainment



Key:

- 0 – Poor
- 10 – Excellent

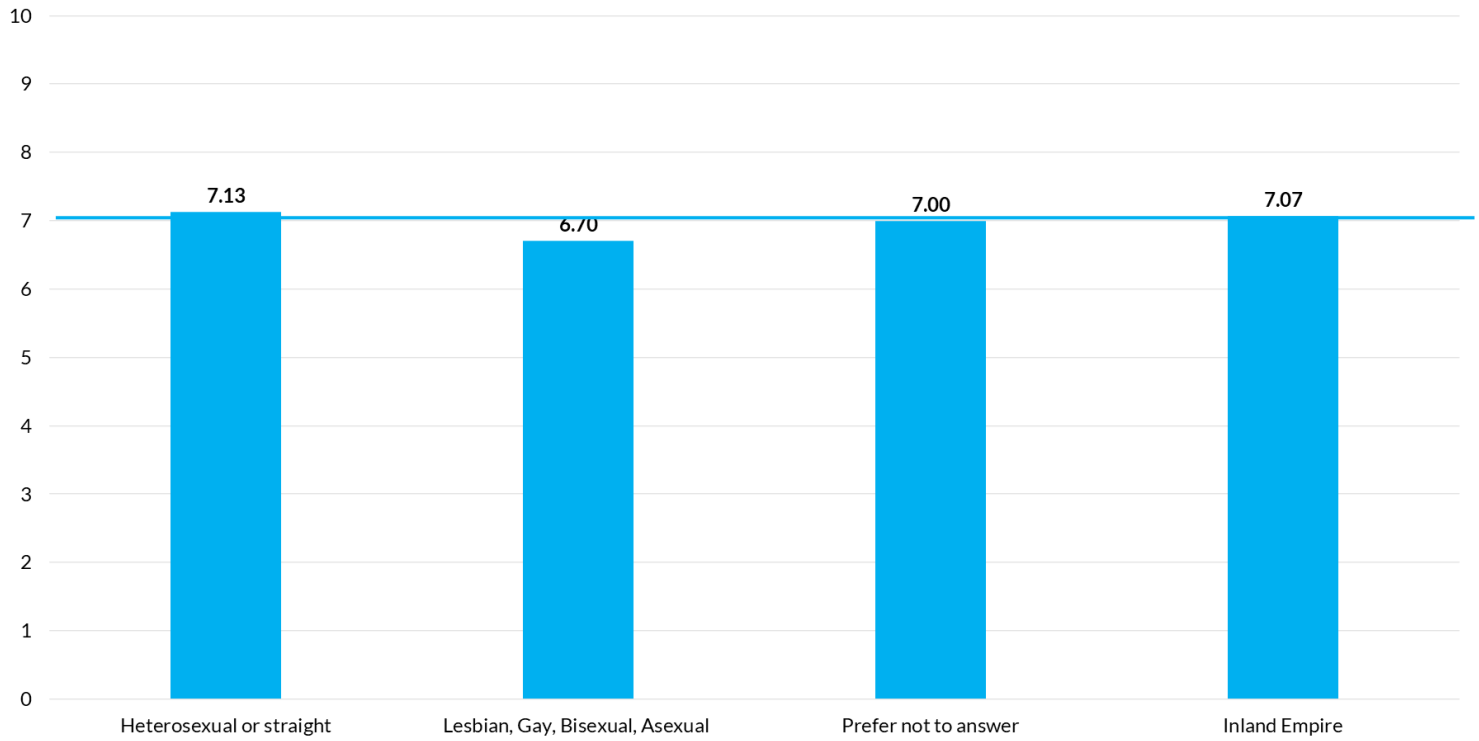
Physical Health by Gender



Key:

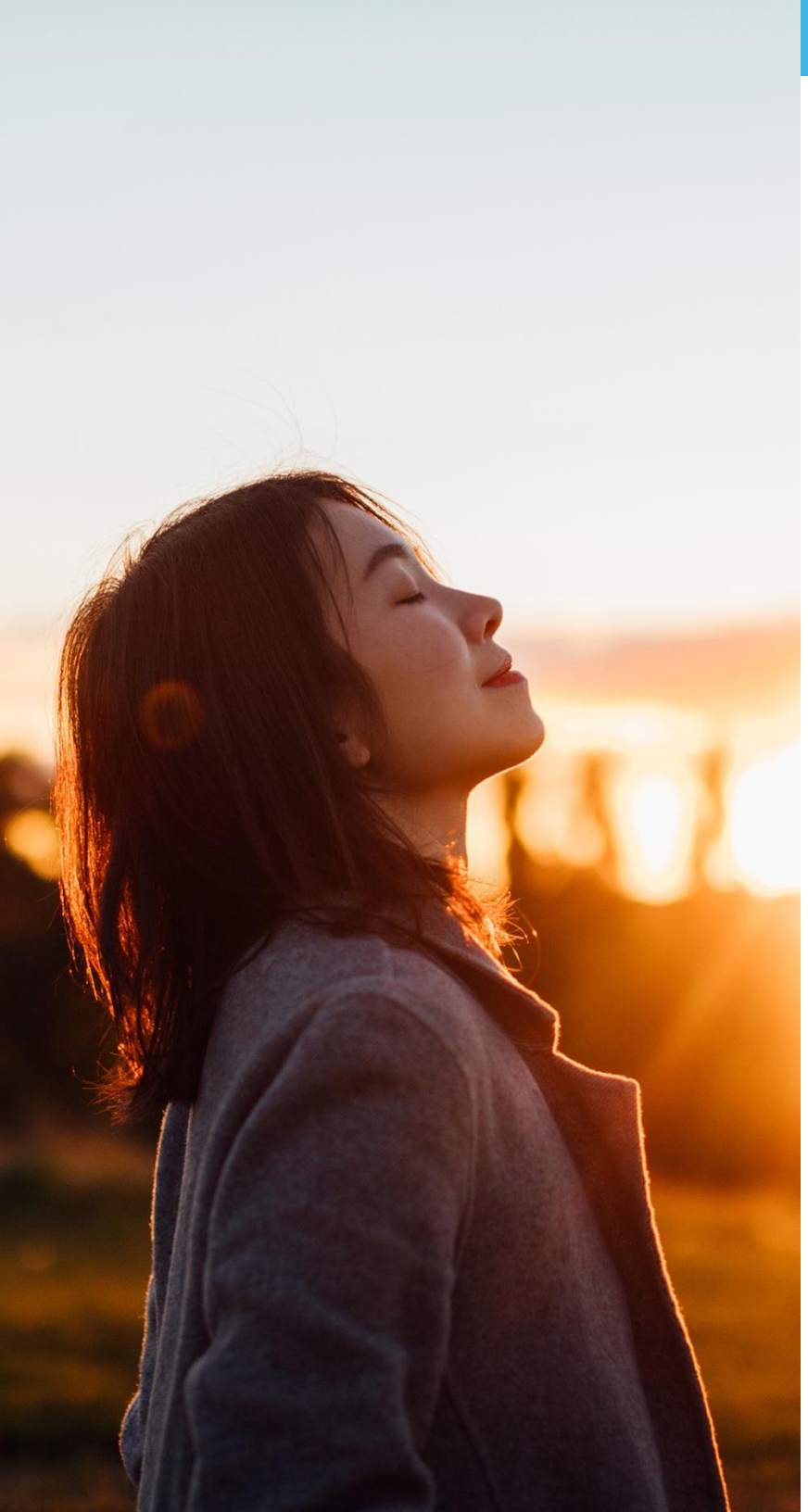
- 0 – Poor
- 10 – Excellent

Physical Health by Sexual Orientation



Key:

- 0 – Poor
- 10 – Excellent

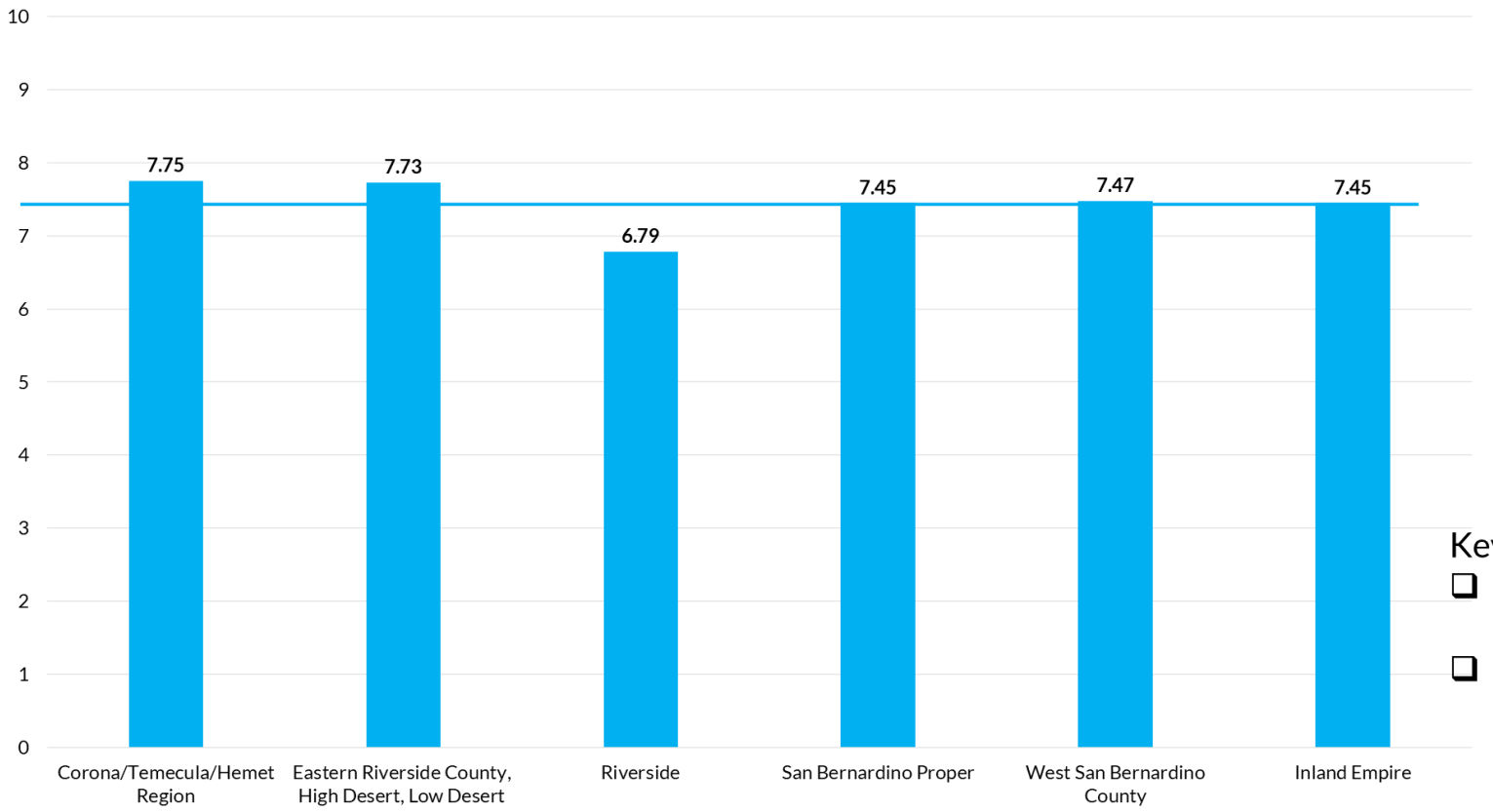


Mental Health by Demographic Data

Question: How would you rate your overall mental health?

- Region
- Age
- Race/ethnicity
- Household income
- Educational attainment
- Gender
- Sexual orientation

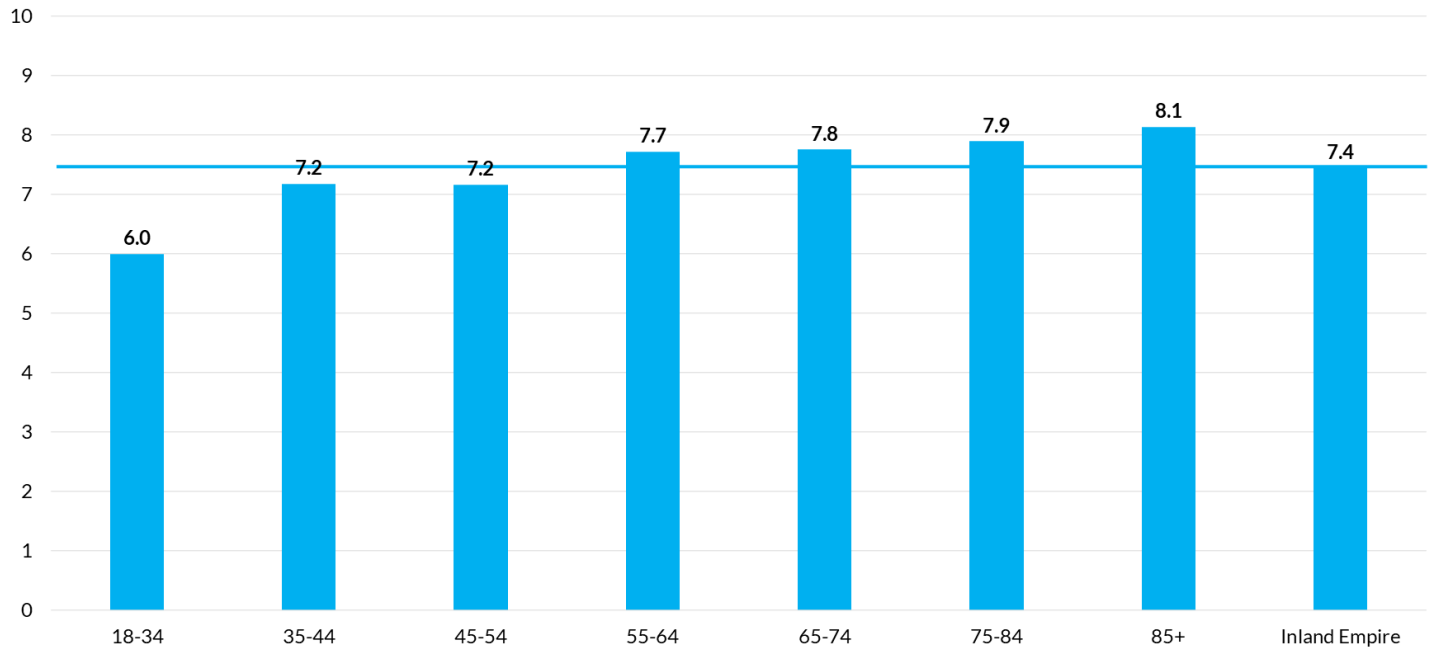
Mental Health by Region



Key:

- 0 – Poor
- 10 – Excellent

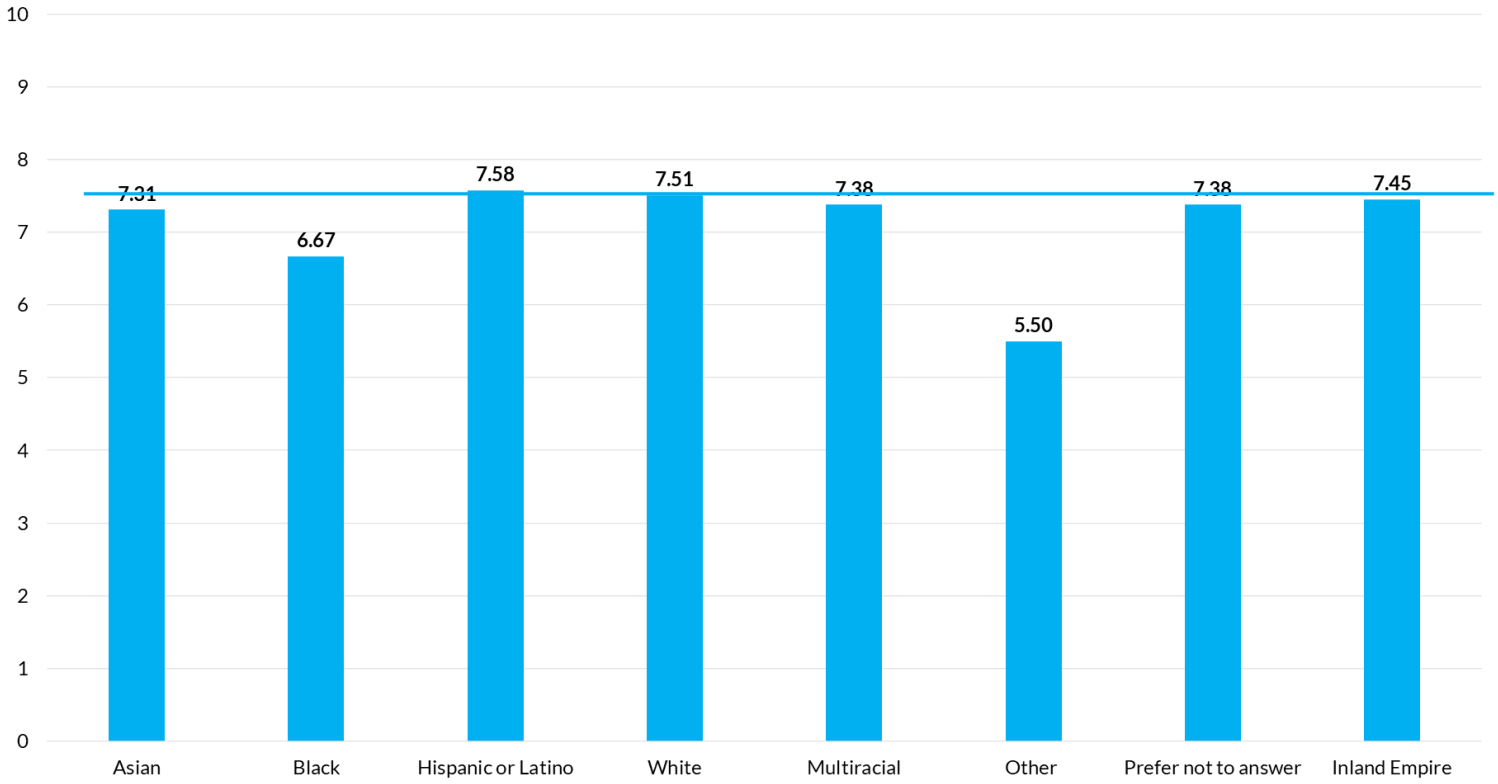
Mental Health by Age



Key:

- ❑ 0 – Poor
- ❑ 10 – Excellent

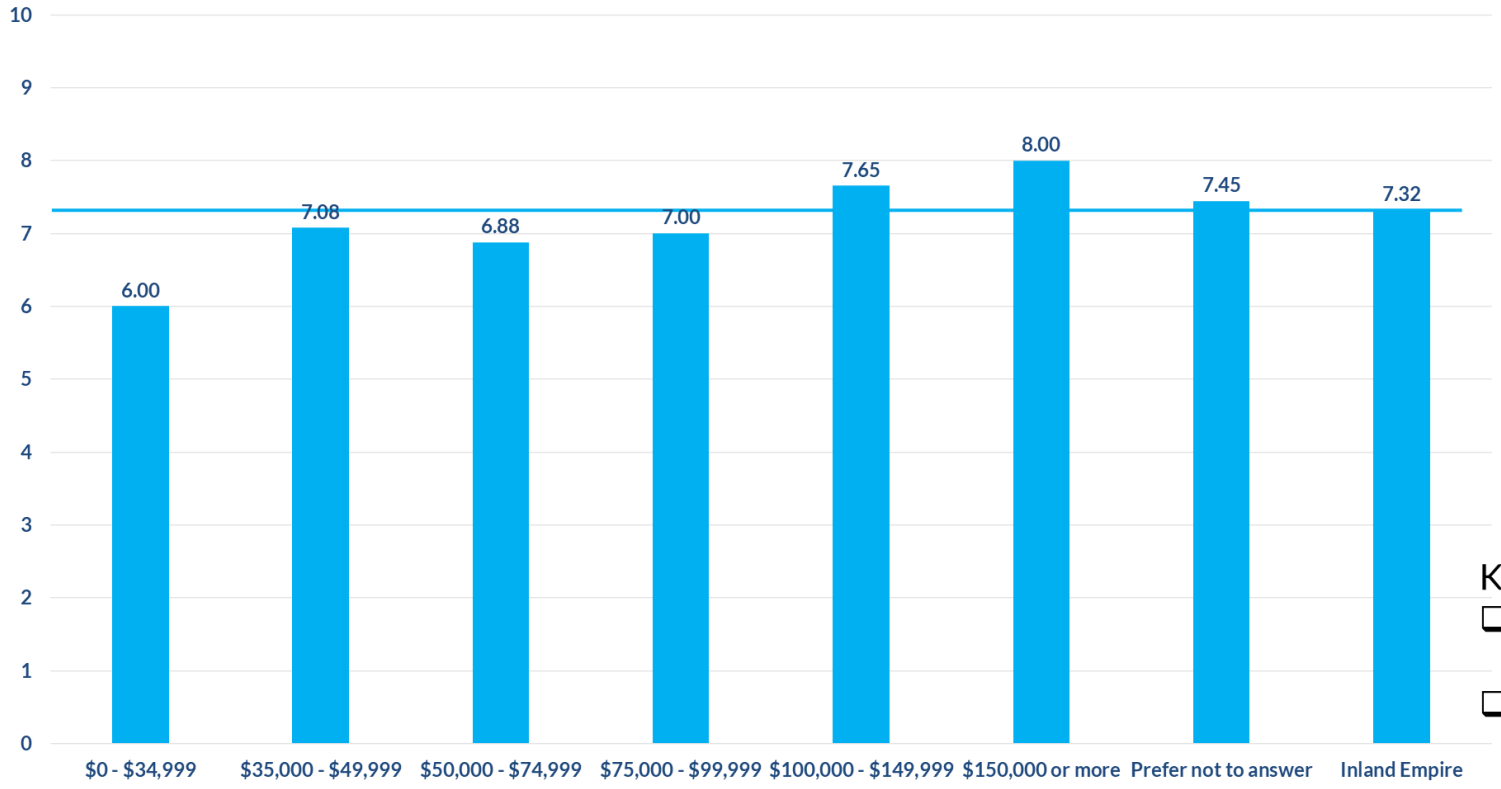
Mental Health by Race/Ethnicity



Key:

- ❑ 0 – Poor
- ❑ 10 – Excellent

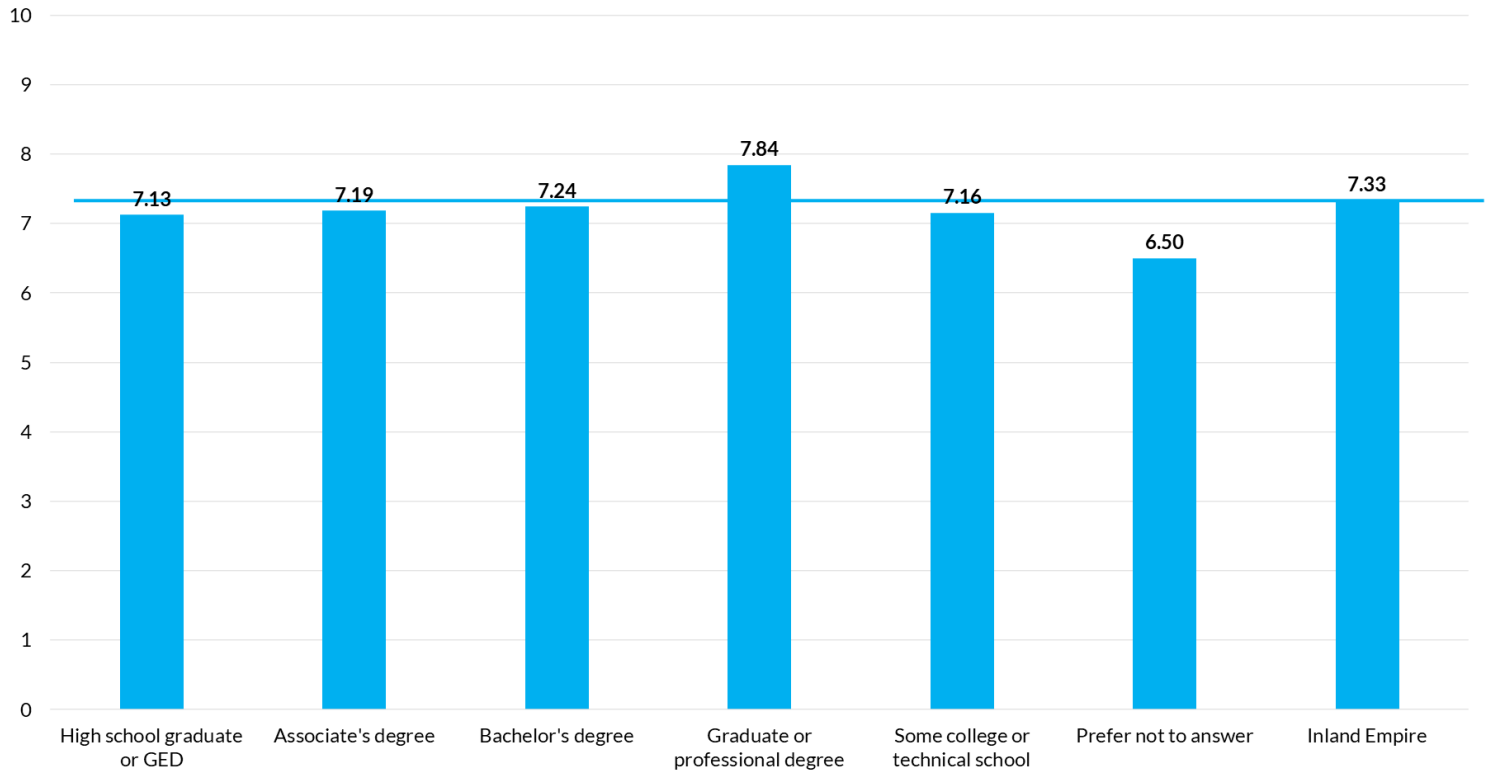
Mental Health by Household Income



Key:

- ❑ 0 – Poor
- ❑ 10 – Excellent

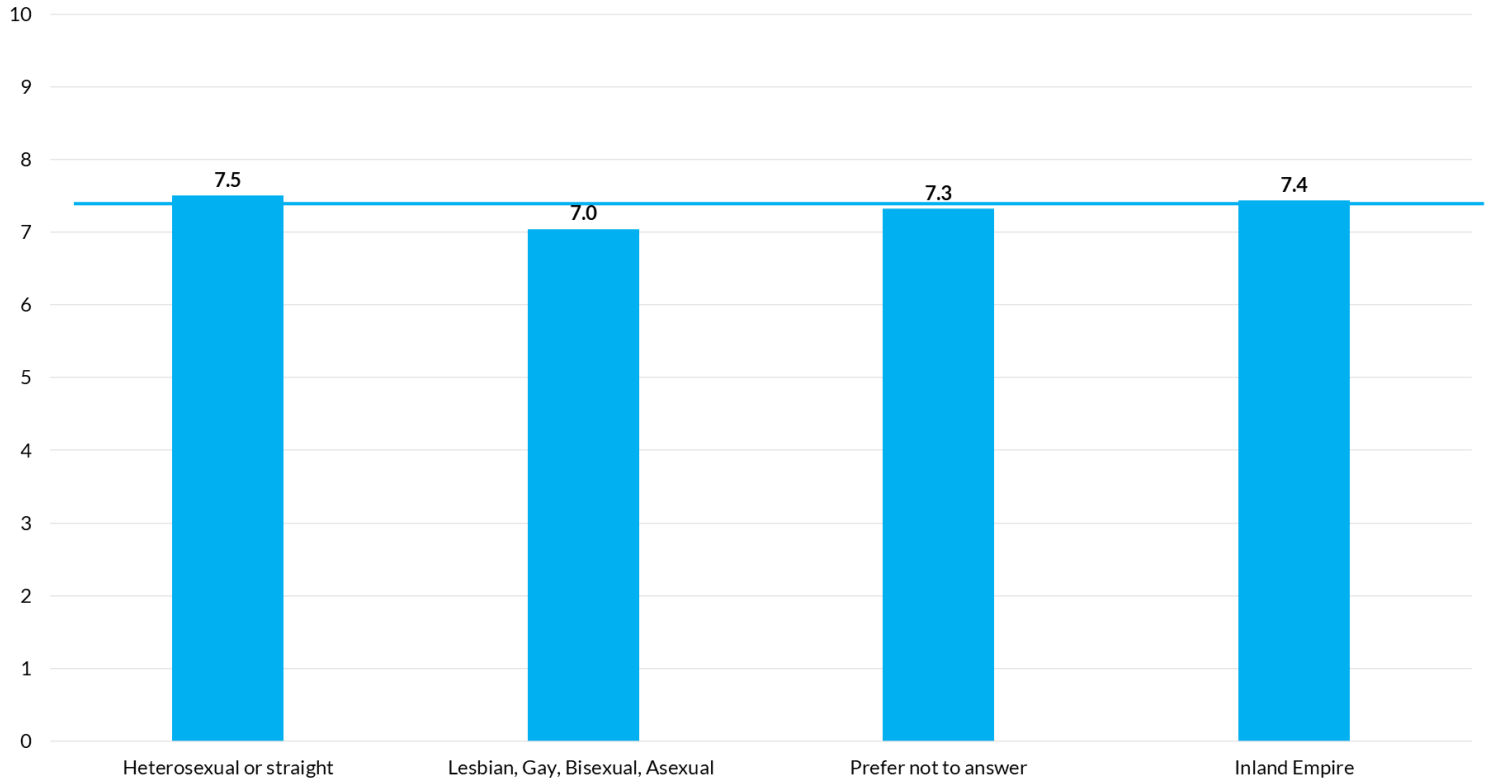
Mental Health by Educational Attainment



Key:

- 0 – Poor
- 10 – Excellent

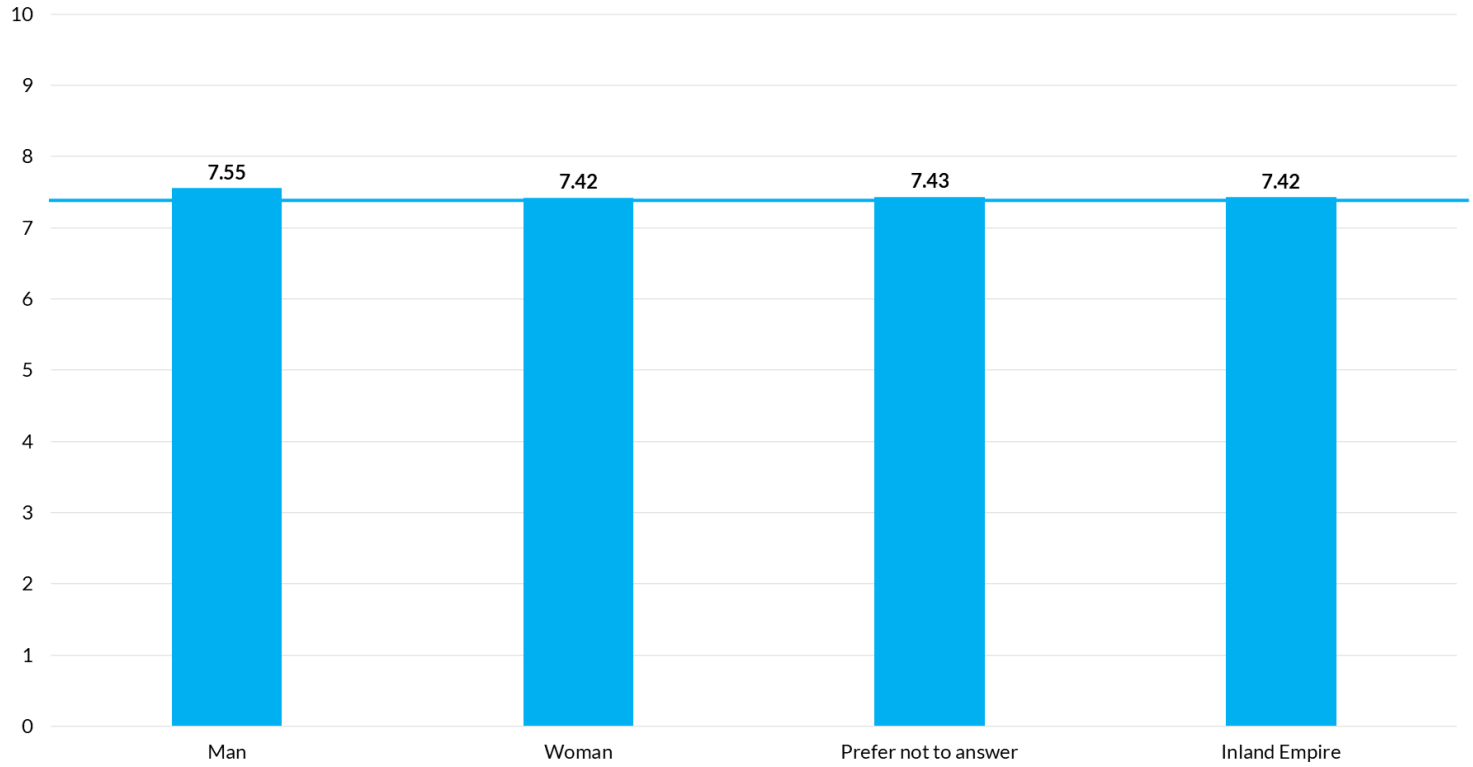
Mental Health by Sexual Orientation



Key:

- 0 – Poor
- 10 – Excellent

Mental Health by Gender



Key:

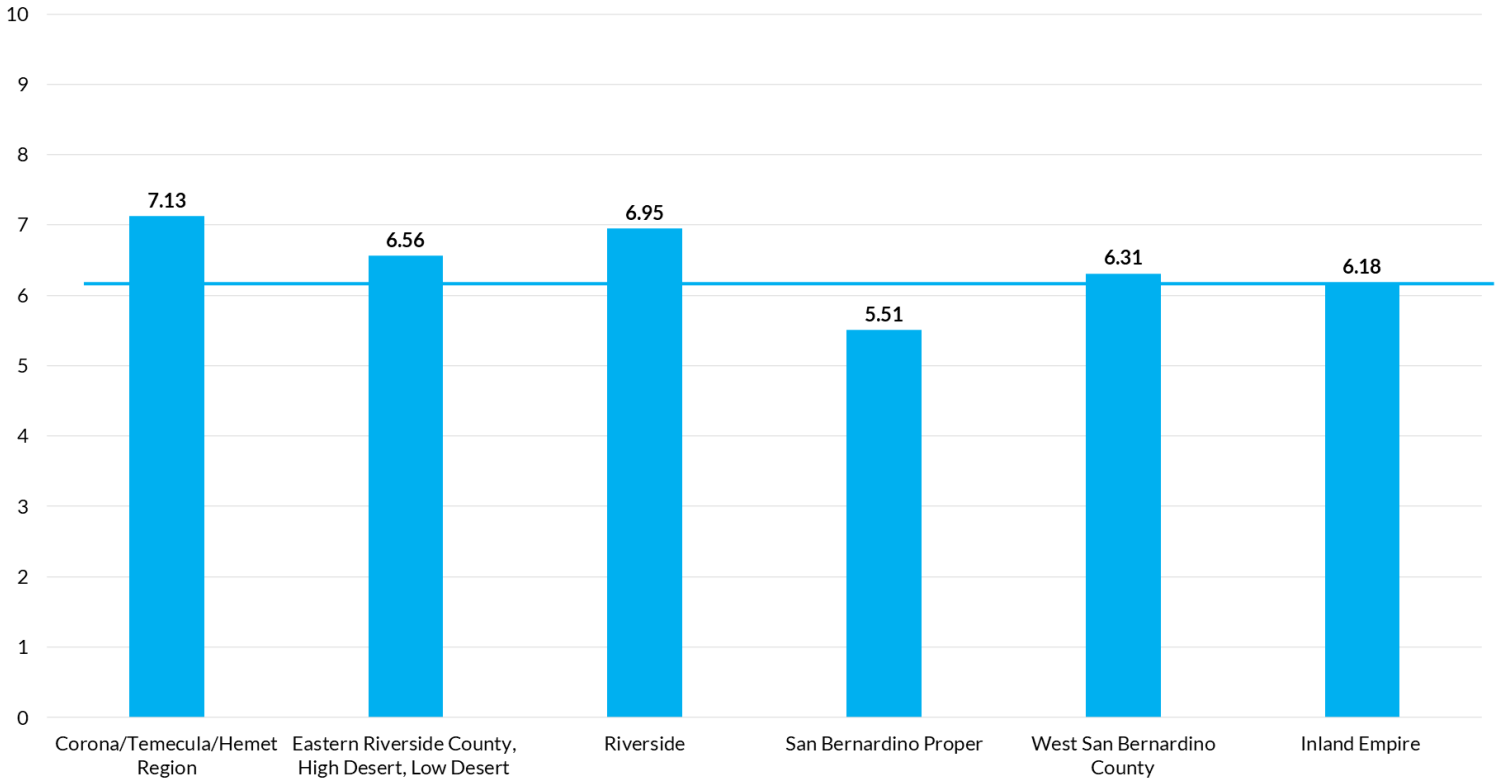
- 0 – Poor
- 10 – Excellent

Physical Limitations by Demographic Data

Question: For at least the past 6 months, to what extent have you been limited because of a health problem in activities people usually do?

- Region
- Age
- Race/ethnicity
- Household income
- Educational attainment
- Gender
- Sexual orientation

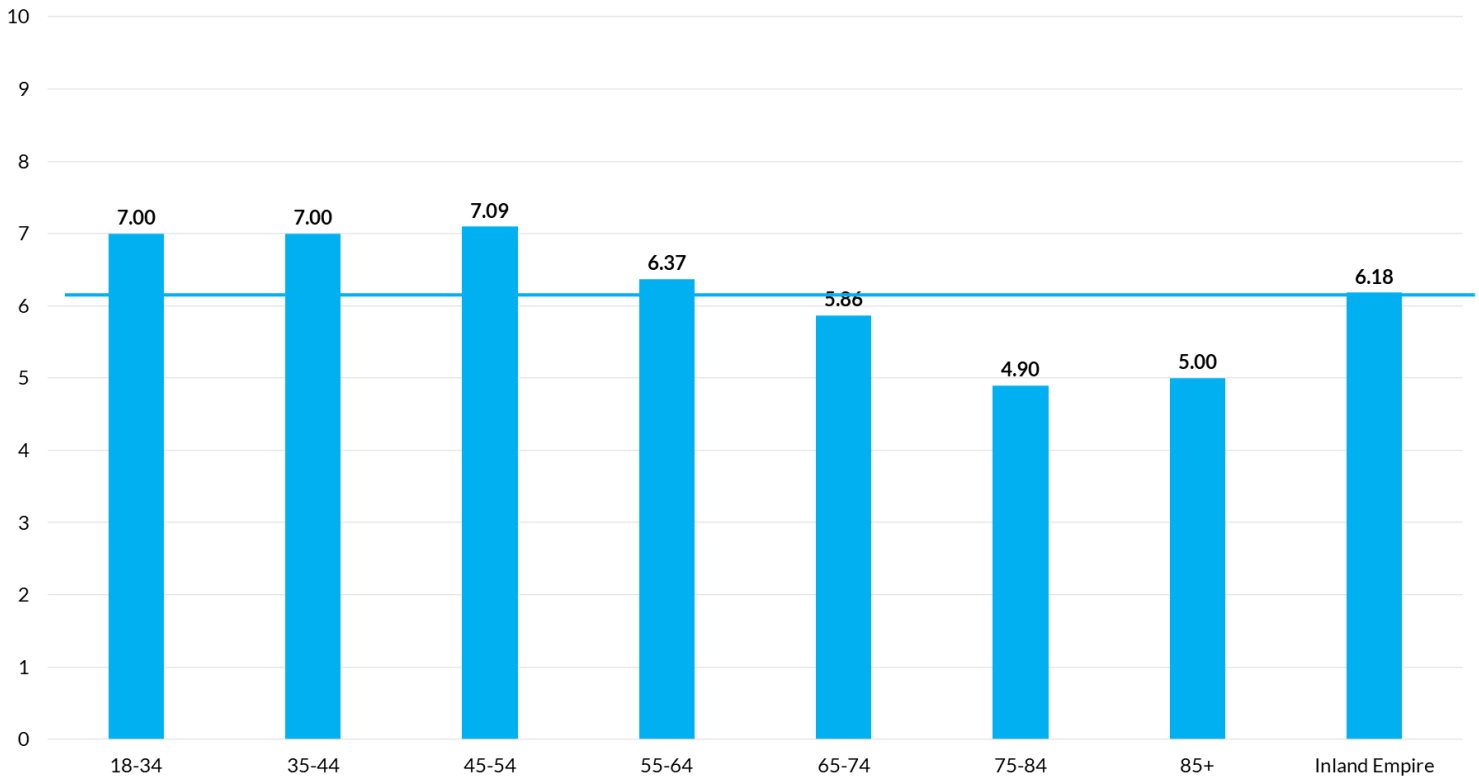
Physical Limitation by Region



Key:

- ❑ 0 – Severely Limited
- ❑ 10 – Not Limited At All

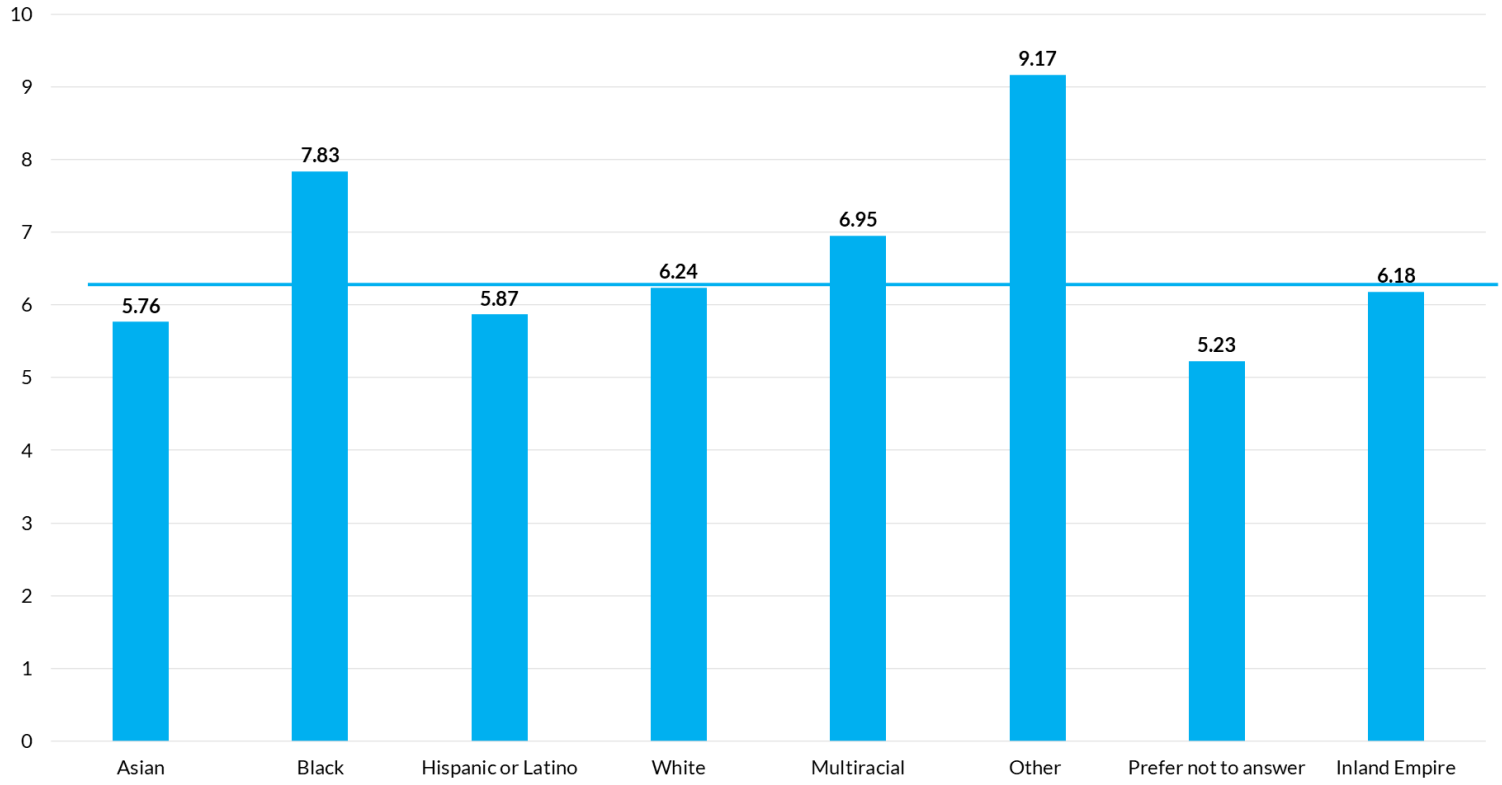
Physical Limitation by Age



Key:

- 0 – Severely Limited
- 10 – Not Limited At All

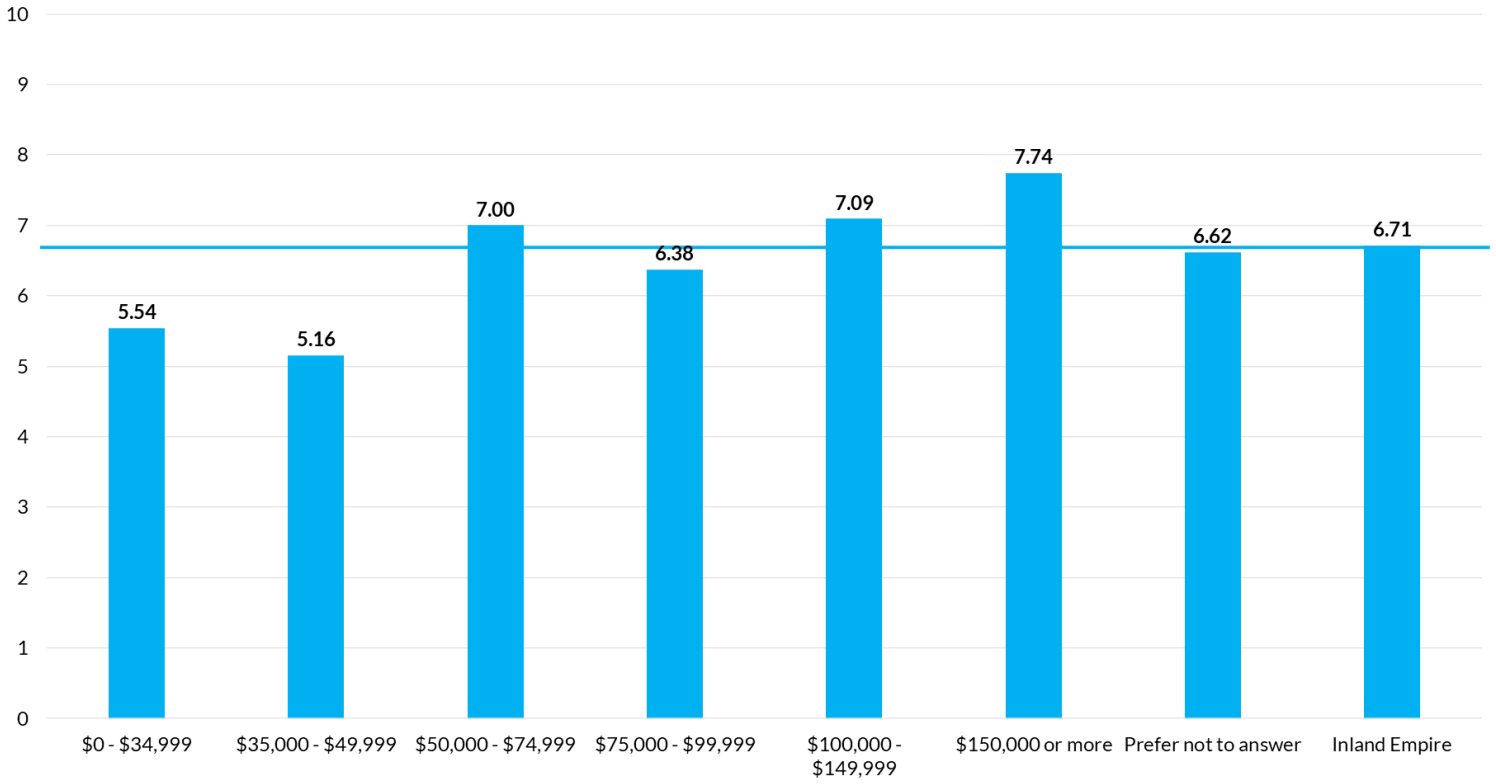
Physical Limitation by Race/Ethnicity



Key:

- 0 – Severely Limited
- 10 – Not Limited At All

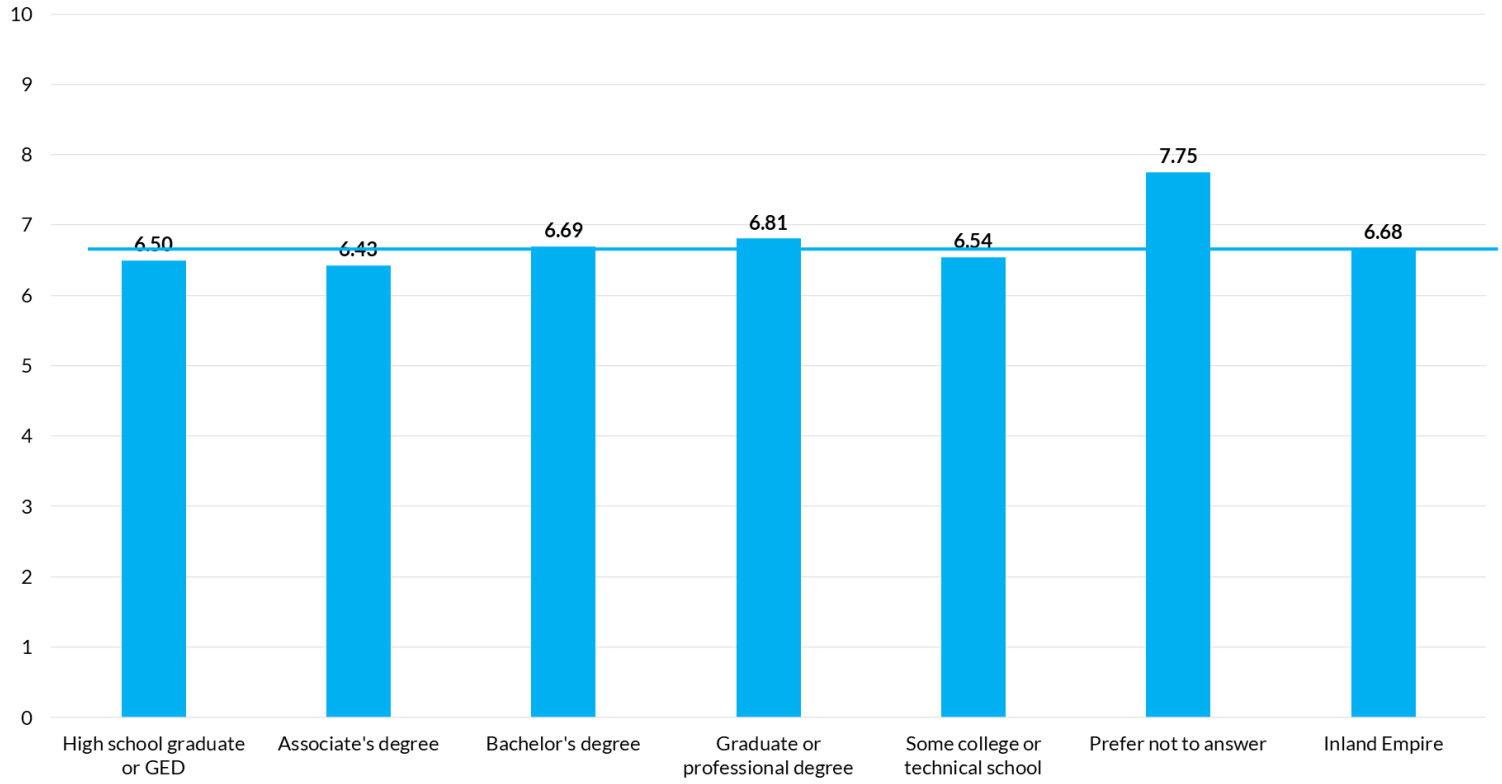
Physical Limitation by Household Income



Key:

- 0 – Severely Limited
- 10 – Not Limited At All

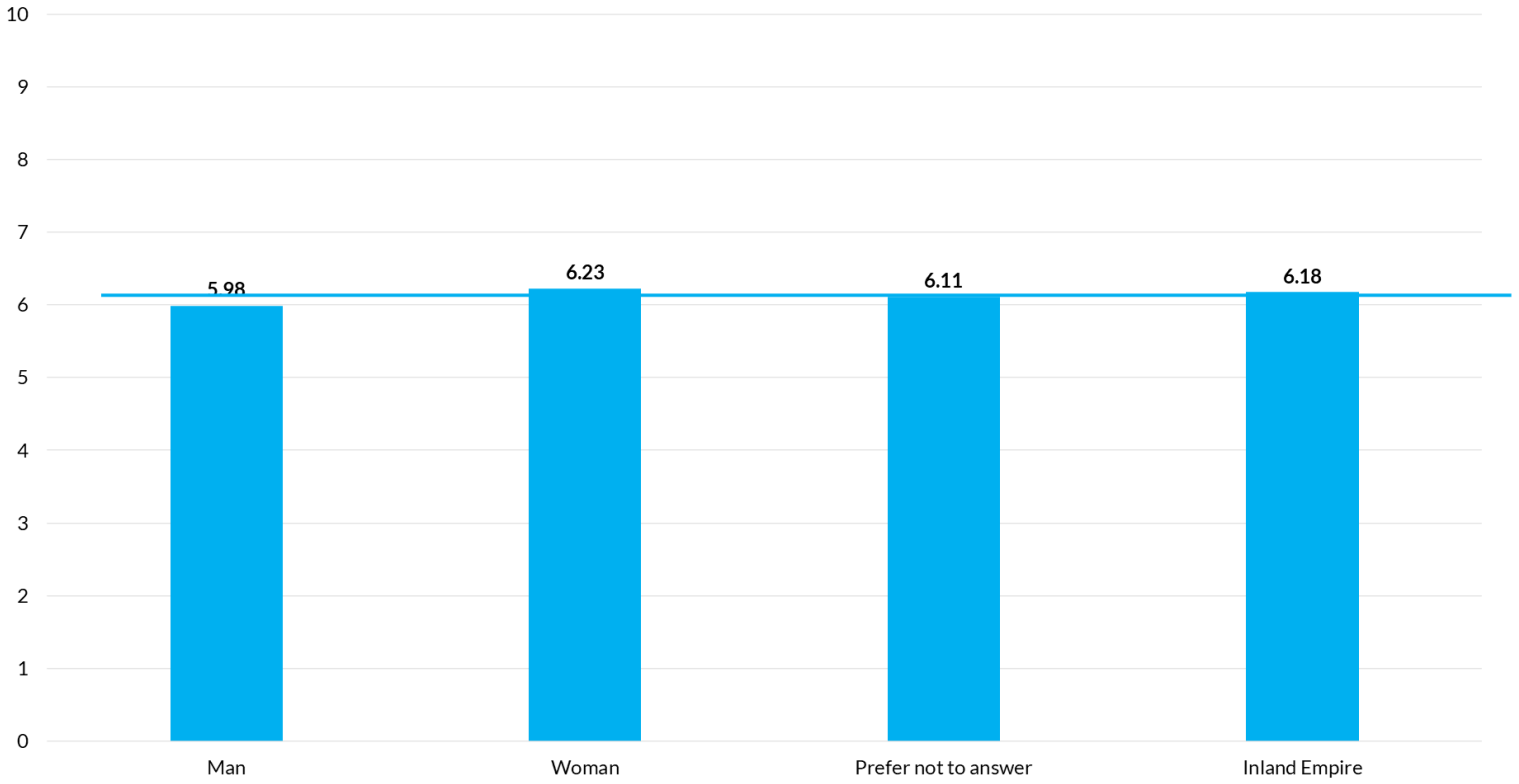
Physical Limitation by Educational Attainment



Key:

- 0 – Severely Limited
- 10 – Not Limited At All

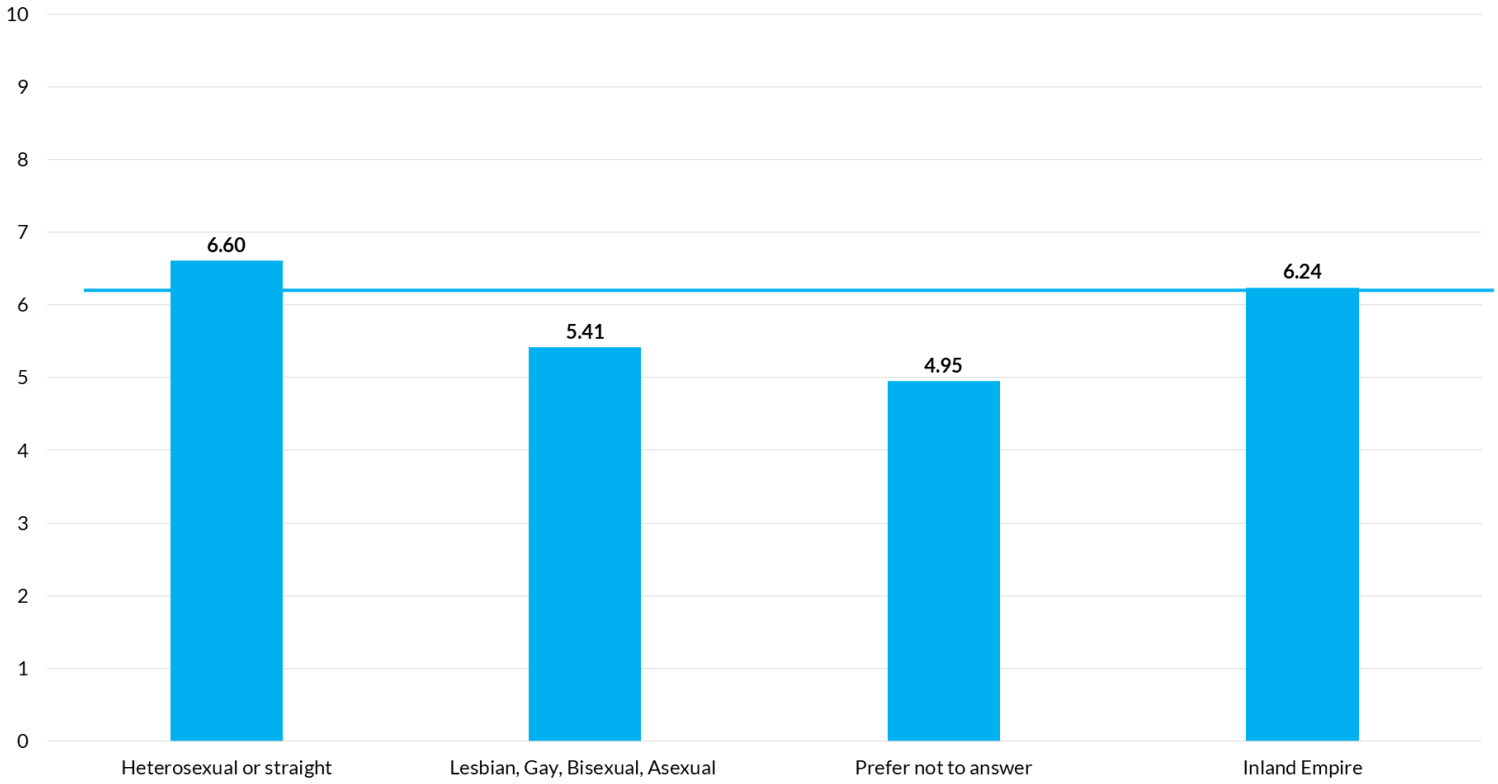
Physical Limitation by Gender



Key:

- 0 – Severely Limited
- 10 – Not Limited At All

Physical Limitation by Sexual Orientation



Key:

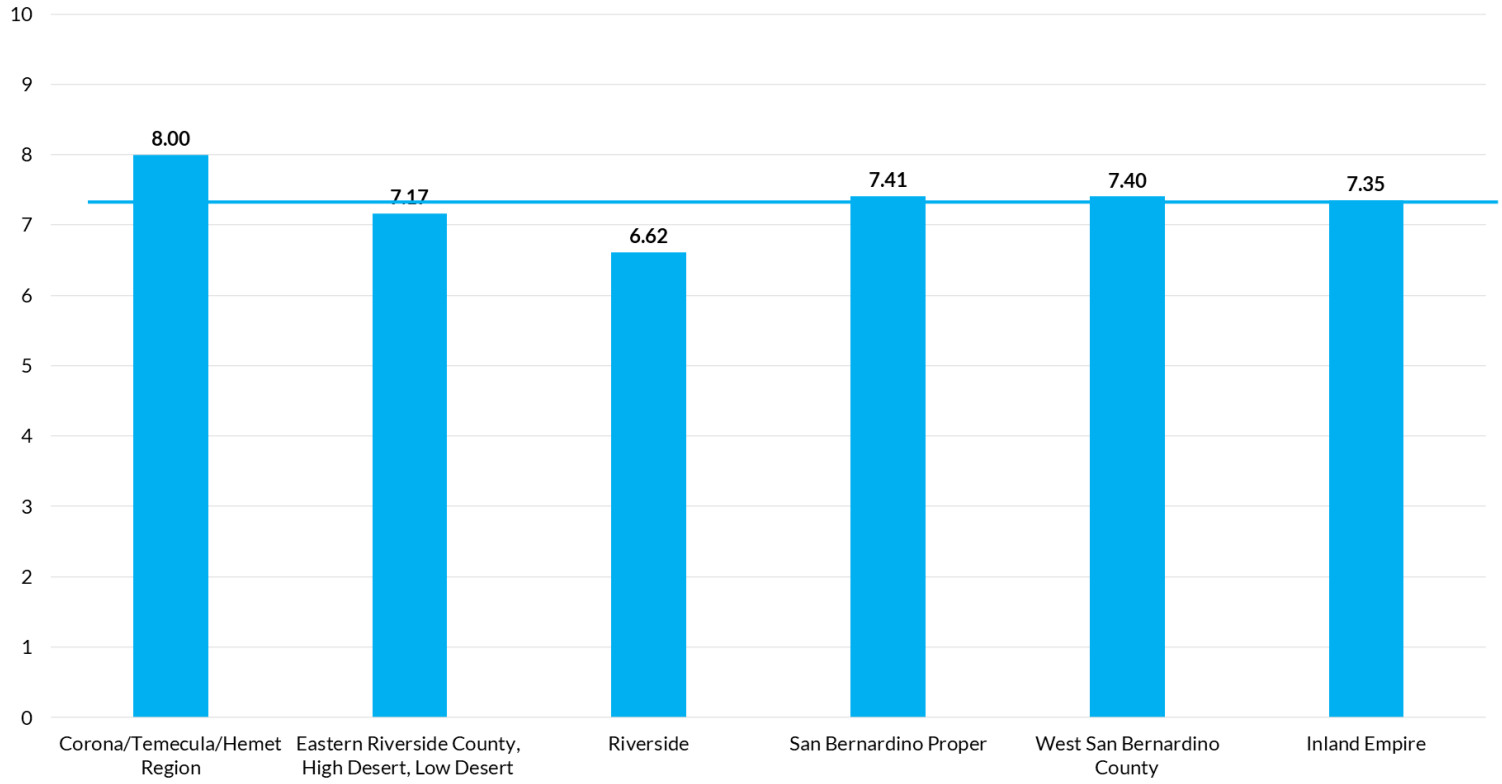
- 0 – Severely Limited
- 10 – Not Limited At All

Sense of Direction and Purpose by Demographic Data

Question: I have a sense of direction and purpose in life.

- Region
- Age
- Race/ethnicity
- Household income
- Educational attainment
- Gender
- Sexual orientation

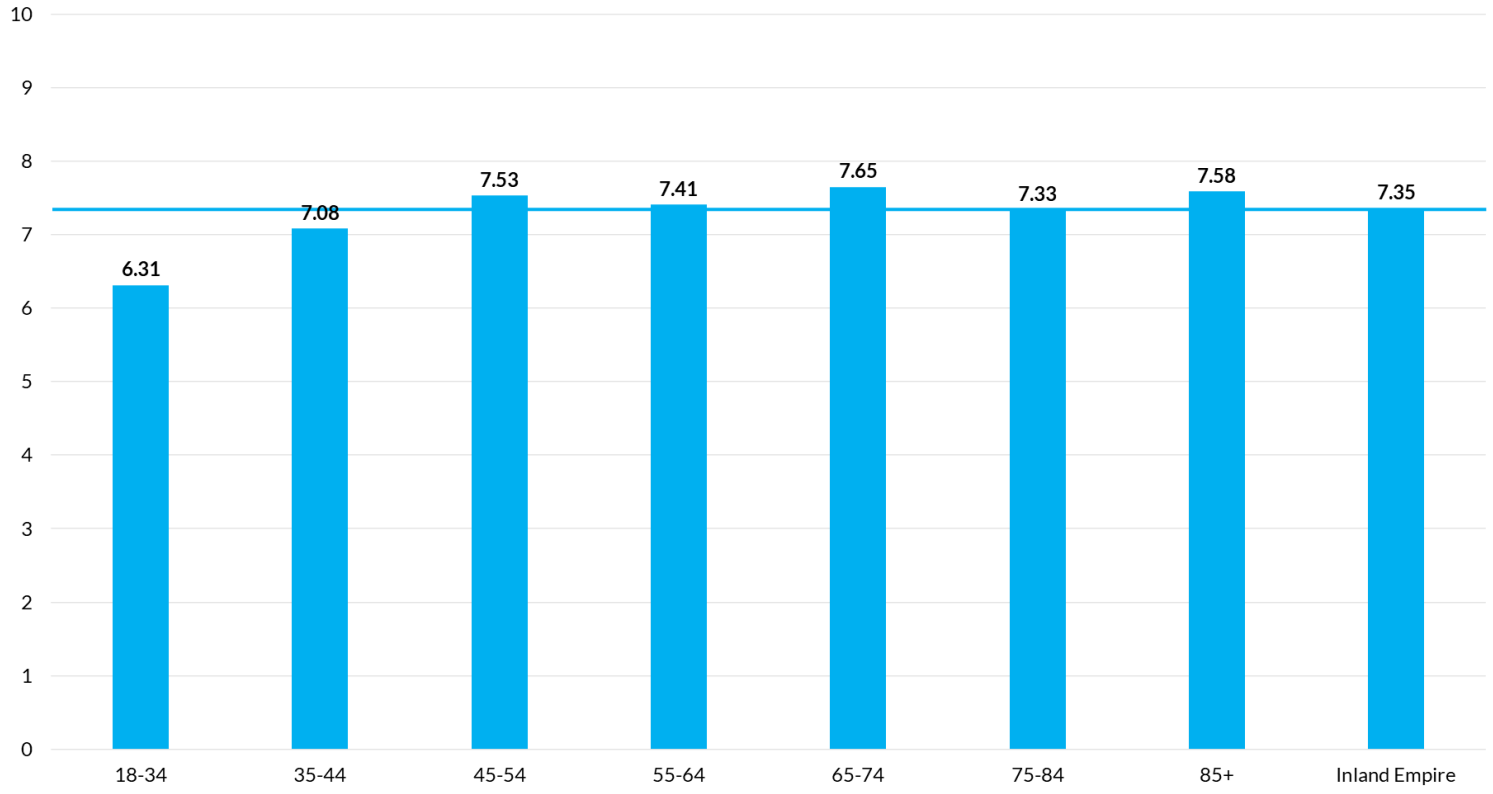
Sense of Direction and Purpose by Region



Key:

- 0 – Strongly Disagree
- 10 – Strongly Agree

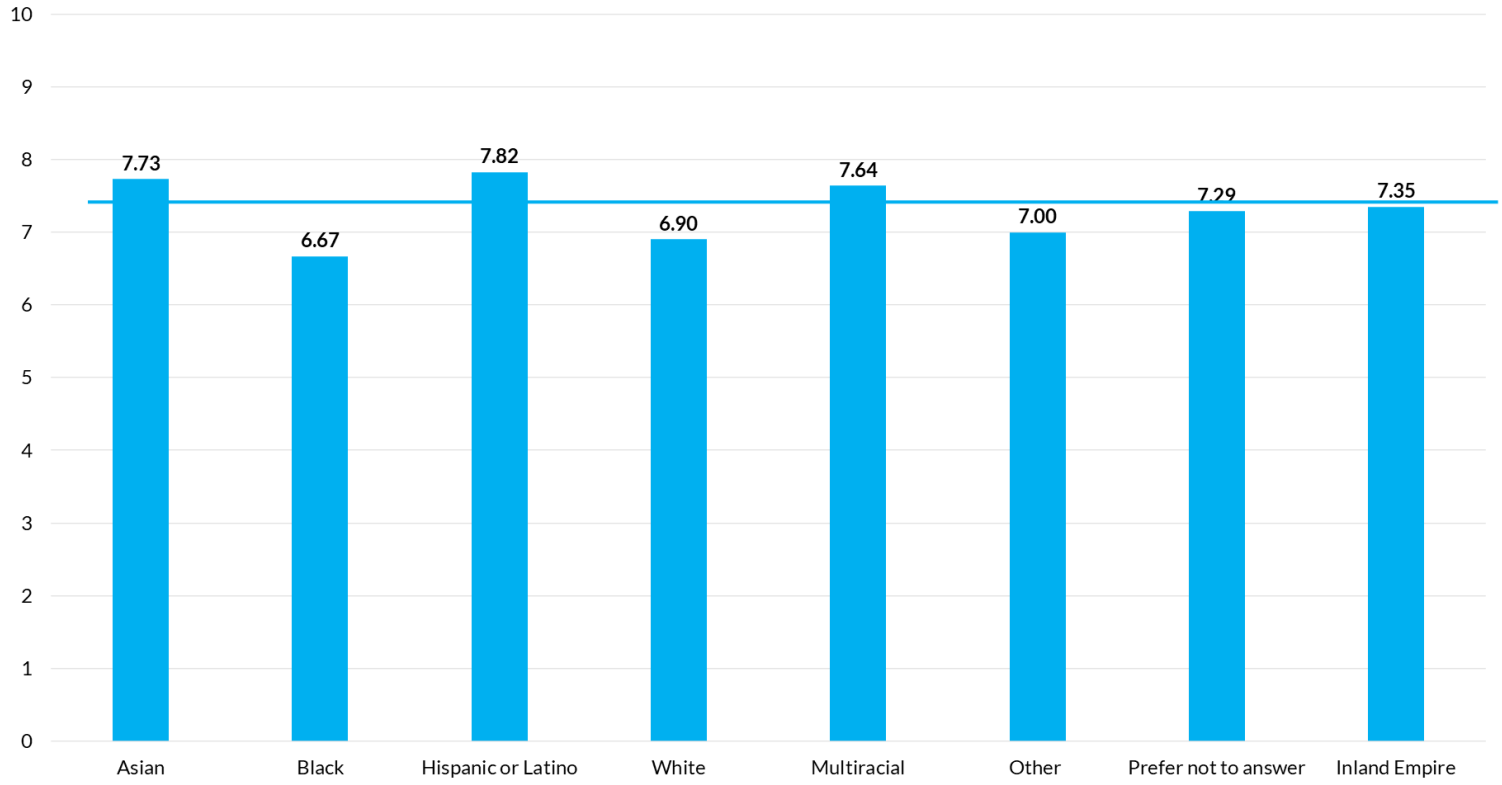
Sense of Direction and Purpose by Age



Key:

- 0 – Strongly Disagree
- 10 – Strongly Agree

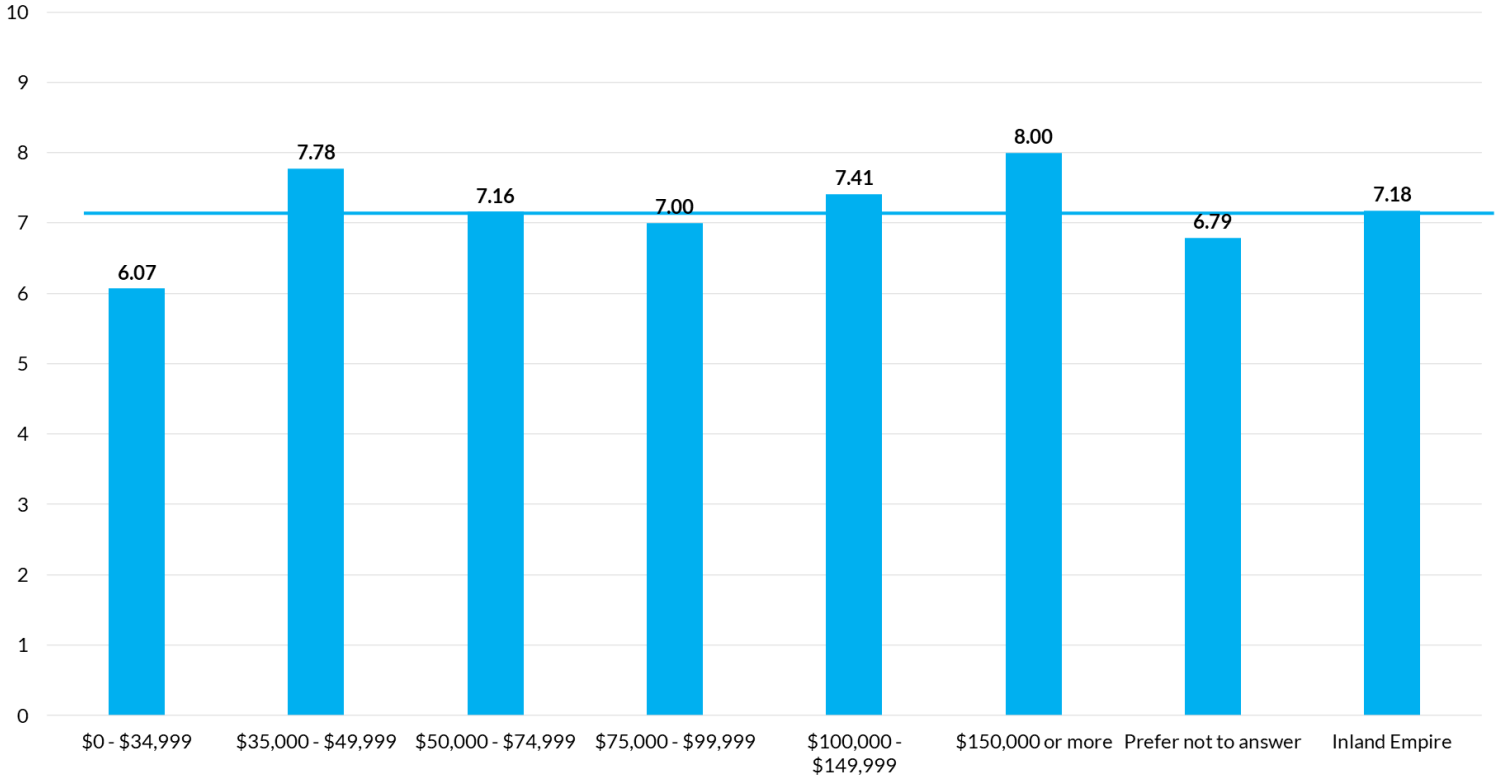
Sense of Direction and Purpose by Race/Ethnicity



Key:

- 0 – Strongly Disagree
- 10 – Strongly Agree

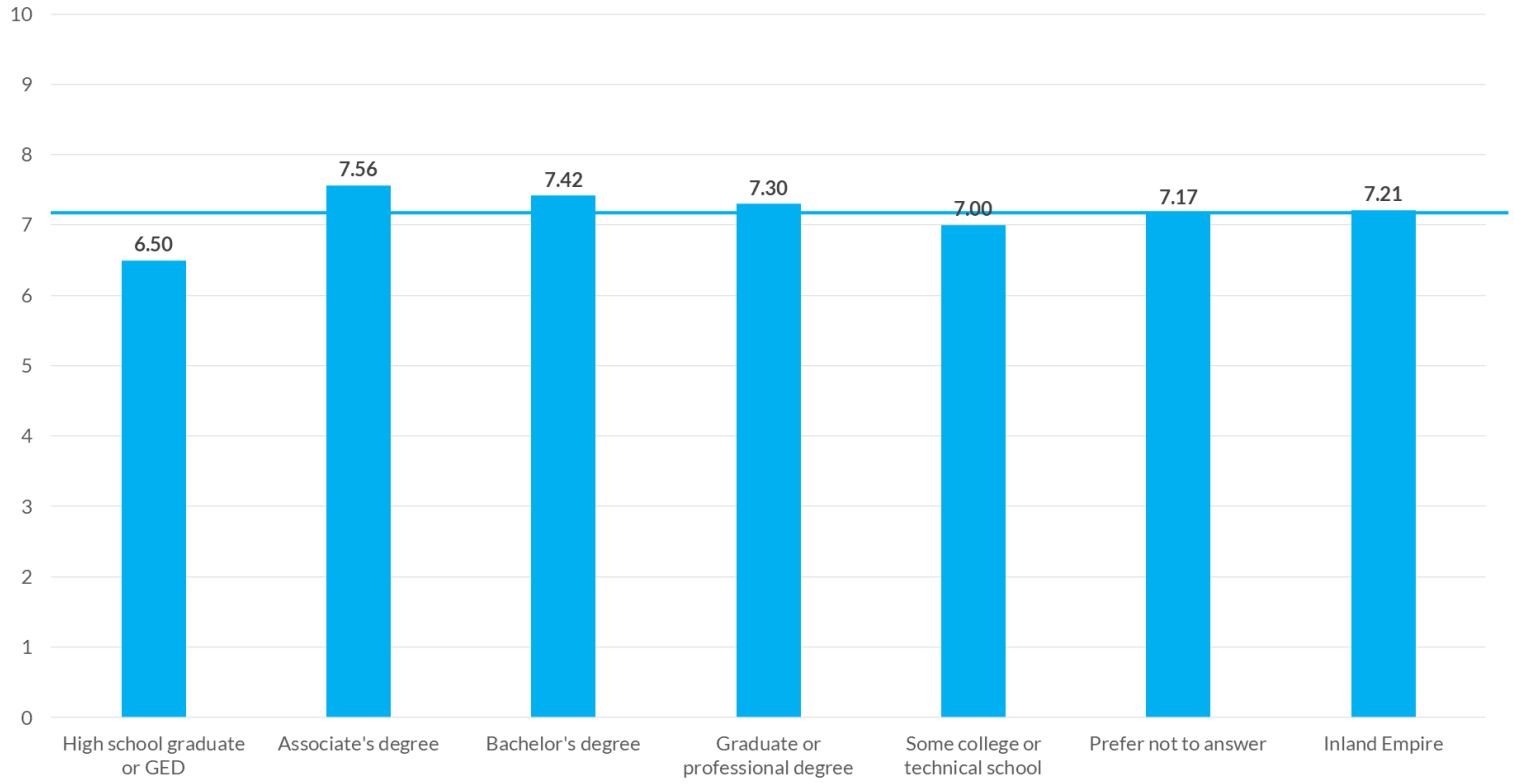
Sense of Direction and Purpose by Household Income



Key:

- ❑ 0 – Strongly Disagree
- ❑ 10 – Strongly Agree

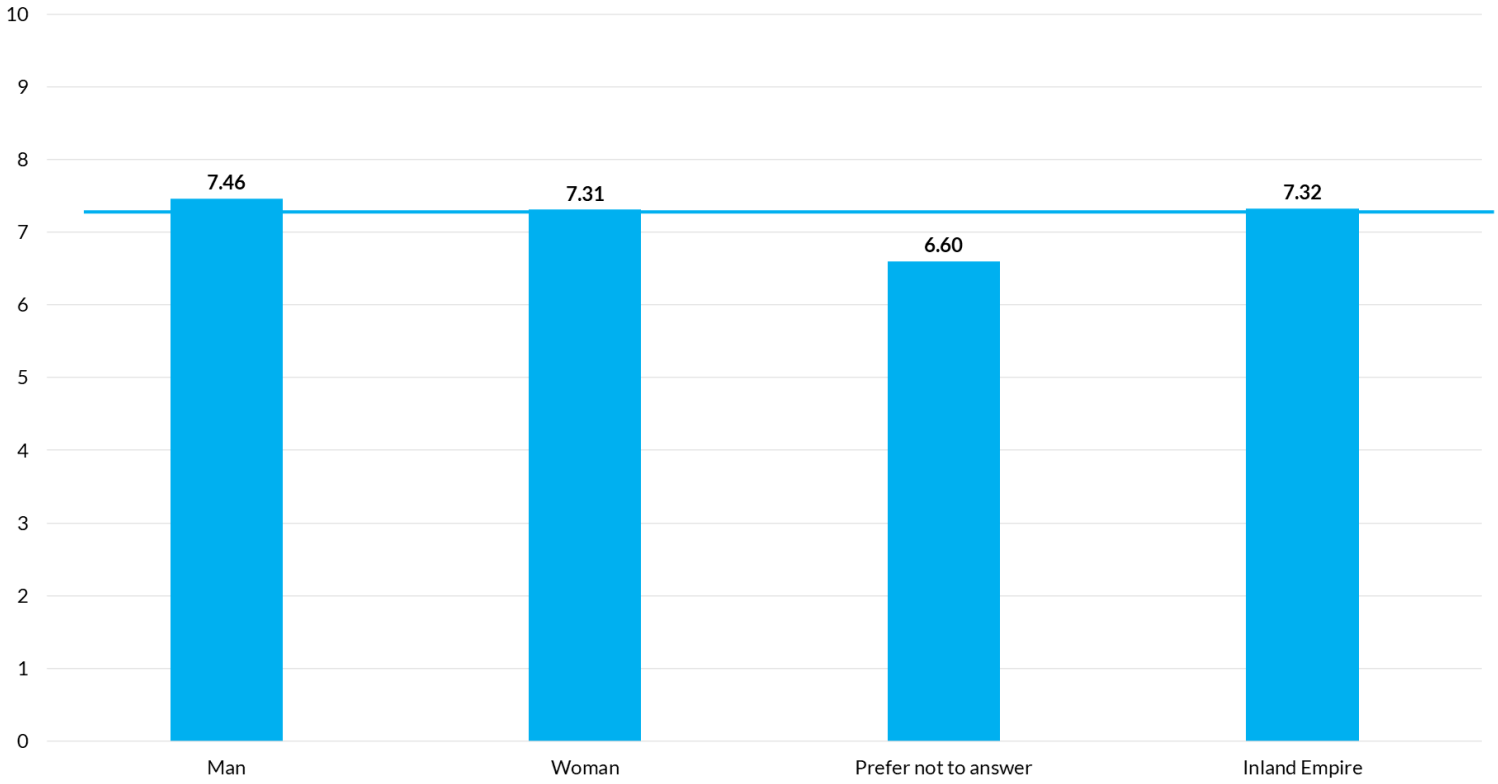
Sense of Direction and Purpose by Educational Attainment



Key:

- 0 – Strongly Disagree
- 10 – Strongly Agree

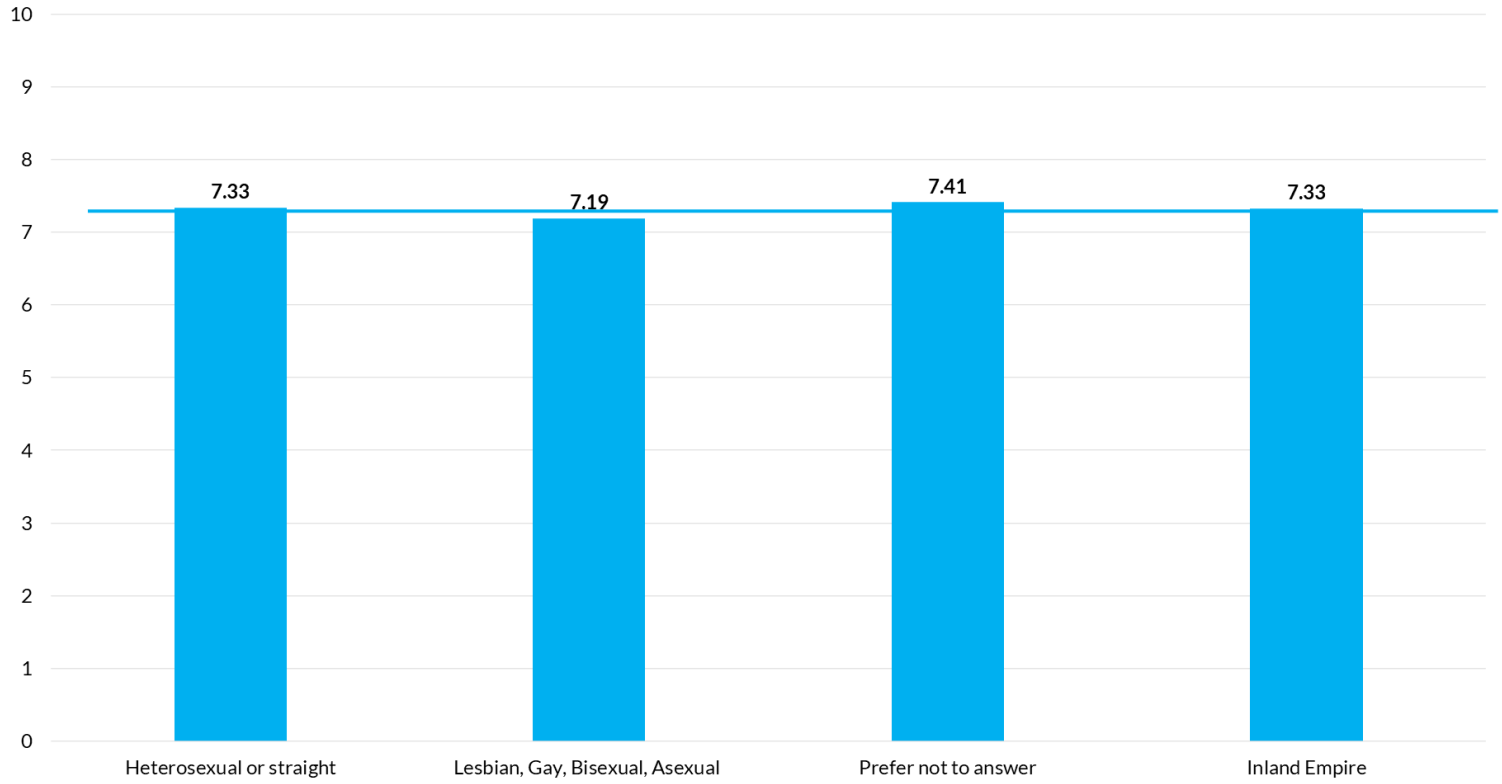
Sense of Direction and Purpose by Gender



Key:

- 0 – Strongly Disagree
- 10 – Strongly Agree

Sense of Direction and Purpose by Sexual Orientation



Key:

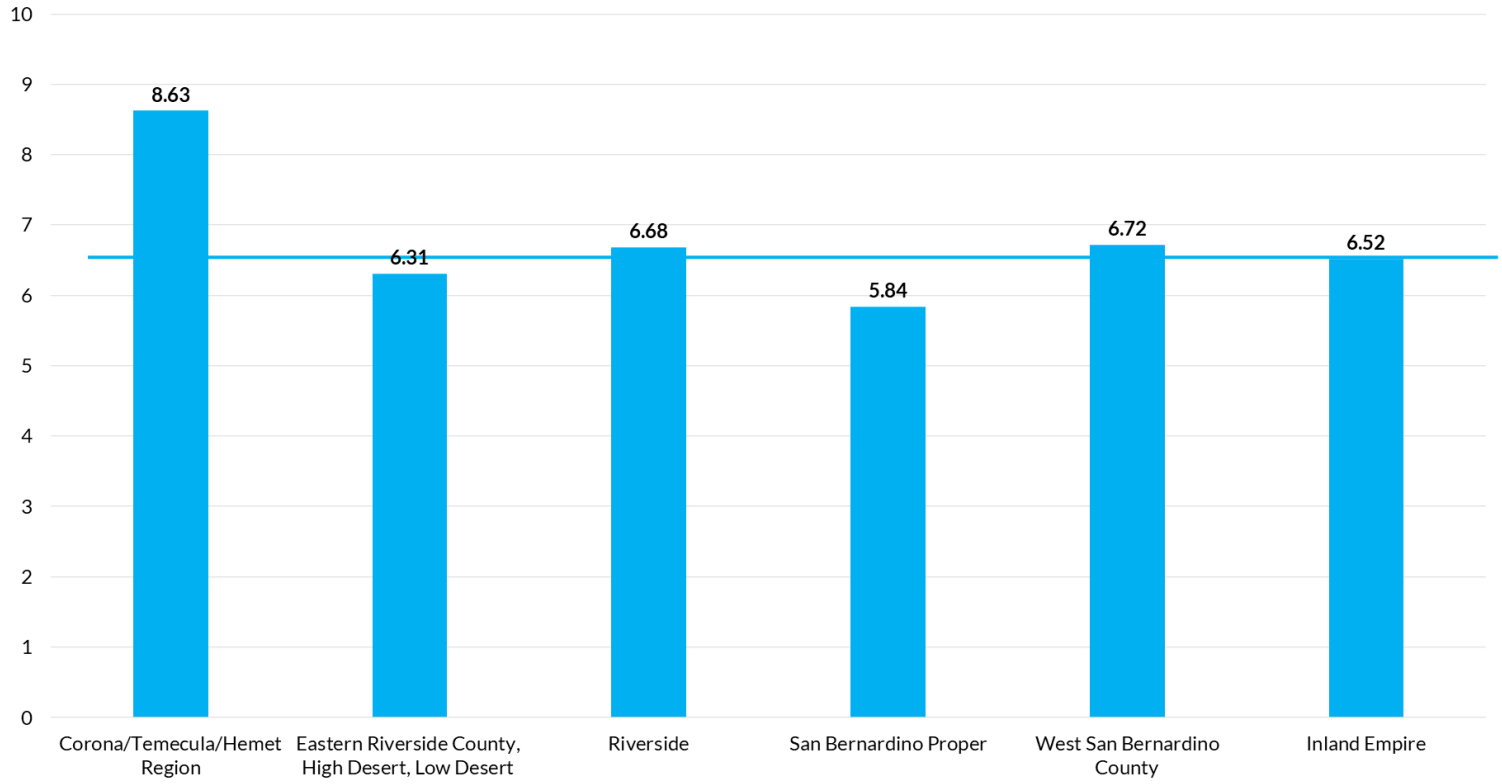
- 0 – Strongly Disagree
- 10 – Strongly Agree

Feelings of Loneliness by Demographic Data

Question: How often do you feel lonely?

- Region
- Age
- Race/ethnicity
- Household income
- Educational attainment
- Gender
- Sexual orientation

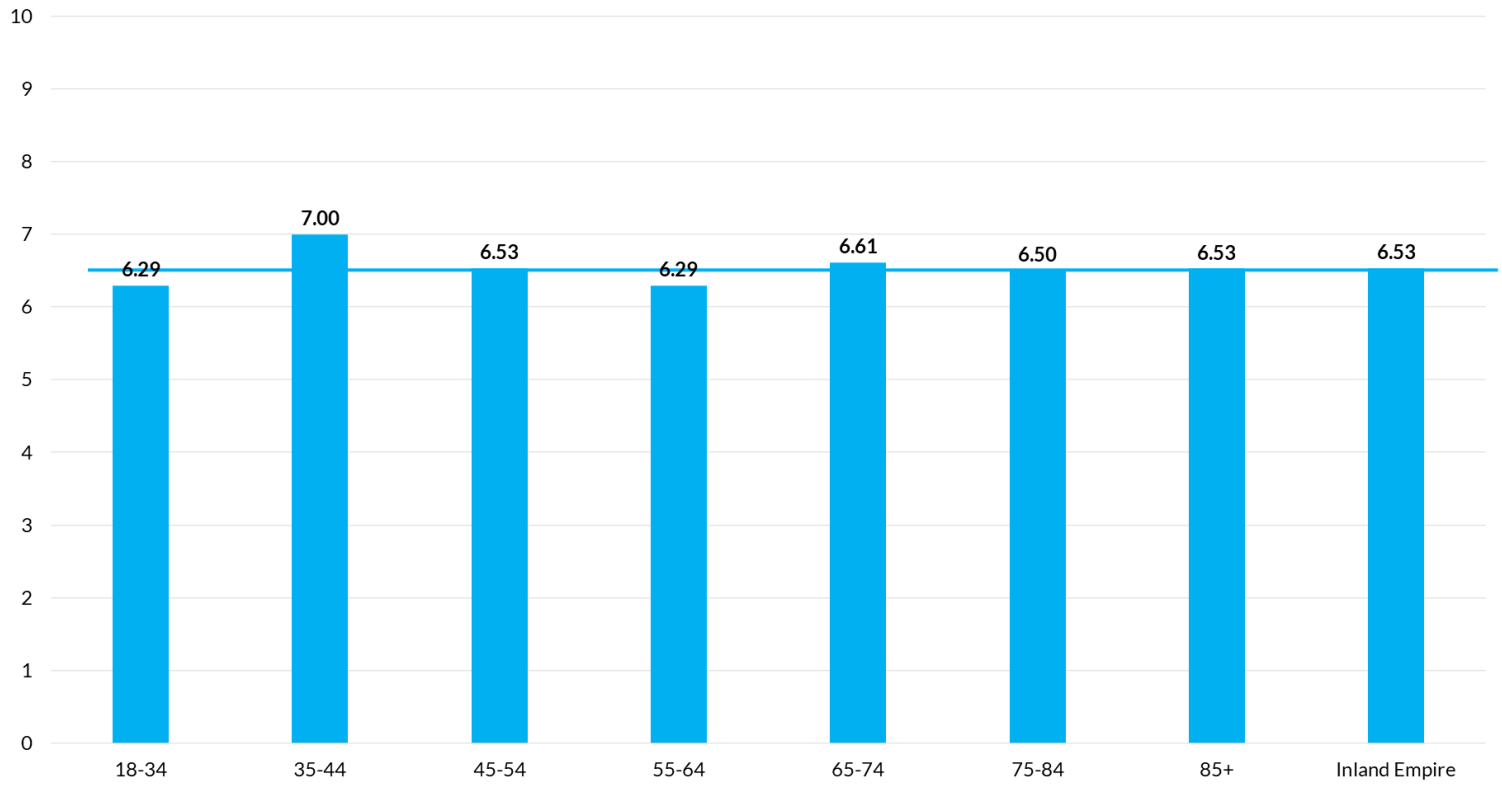
Feelings of Loneliness by Region



Key:

- ❑ 0 – Always
- ❑ 10 – Never

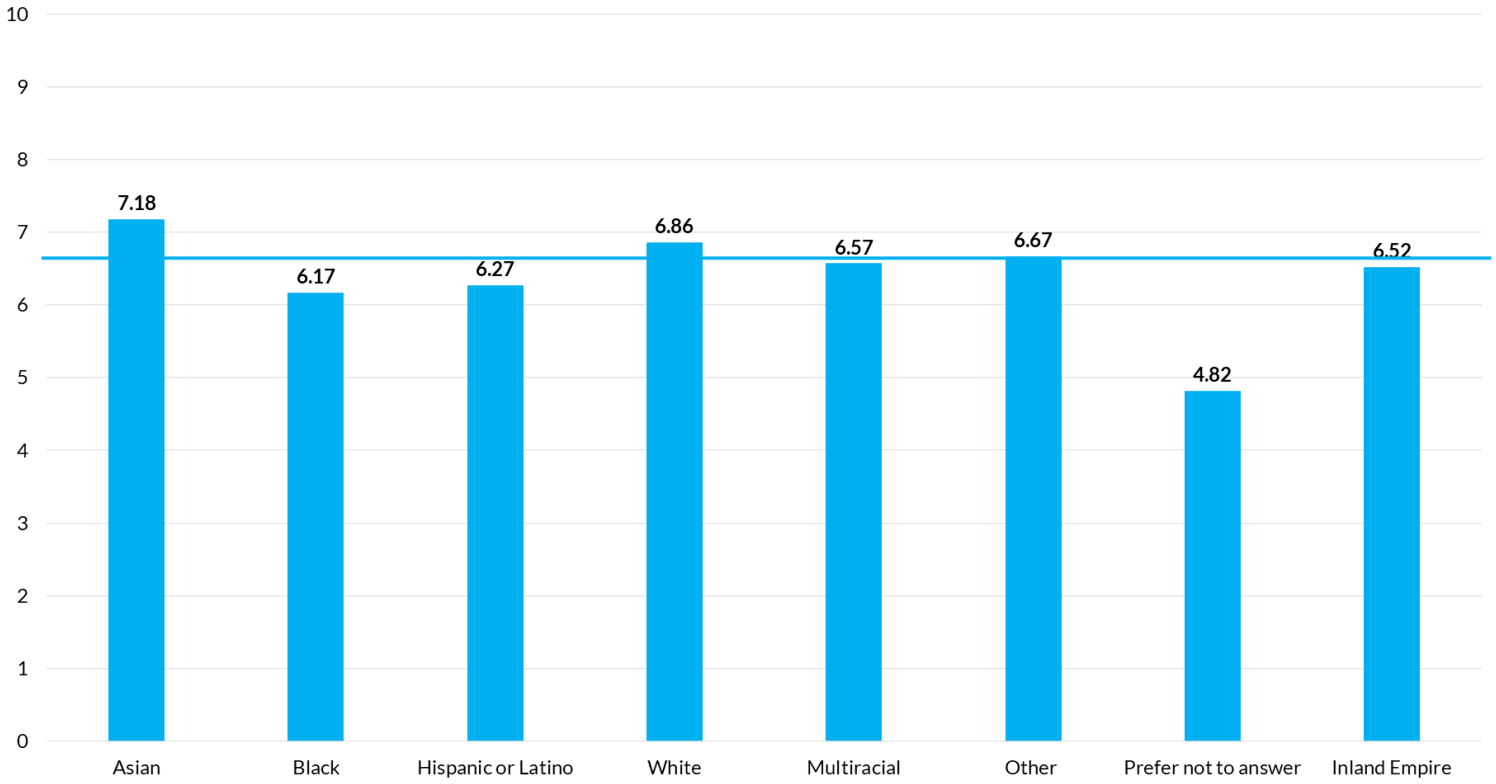
Feelings of Loneliness by Age



Key:

- 0 – Always
- 10 – Never

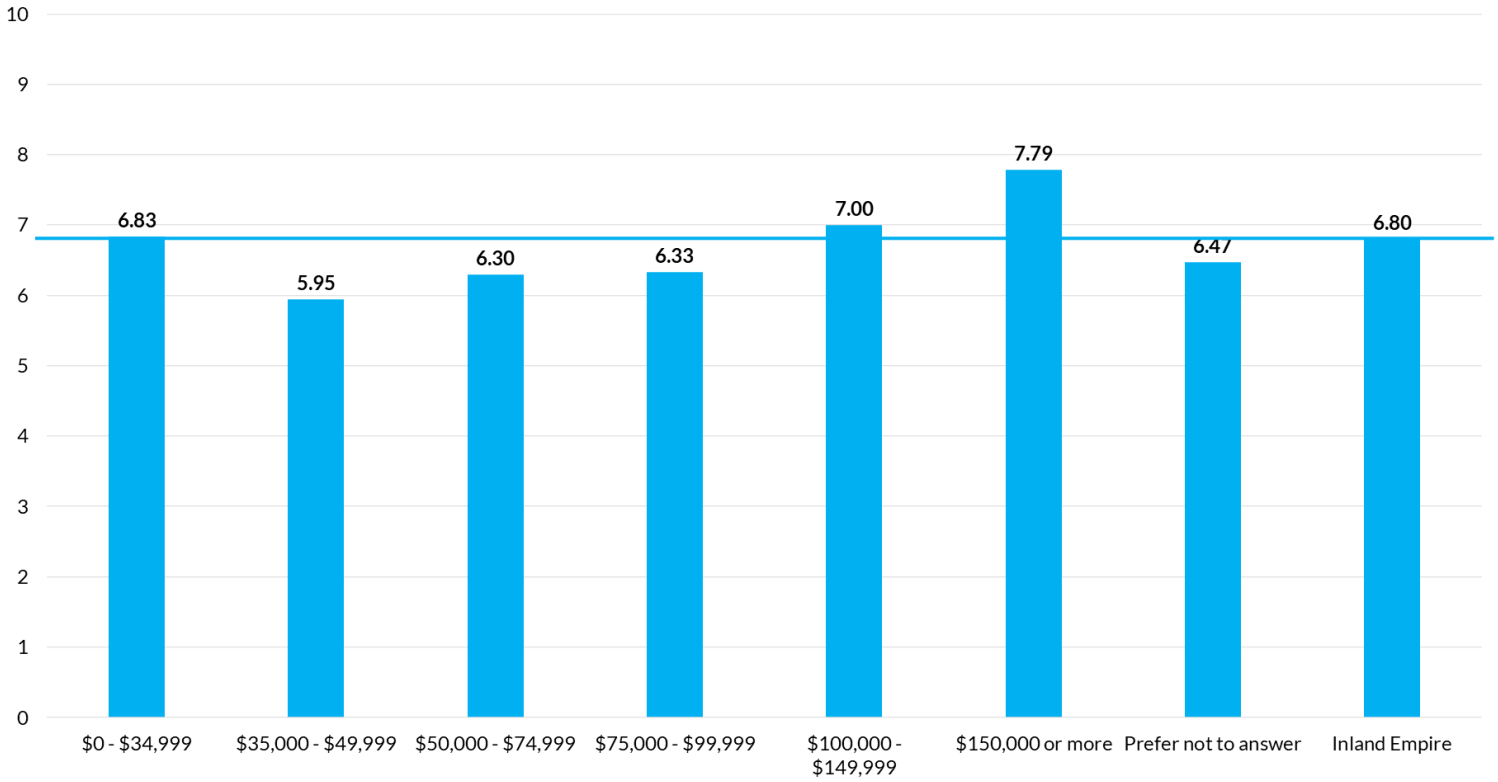
Feelings of Loneliness by Race/Ethnicity



Key:

- 0 – Always
- 10 – Never

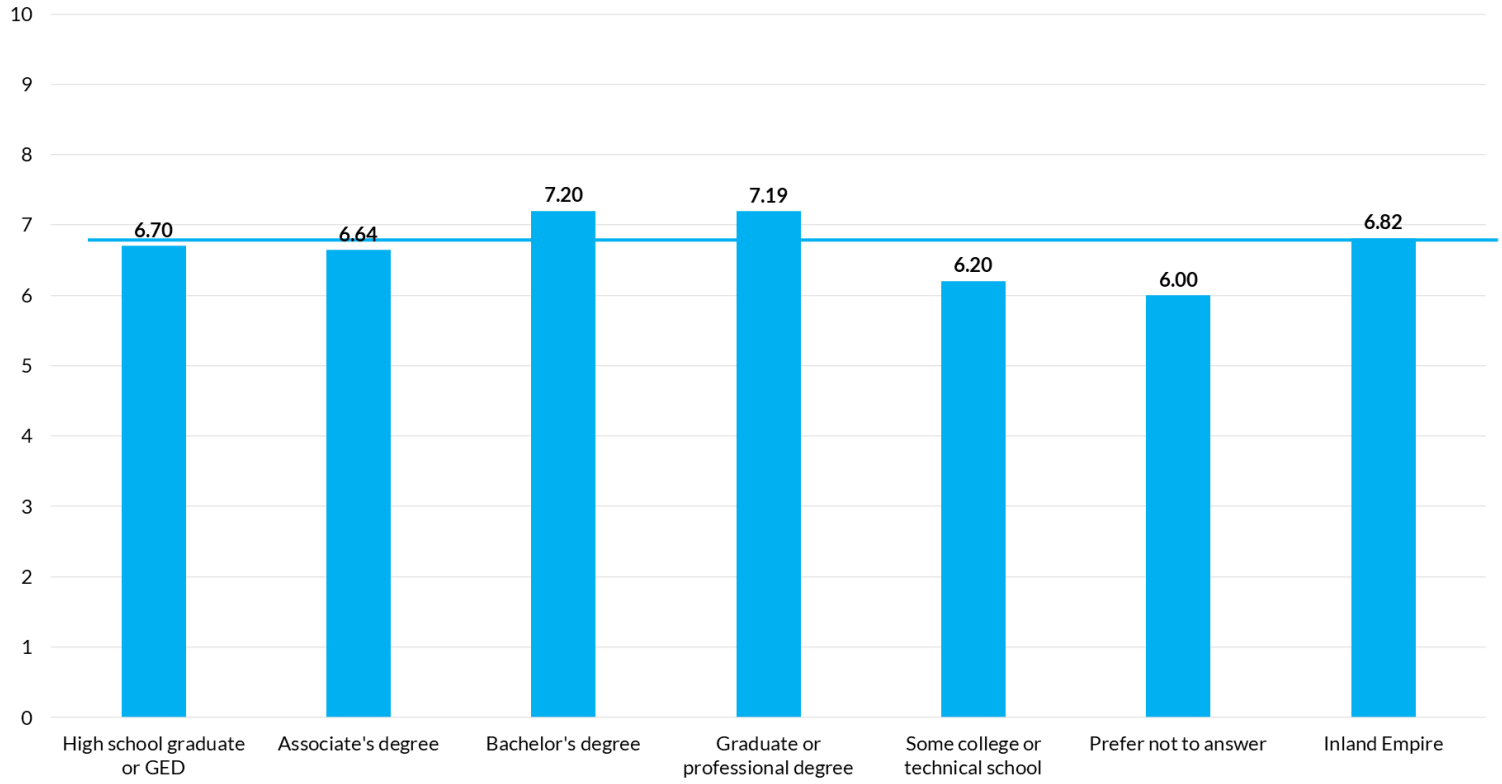
Feelings of Loneliness by Household Income



Key:

- ❑ 0 – Always
- ❑ 10 – Never

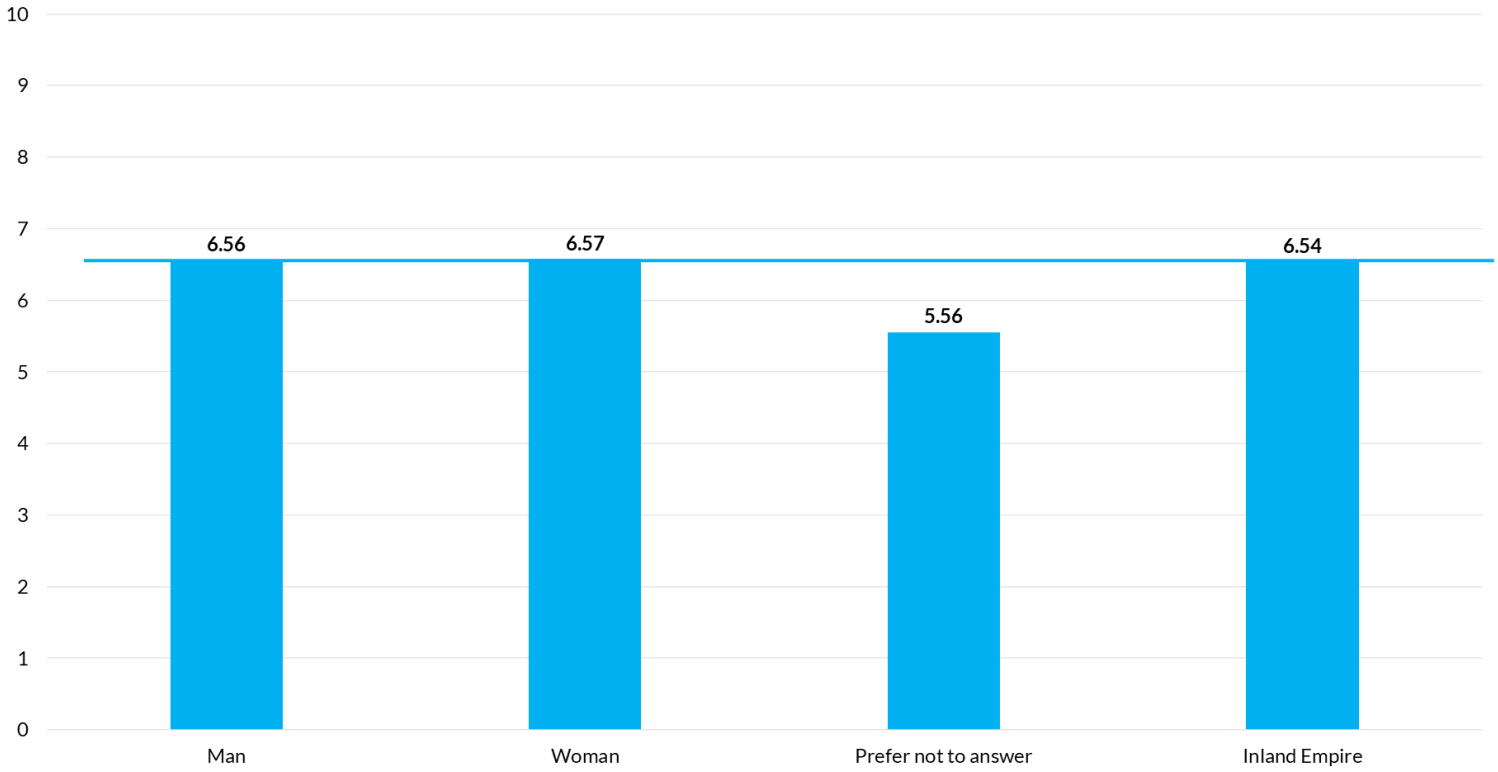
Feelings of Loneliness by Educational Attainment



Key:

- 0 – Always
- 10 – Never

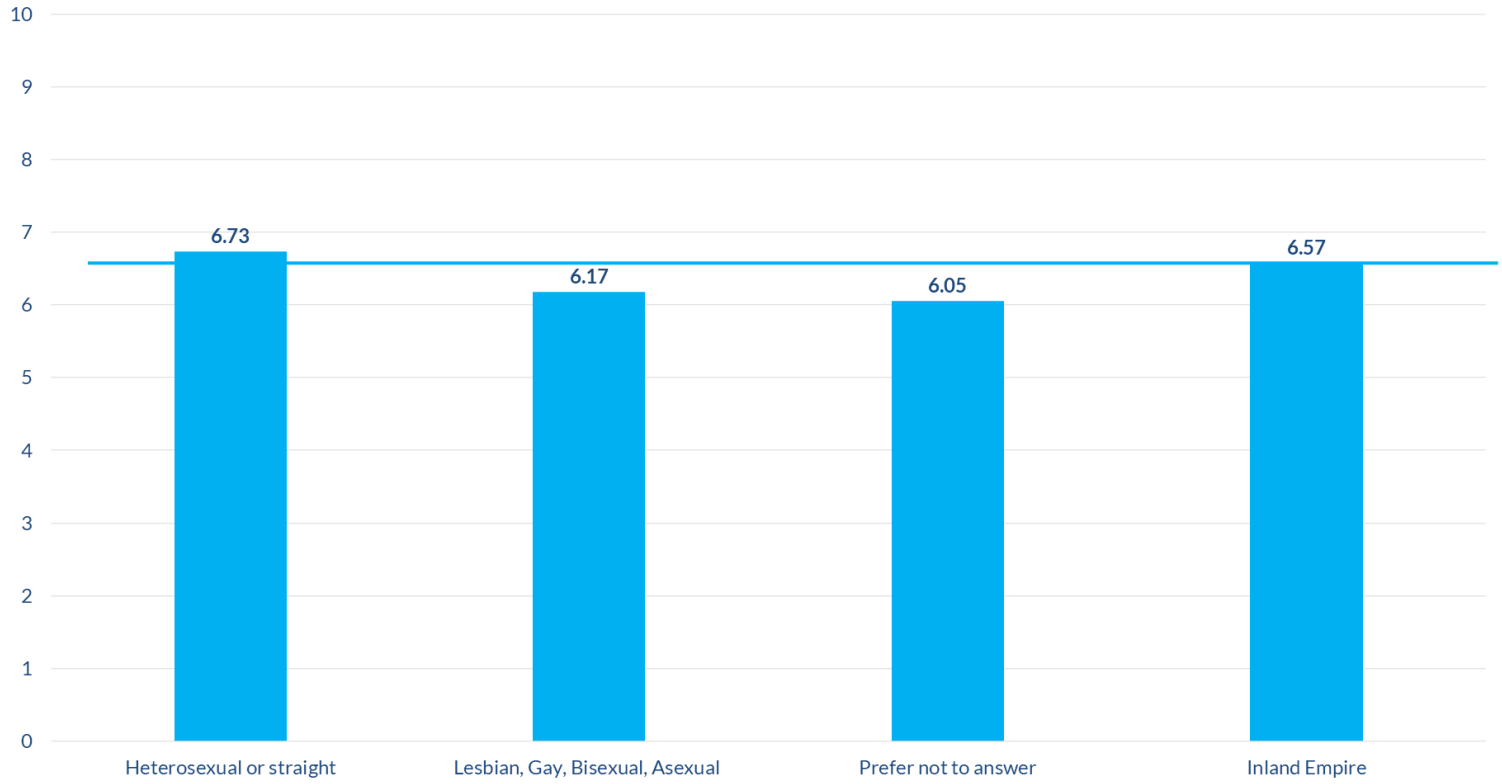
Feelings of Loneliness by Gender



Key:

- 0 – Always
- 10 – Never

Feelings of Loneliness by Sexual Orientation



Key:

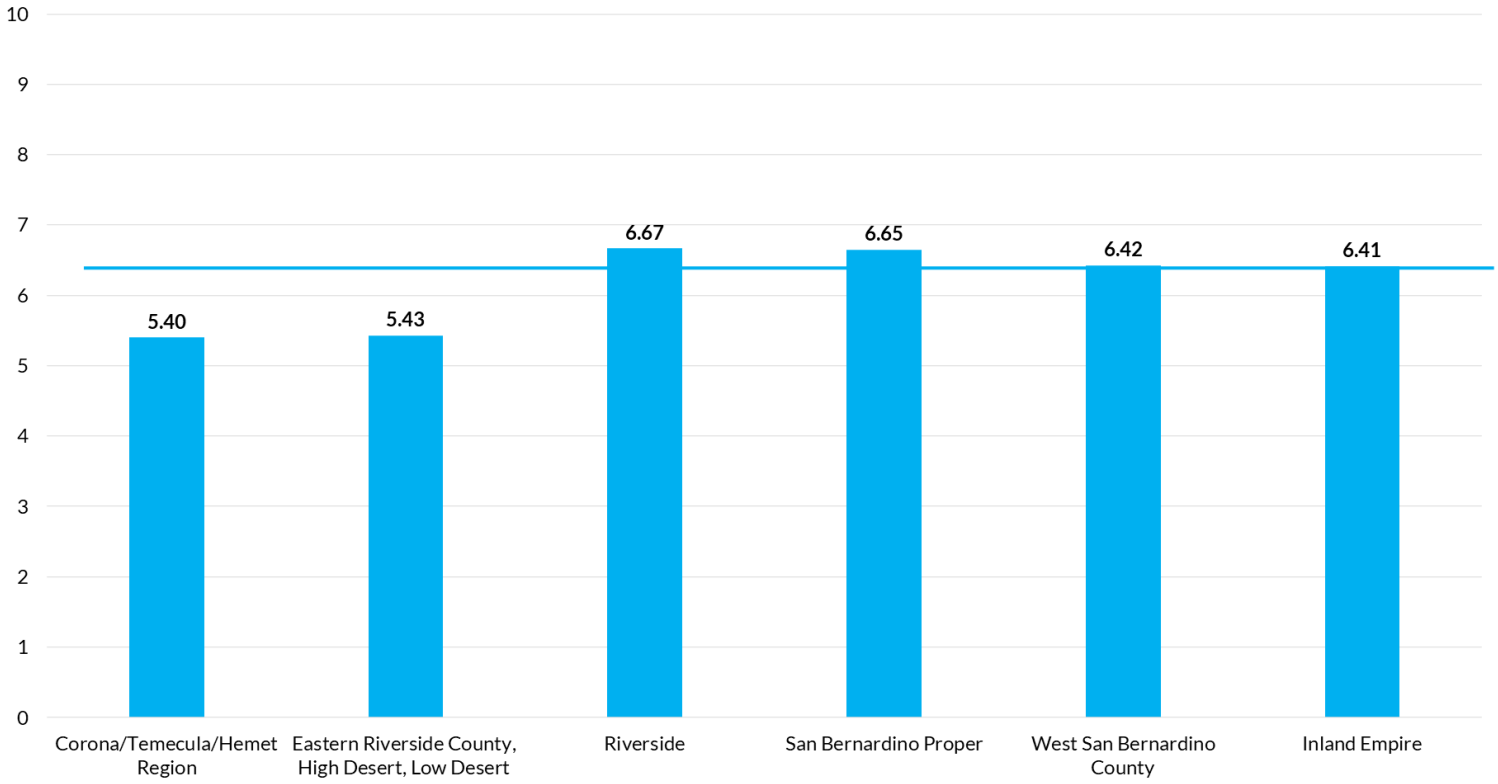
- 0 – Always
- 10 – Never

Sense of Belonging by Demographic Data

Question: How would you describe your sense of belonging to your local community?

- Region
- Age
- Race/ethnicity
- Household income
- Educational attainment
- Gender
- Sexual orientation

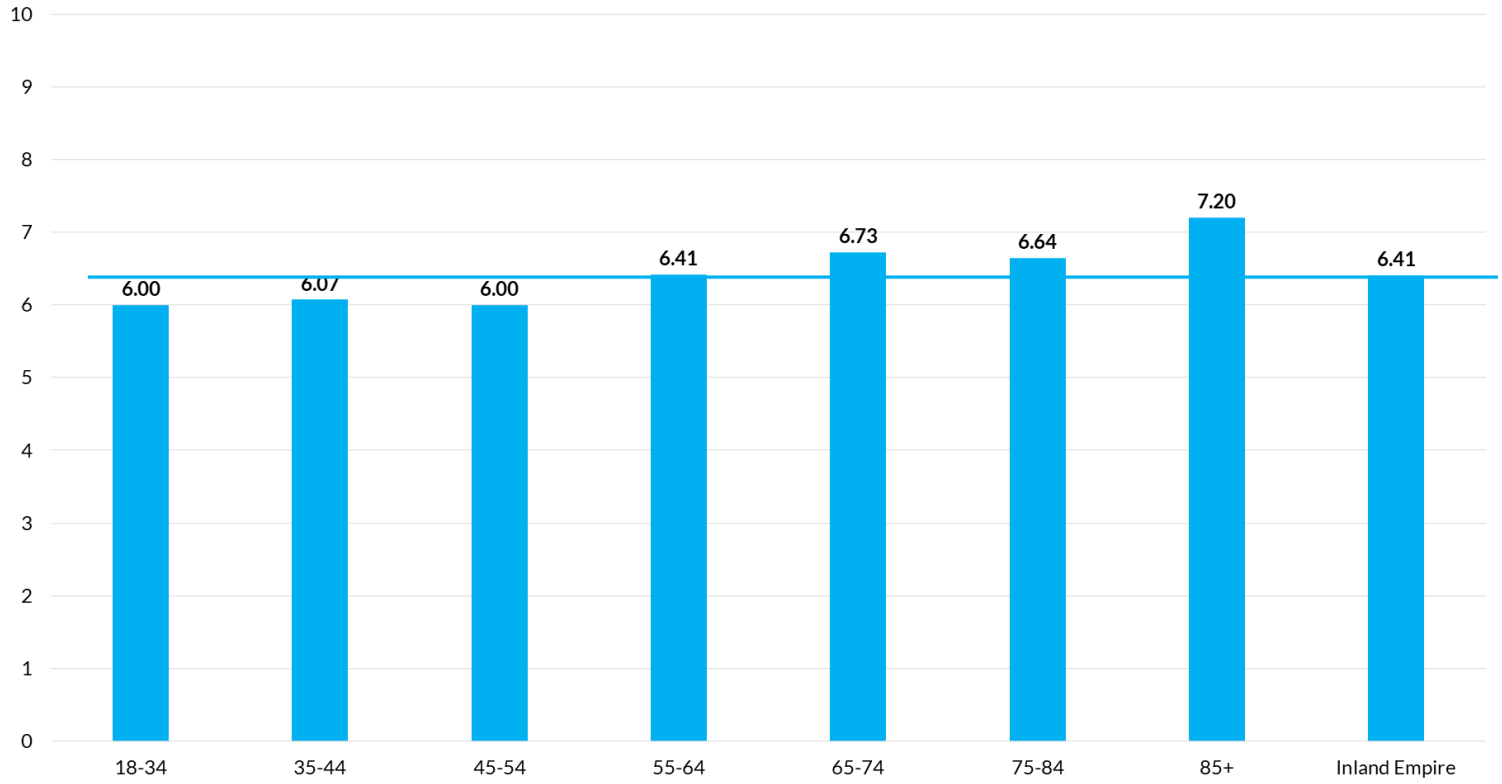
Sense of Belonging by Region



Key:

- 0 – Very Weak
- 10 – Very Strong

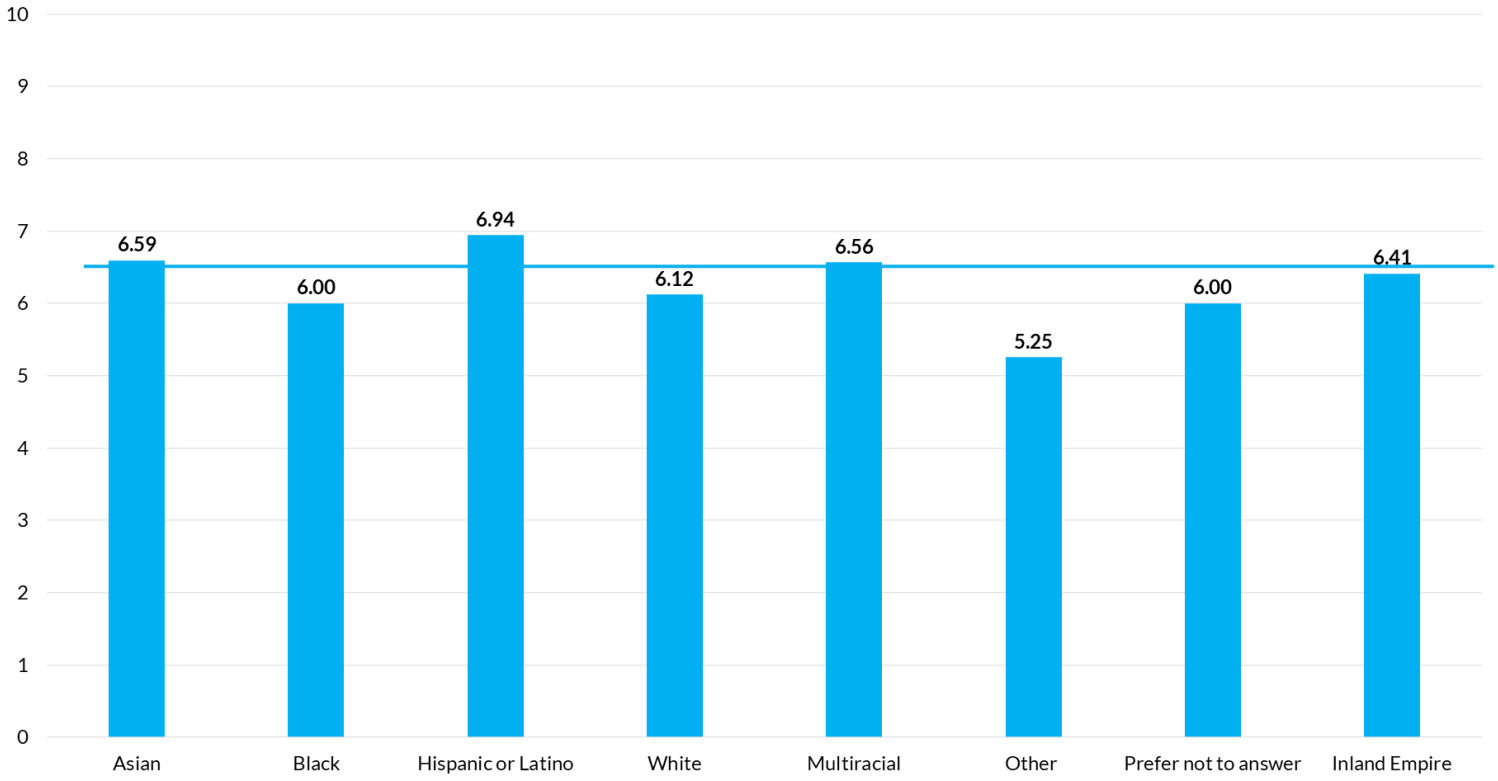
Sense of Belonging by Age



Key:

- 0 – Very Weak
- 10 – Very Strong

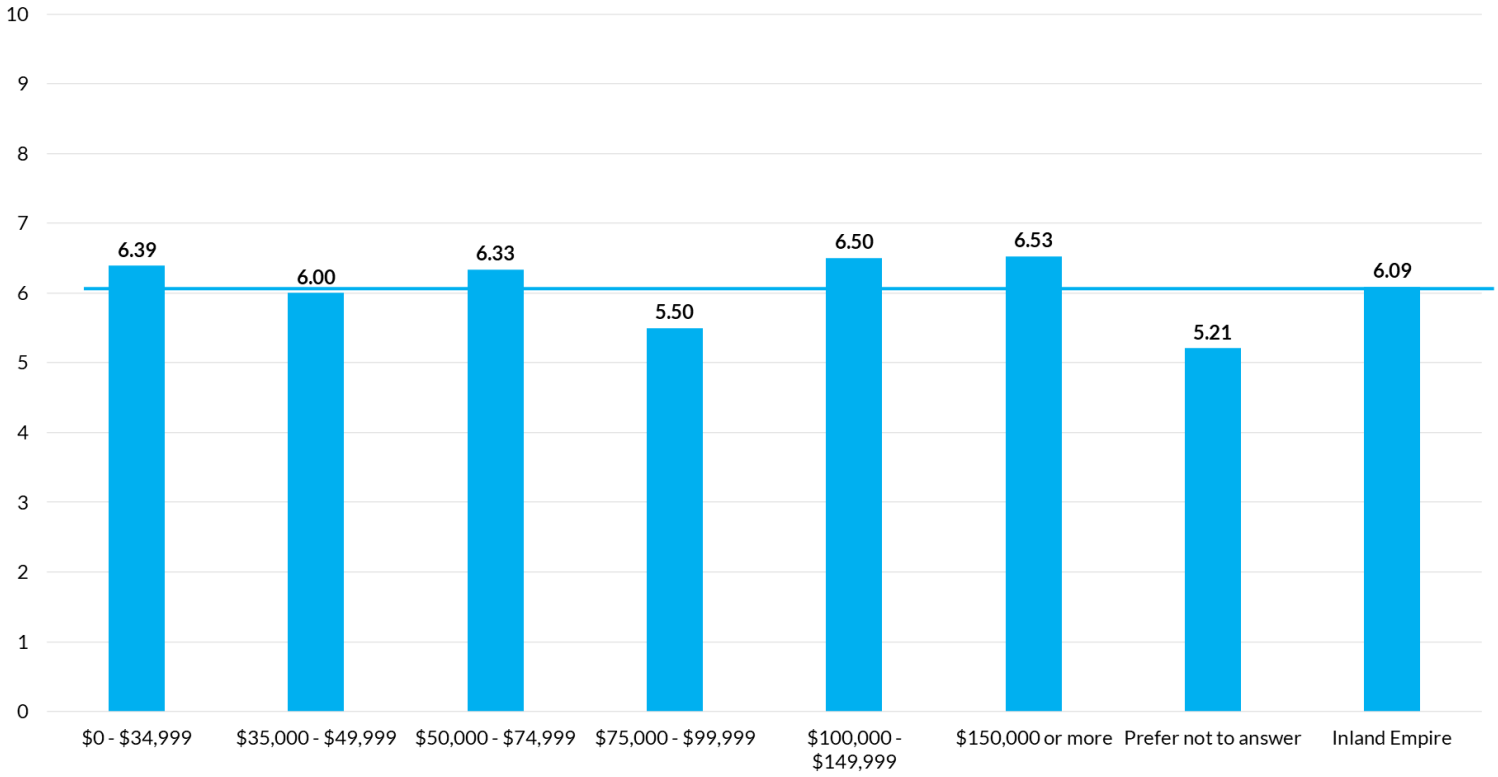
Sense of Belonging by Race/Ethnicity



Key:

- 0 – Very Weak
- 10 – Very Strong

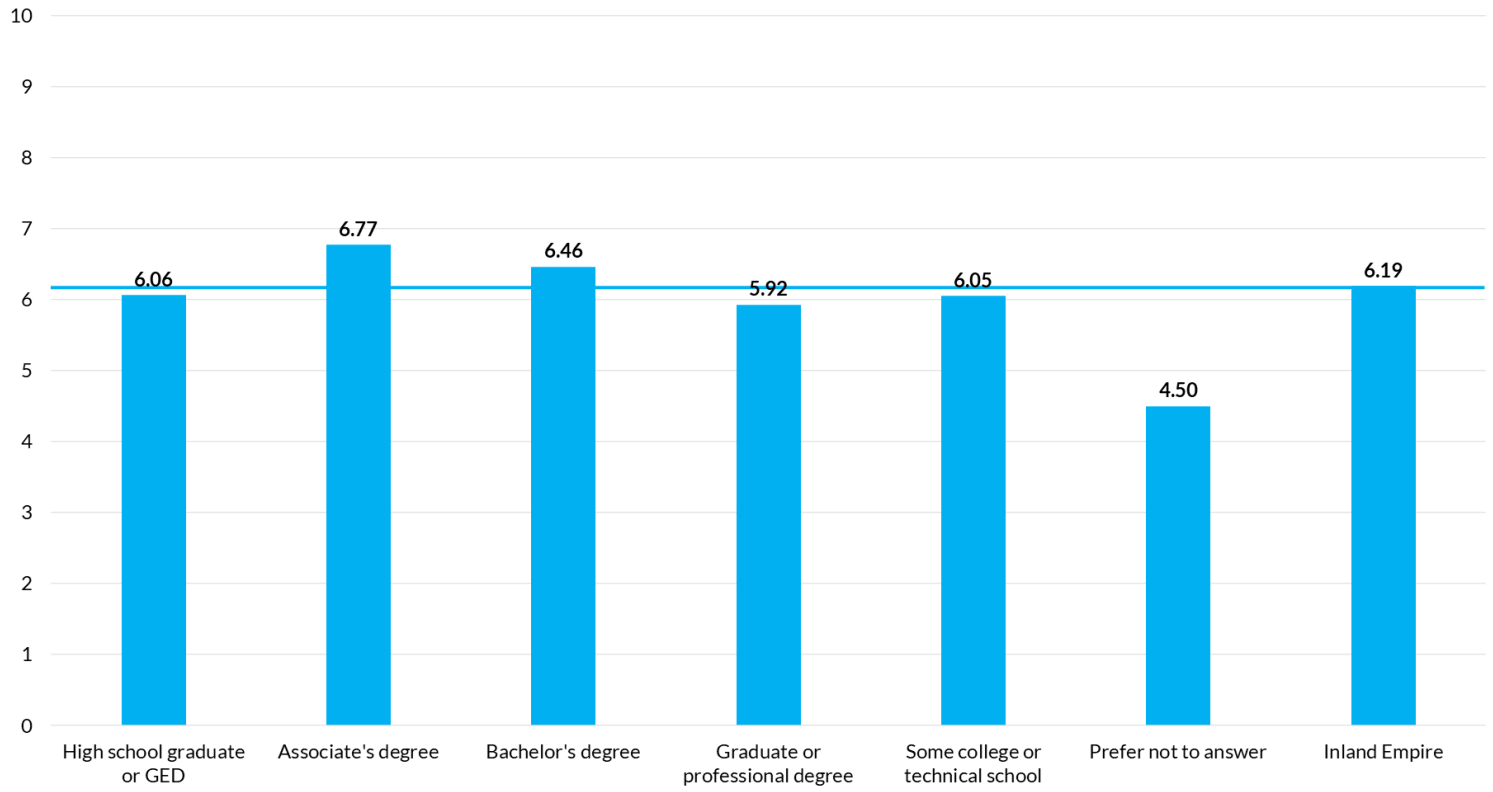
Sense of Belonging by Household Income



Key:

- 0 – Very Weak
- 10 – Very Strong

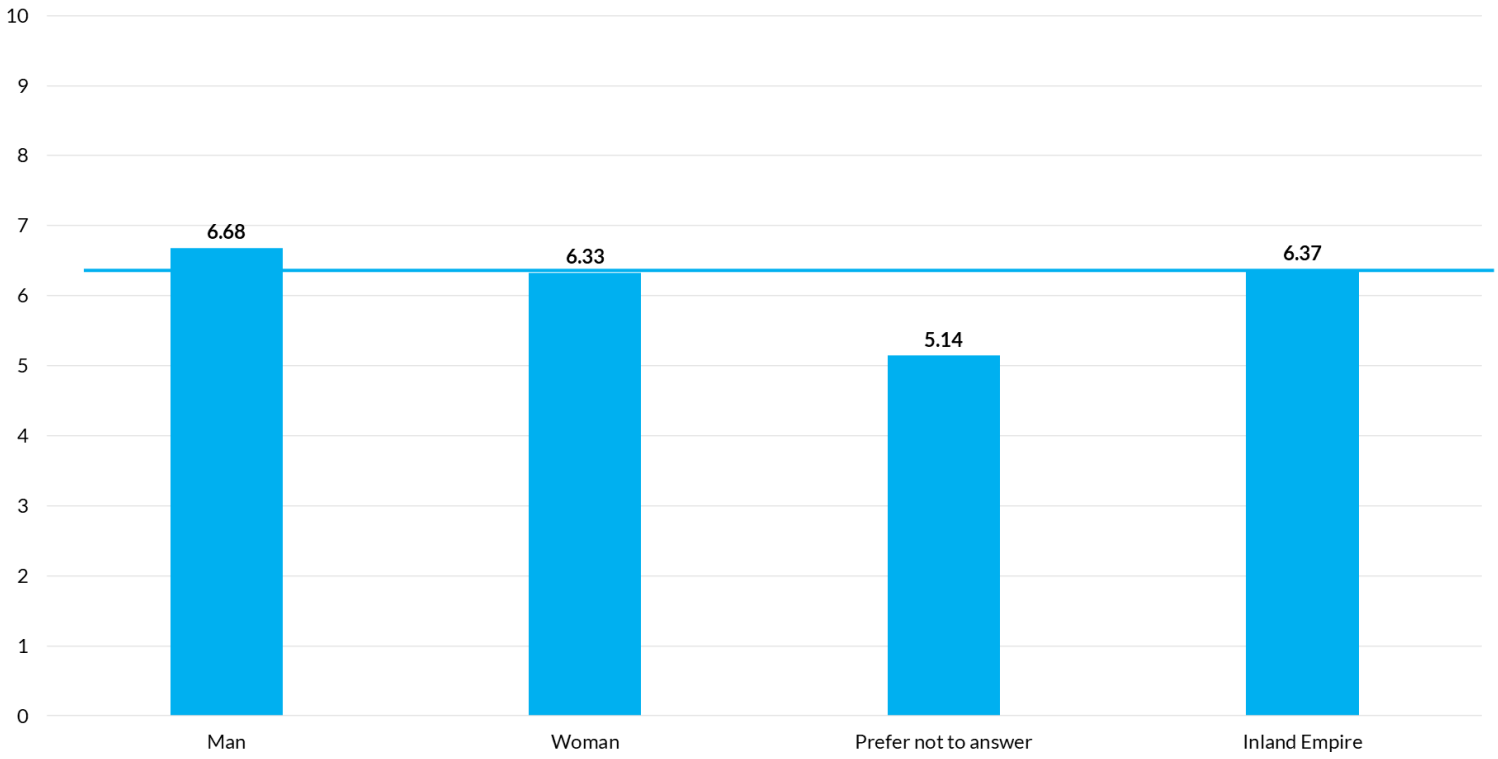
Sense of Belonging by Educational Attainment



Key:

- 0 – Very Weak
- 10 – Very Strong

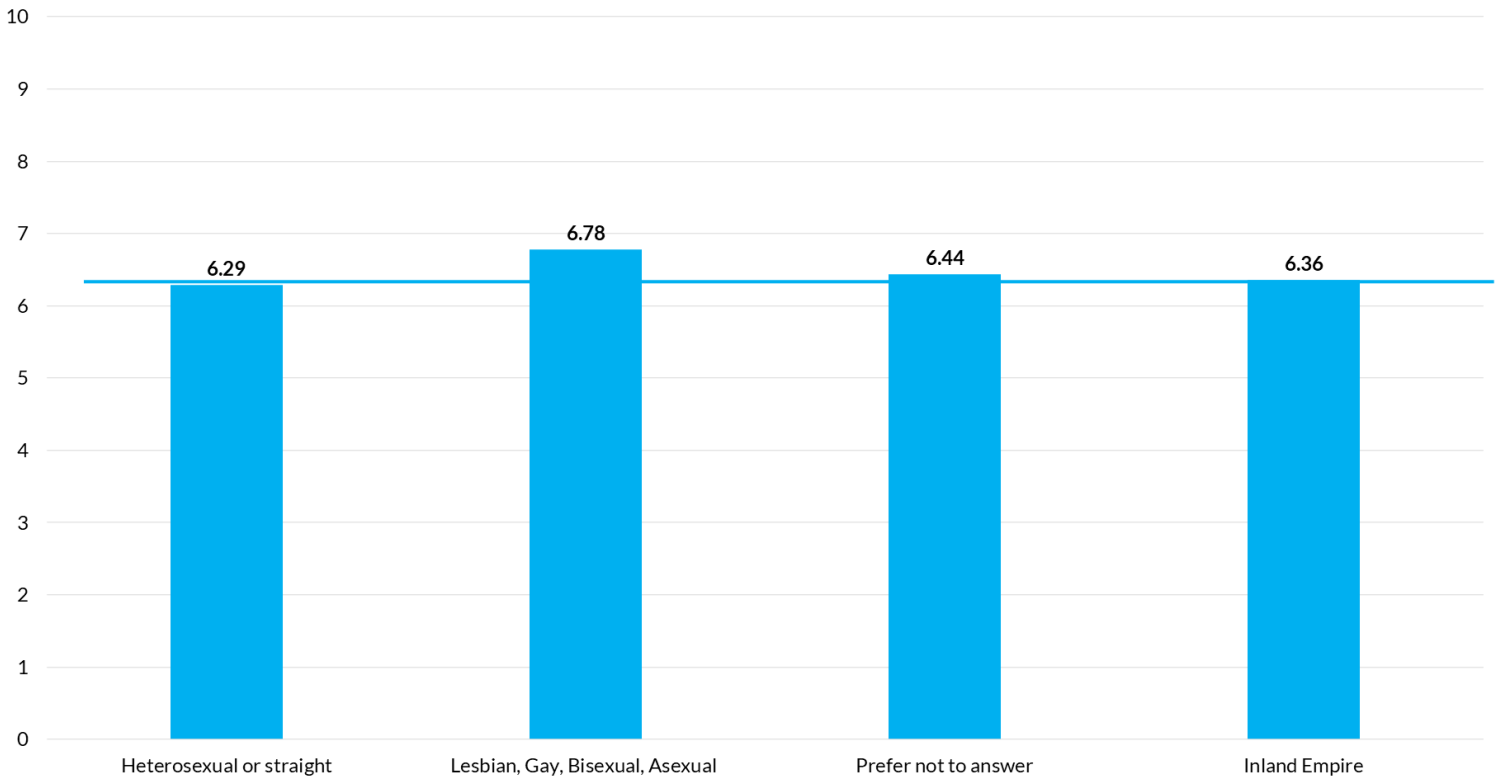
Sense of Belonging by Gender



Key:

- 0 – Very Weak
- 10 – Very Strong

Sense of Belonging by Sexual Orientation



Key:

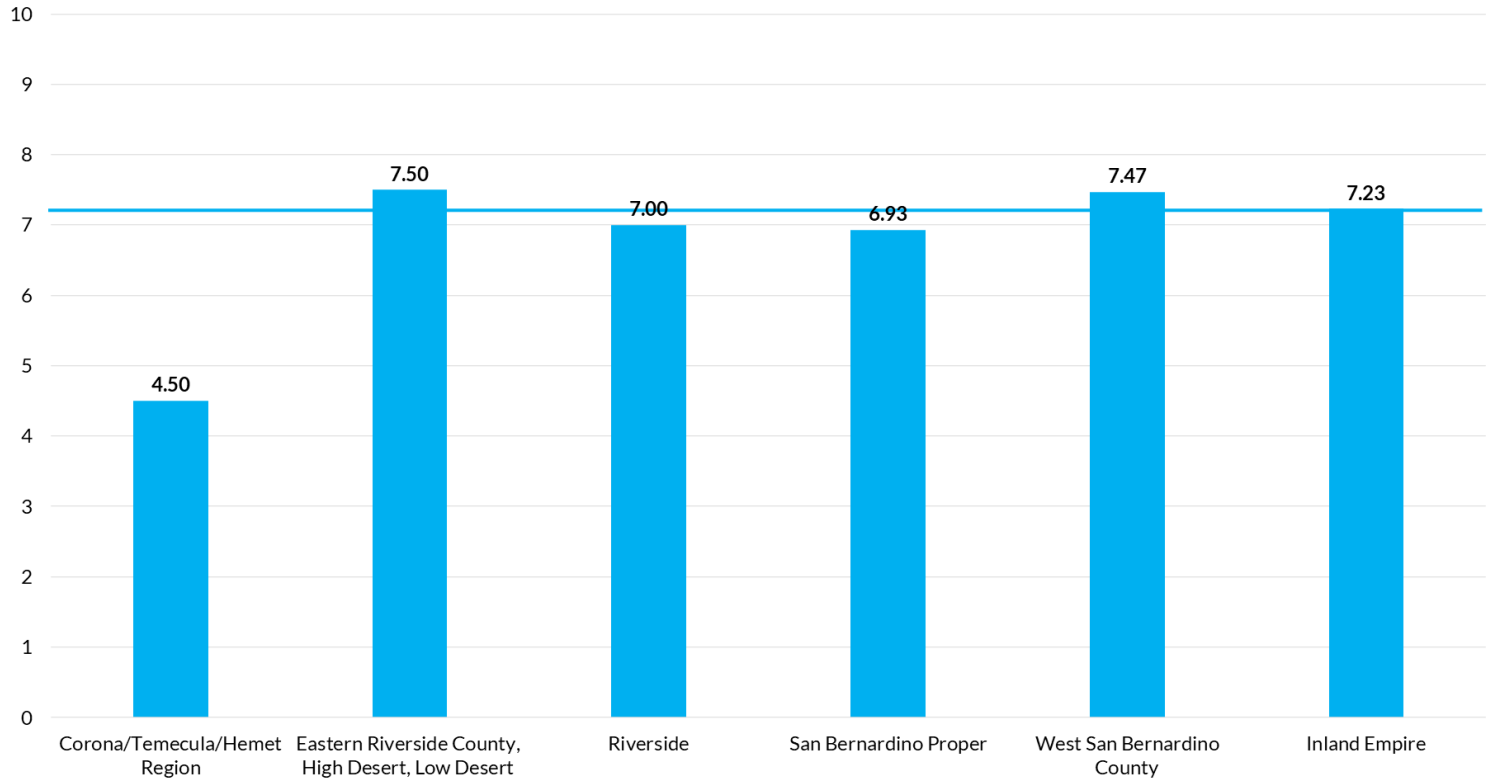
- 0 – Very Weak
- 10 – Very Strong

Someone to Help Me by Demographic Data

Question: If you were in trouble, do you have relatives or friends you could count on to help you whenever you needed them, or not?

- Region
- Age
- Race/ethnicity
- Household income
- Educational attainment
- Gender
- Sexual orientation

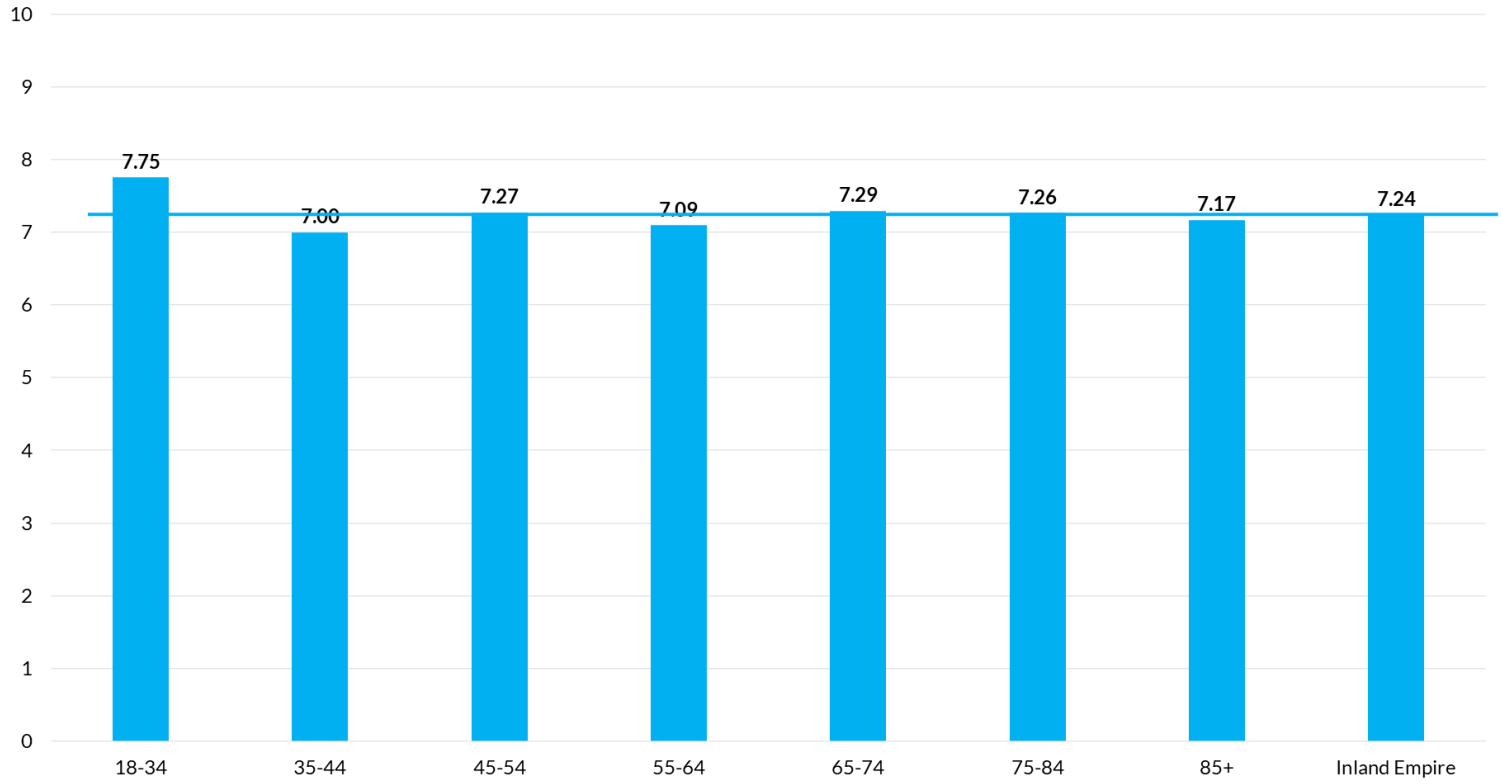
Someone to Help Me by Region



Key:

- ❑ 0 – Never
- ❑ 10 – Always

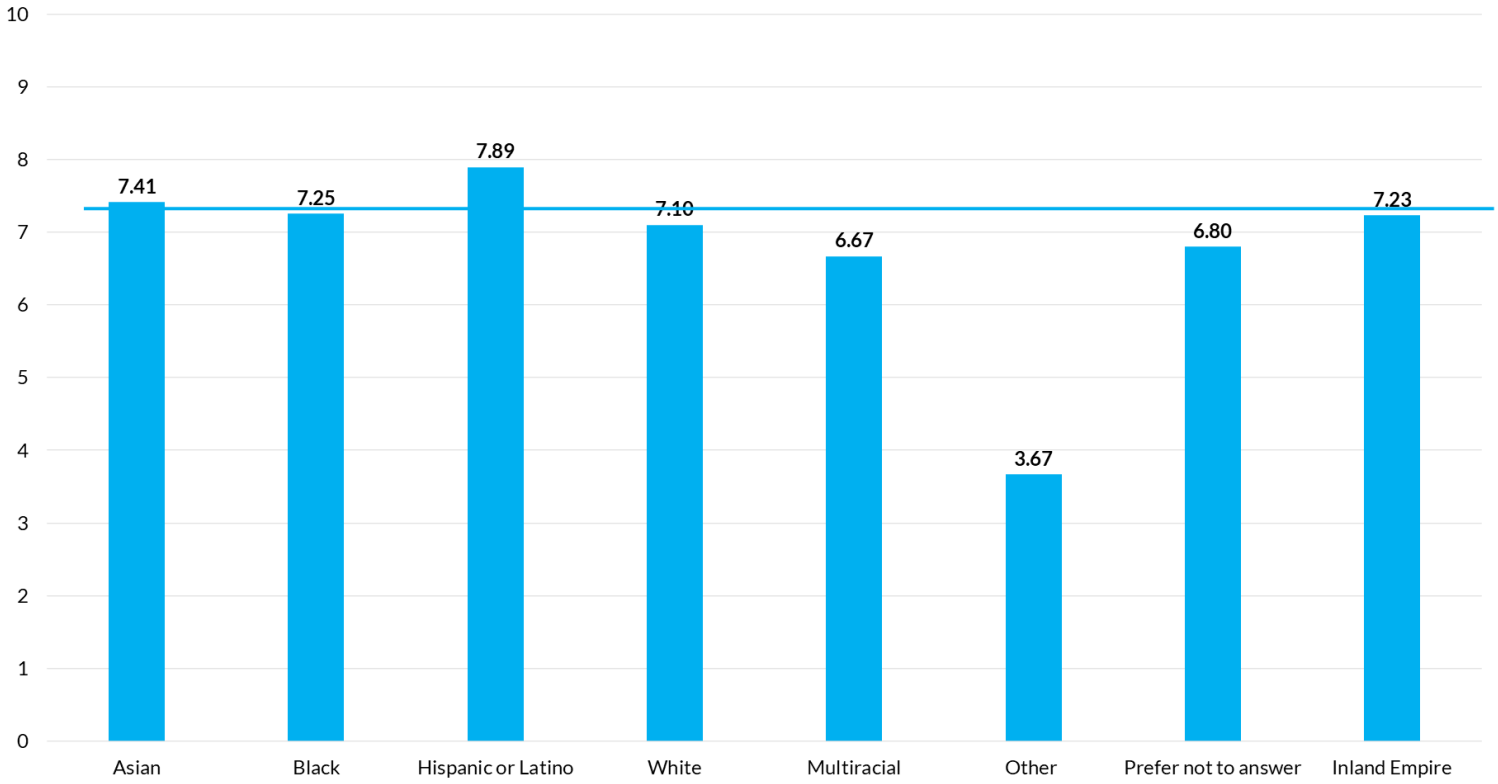
Someone to Help Me by Age



Key:

- ❑ 0 – Never
- ❑ 10 – Always

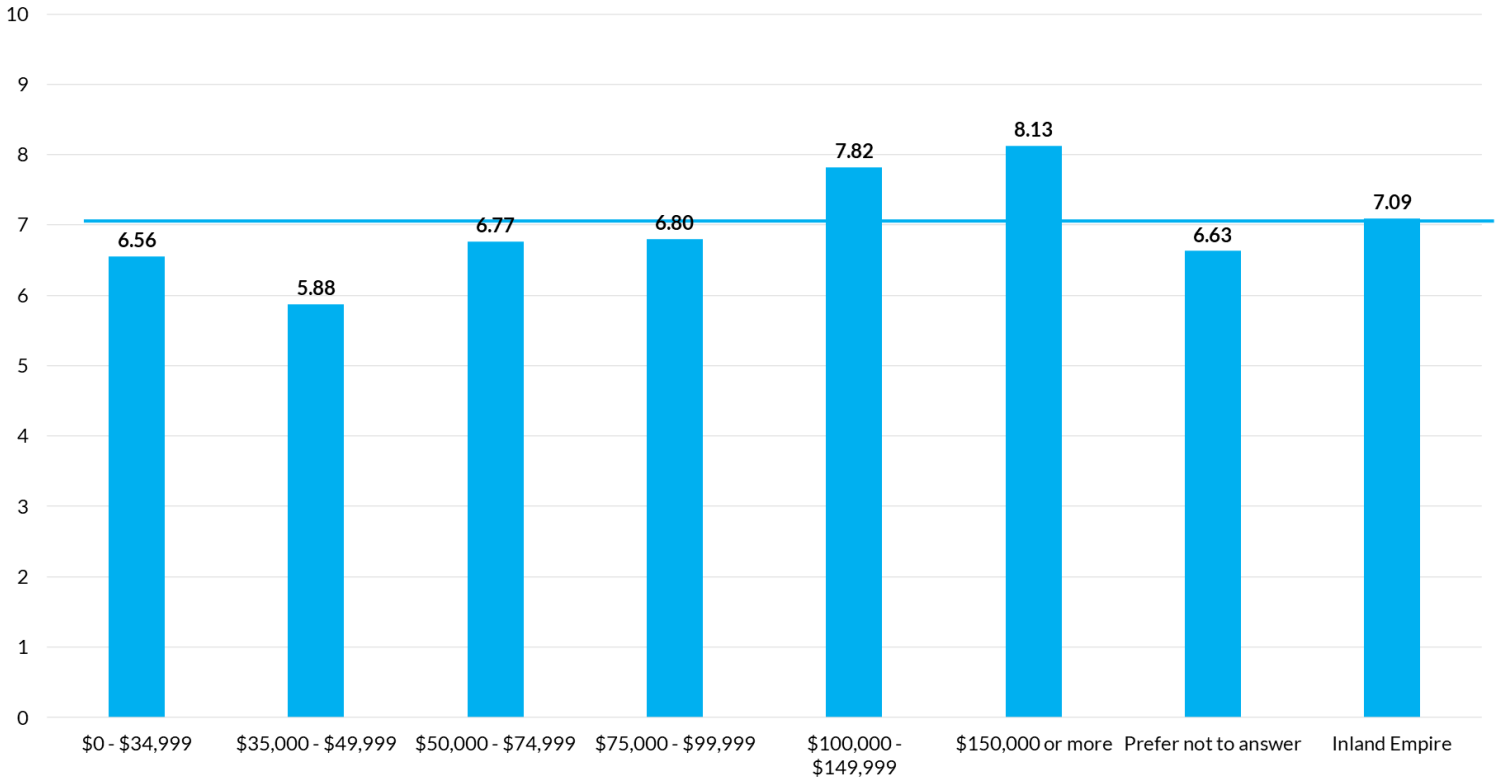
Someone to Help Me by Race/Ethnicity



Key:

- 0 – Never
- 10 – Always

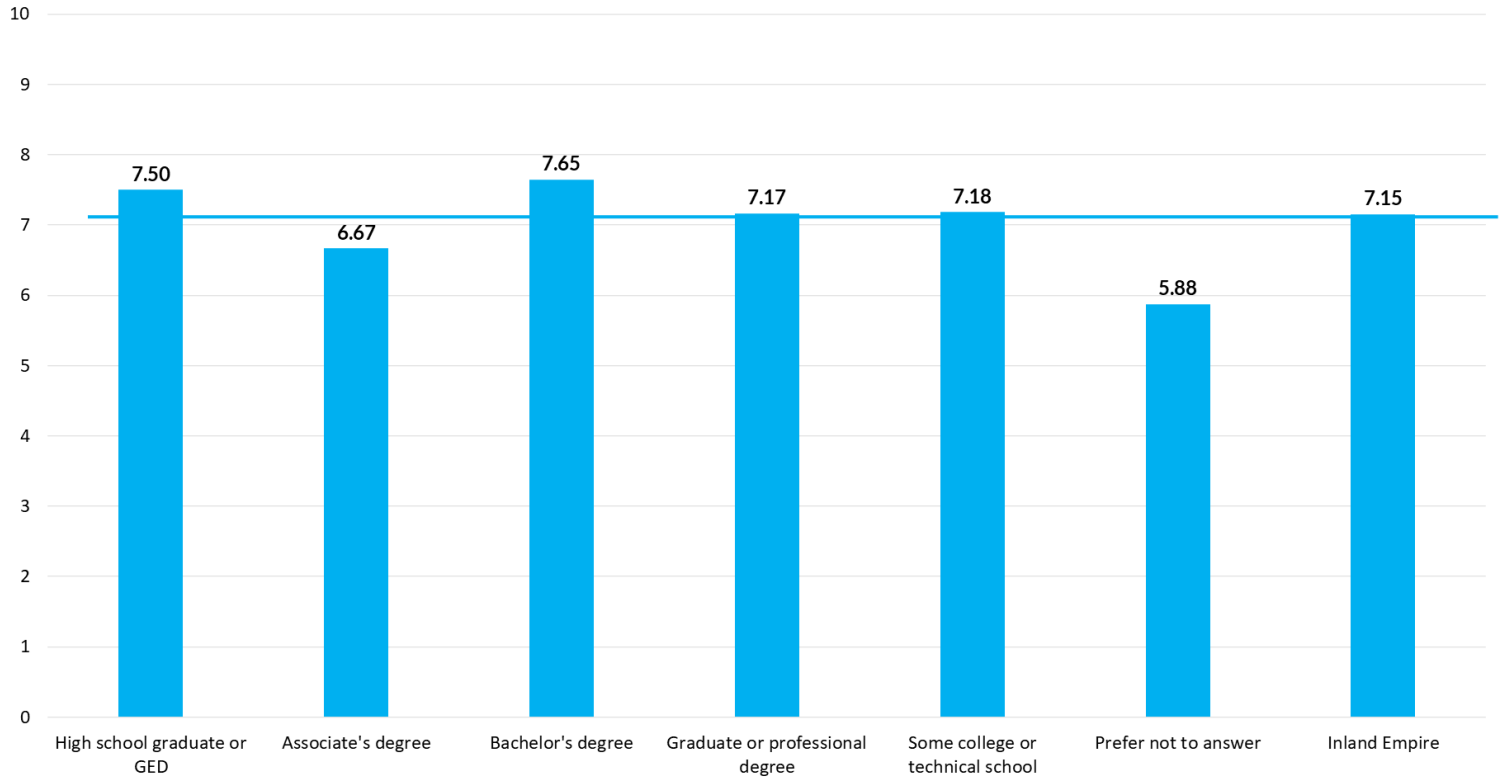
Someone to Help Me by Household Income



Key:

- ❑ 0 – Never
- ❑ 10 – Always

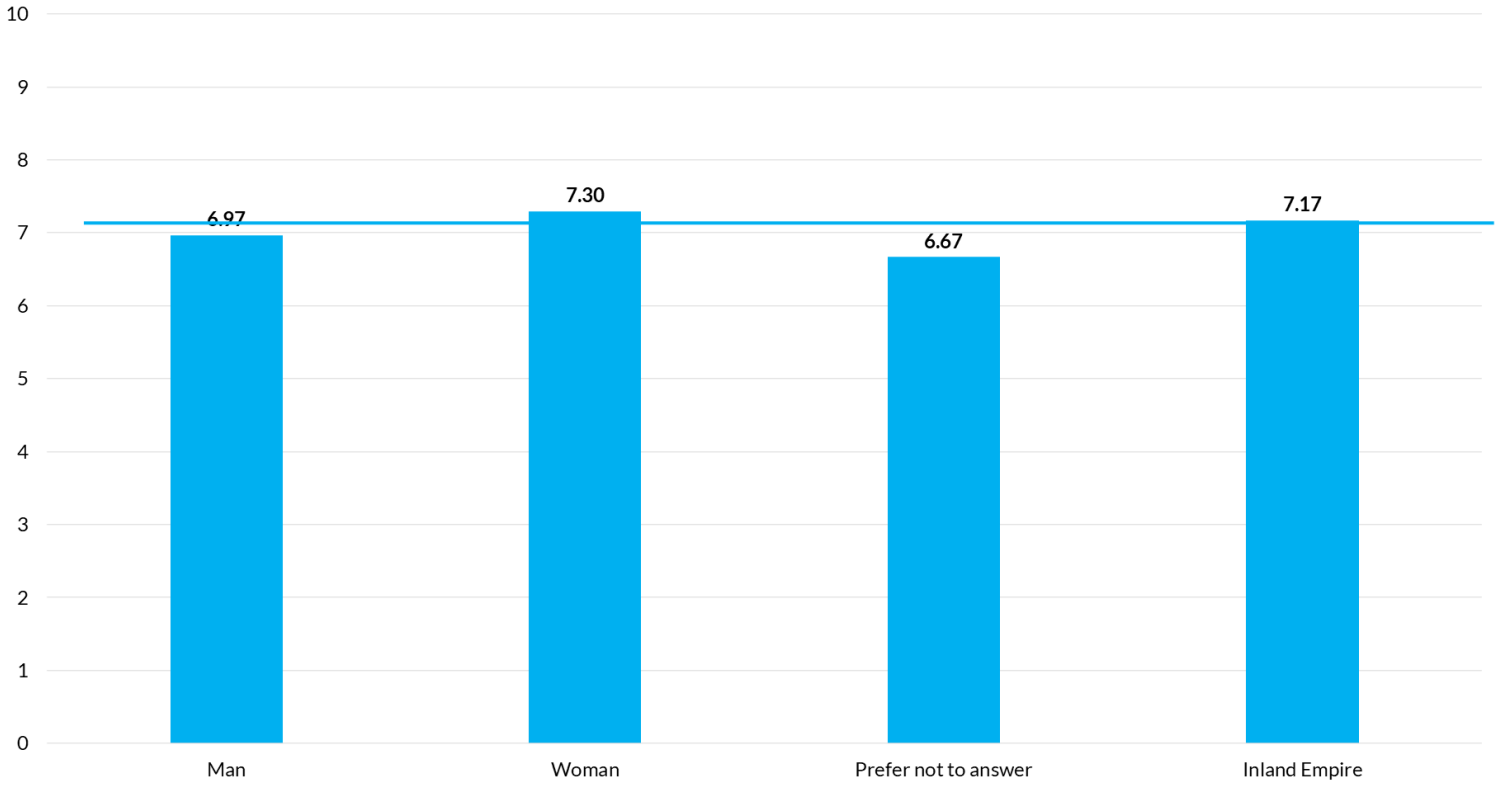
Someone to Help Me by Educational Attainment



Key:

- 0 – Never
- 10 – Always

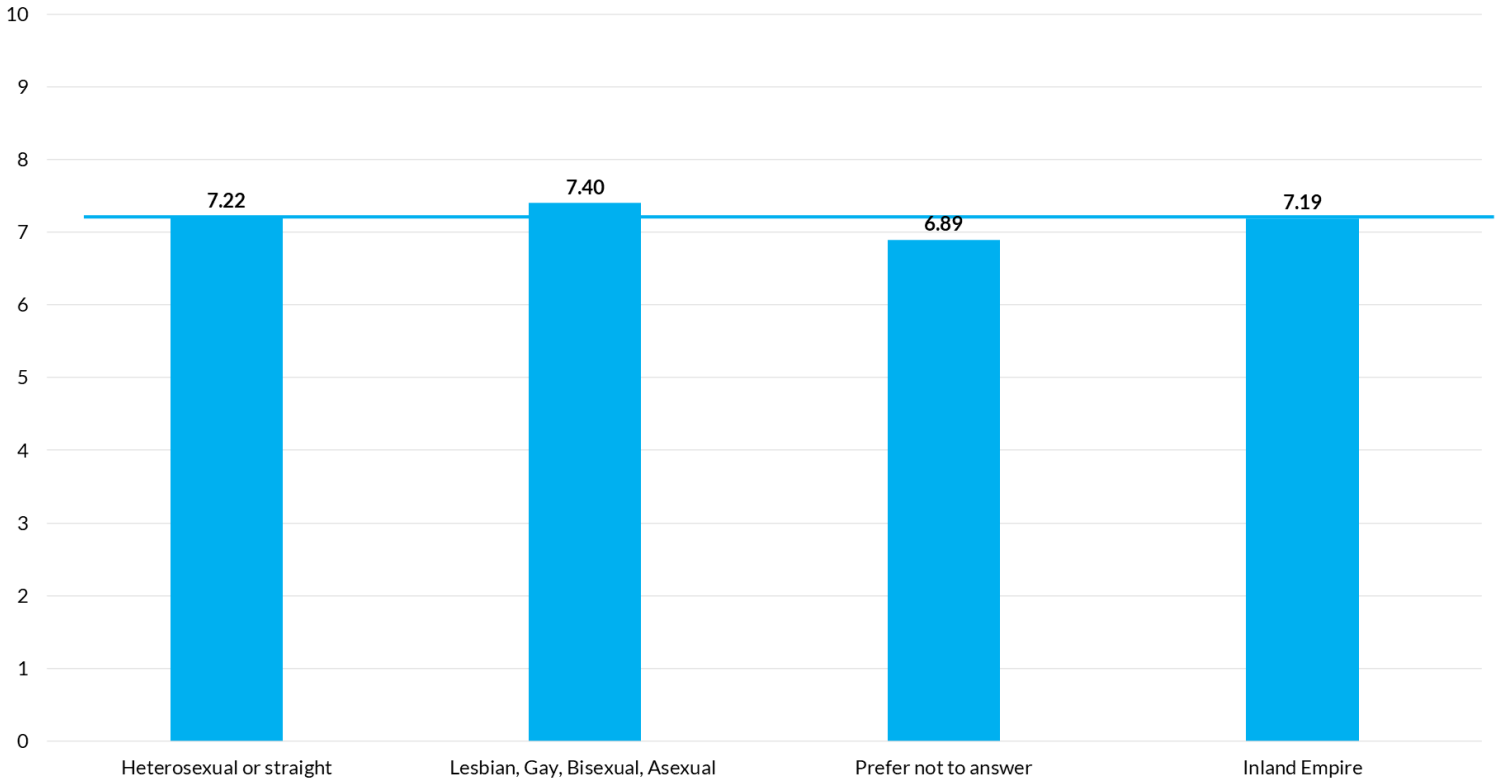
Someone to Help Me by Gender



Key:

- 0 – Never
- 10 – Always

Someone to Help Me by Sexual Orientation



Key:

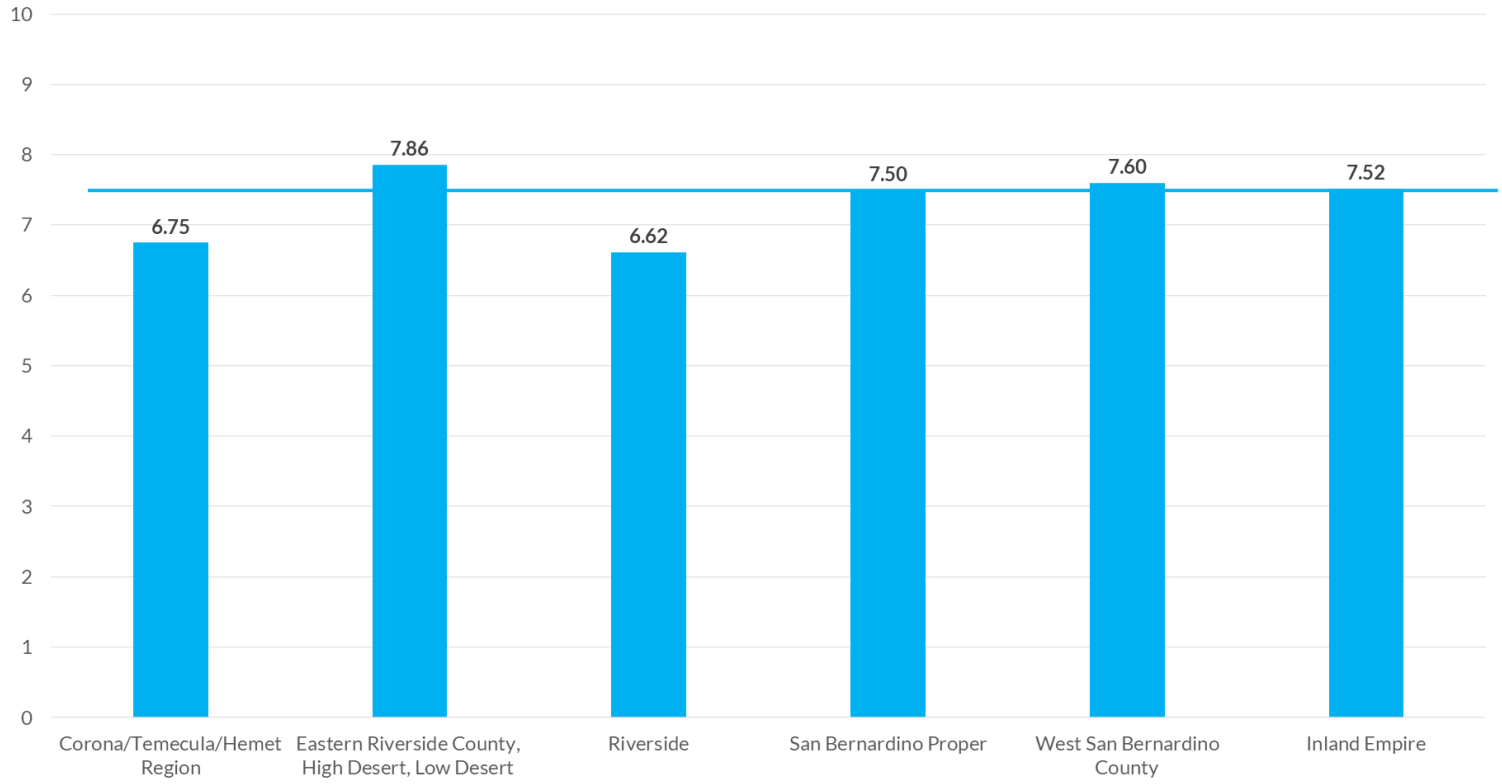
- 0 – Never
- 10 – Always

Positive Emotions by Demographic Data

Question: During the past two weeks, how often have you experienced positive emotions such as joy, affection, or hope?

- Region
- Age
- Race/ethnicity
- Household income
- Educational attainment
- Gender
- Sexual orientation

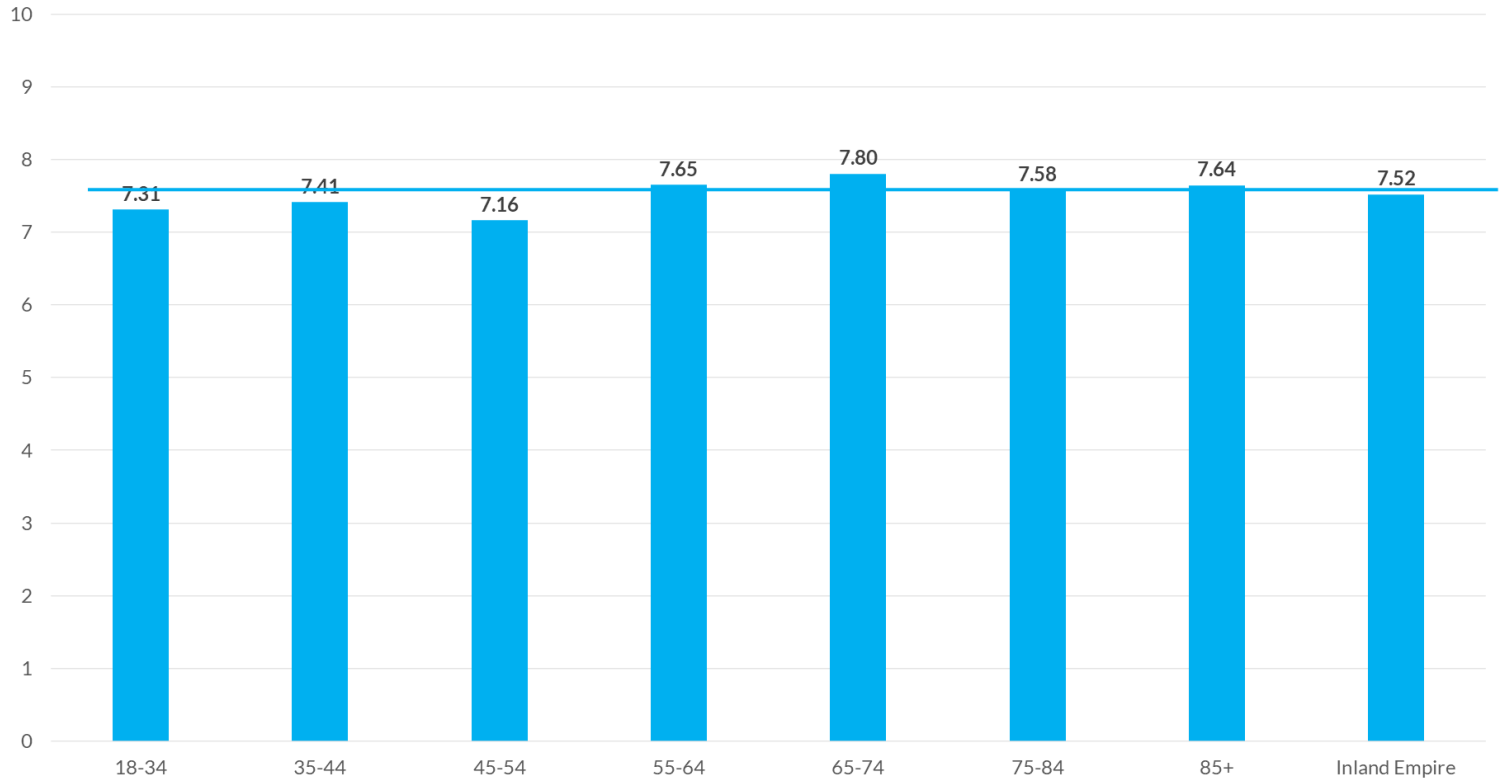
Positive Emotions by Region



Key:

- ❑ 0 – Never
- ❑ 10 – Always

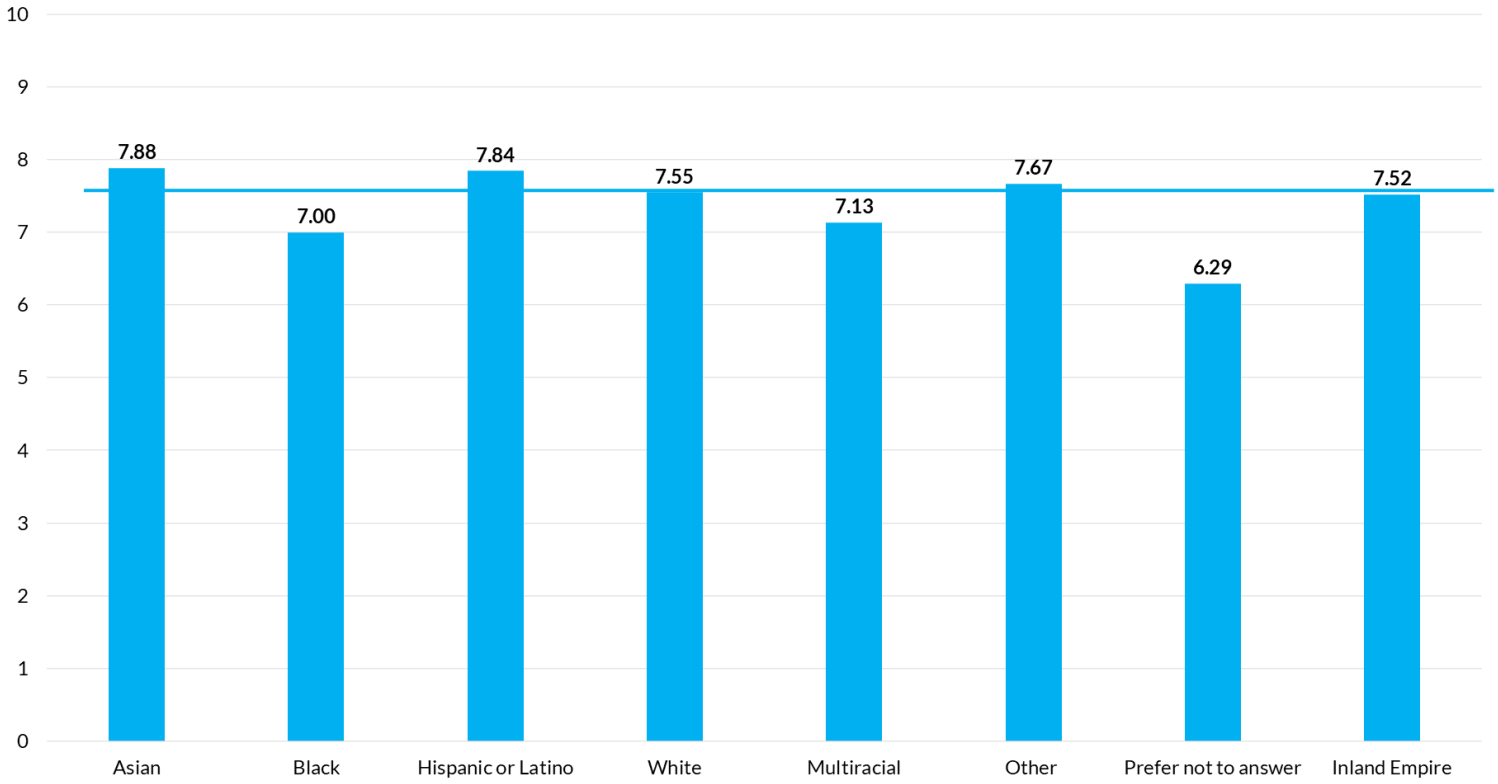
Positive Emotions by Age



Key:

- ❑ 0 – Never
- ❑ 10 – Always

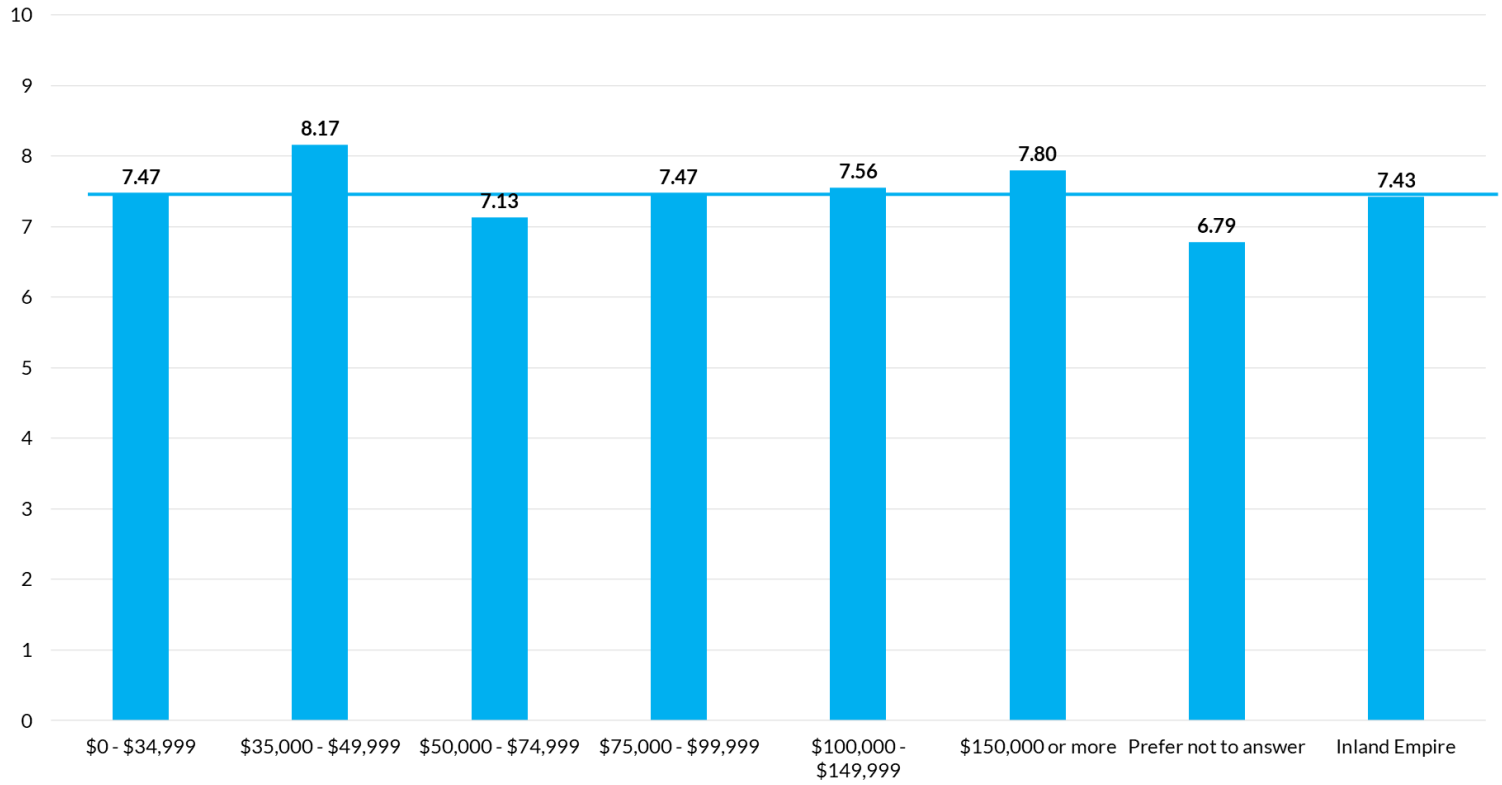
Positive Emotions by Race/Ethnicity



Key:

- 0 – Never
- 10 – Always

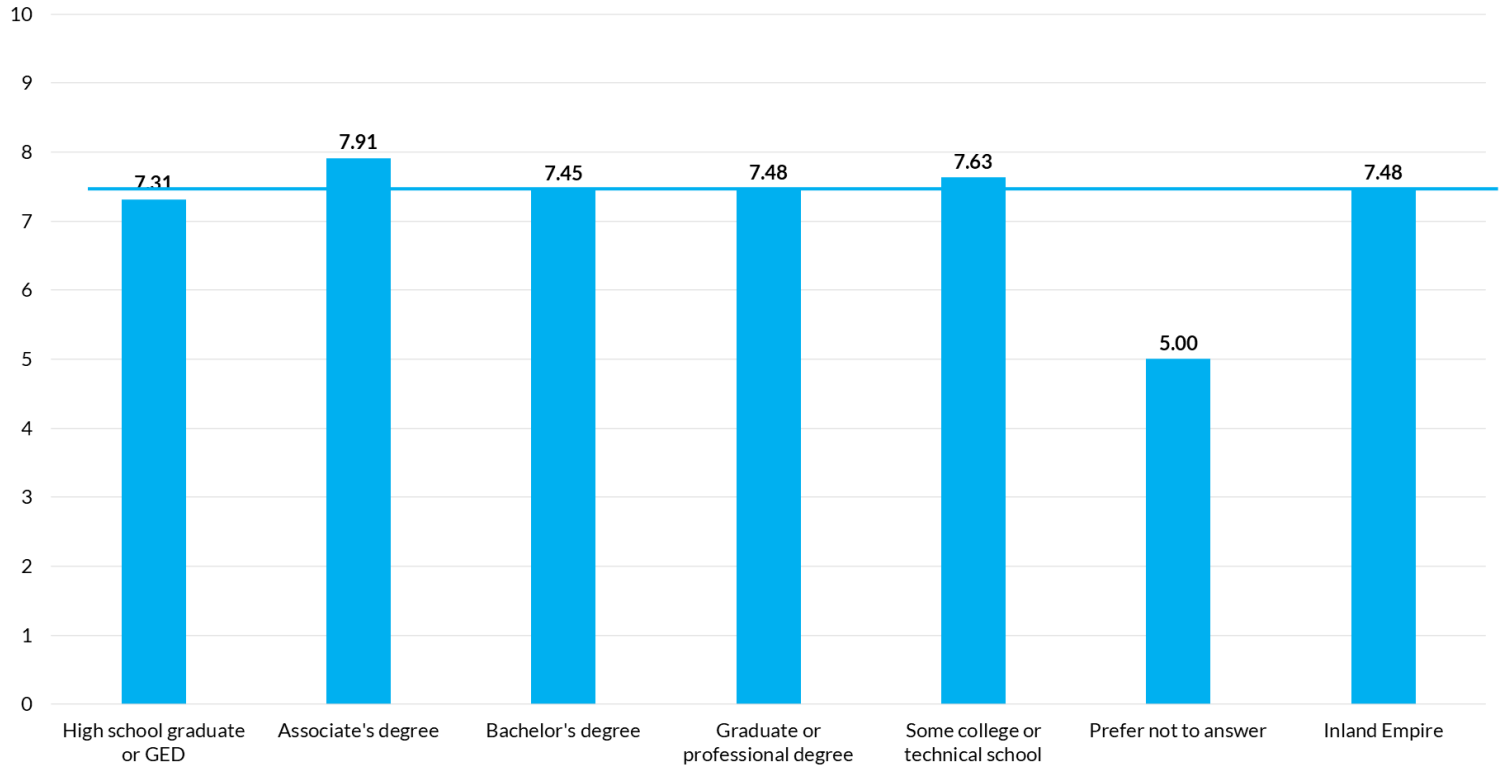
Positive Emotions by Household Income



Key:

- 0 – Never
- 10 – Always

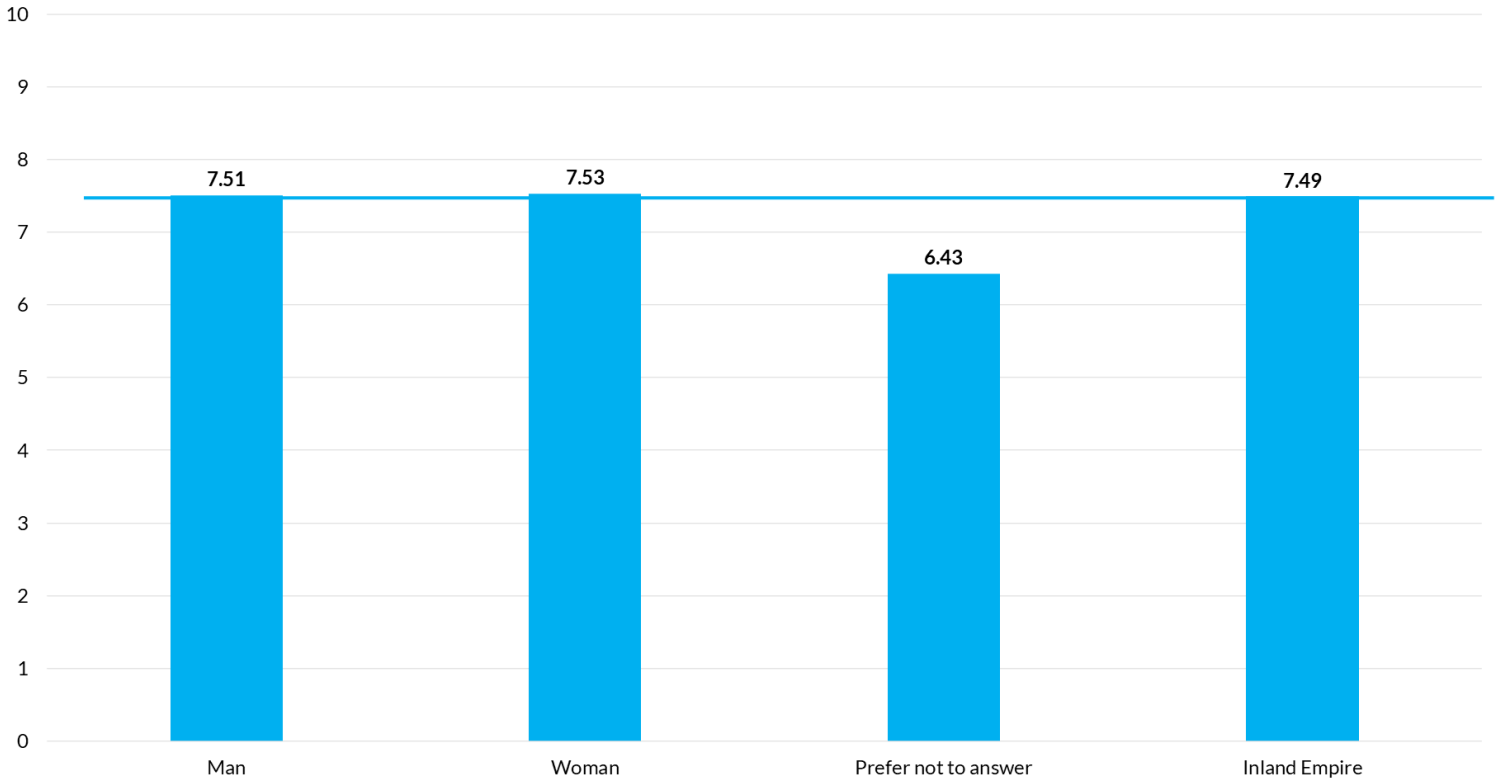
Positive Emotions by Educational Attainment



Key:

- 0 – Never
- 10 – Always

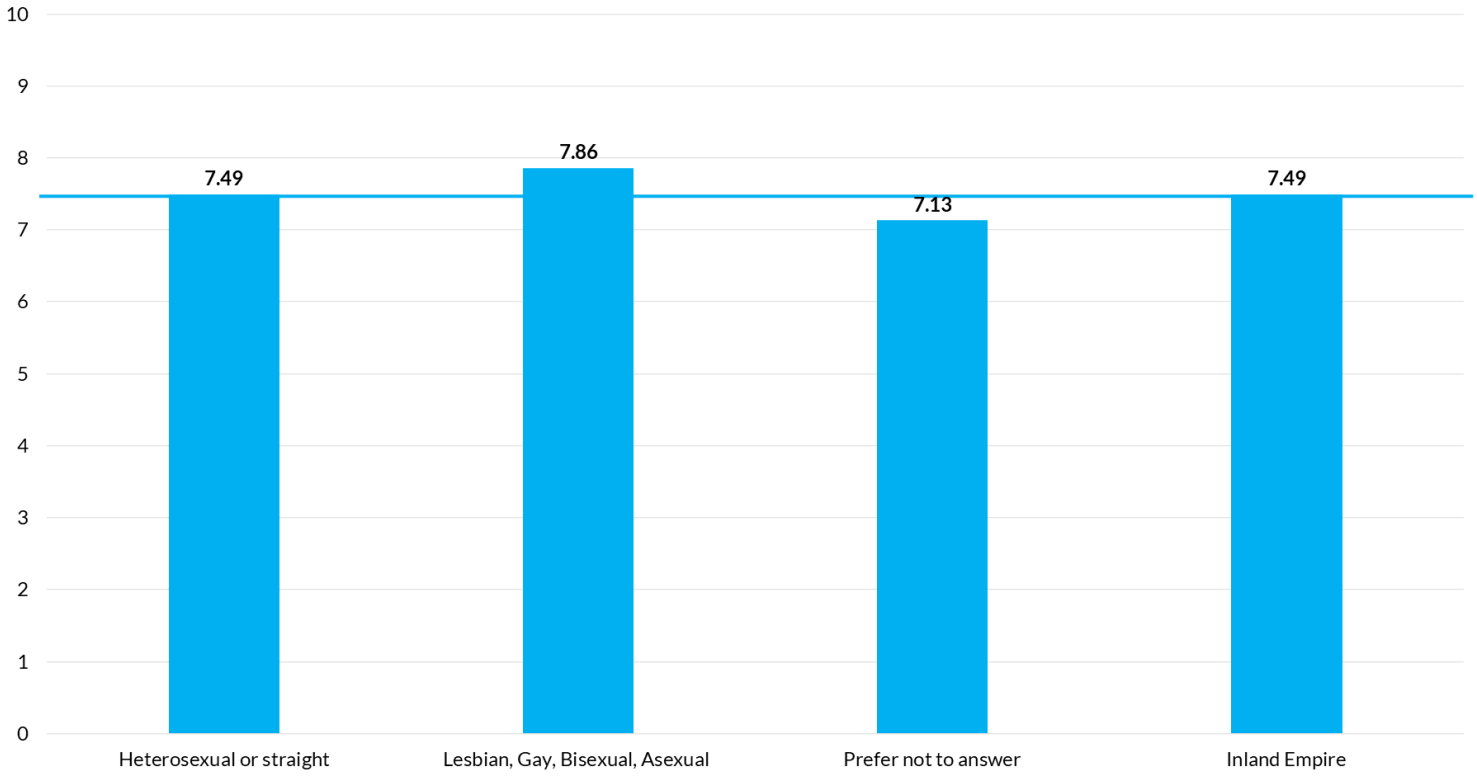
Positive Emotions by Gender



Key:

- 0 – Never
- 10 – Always

Positive Emotions by Sexual Orientation



Key:

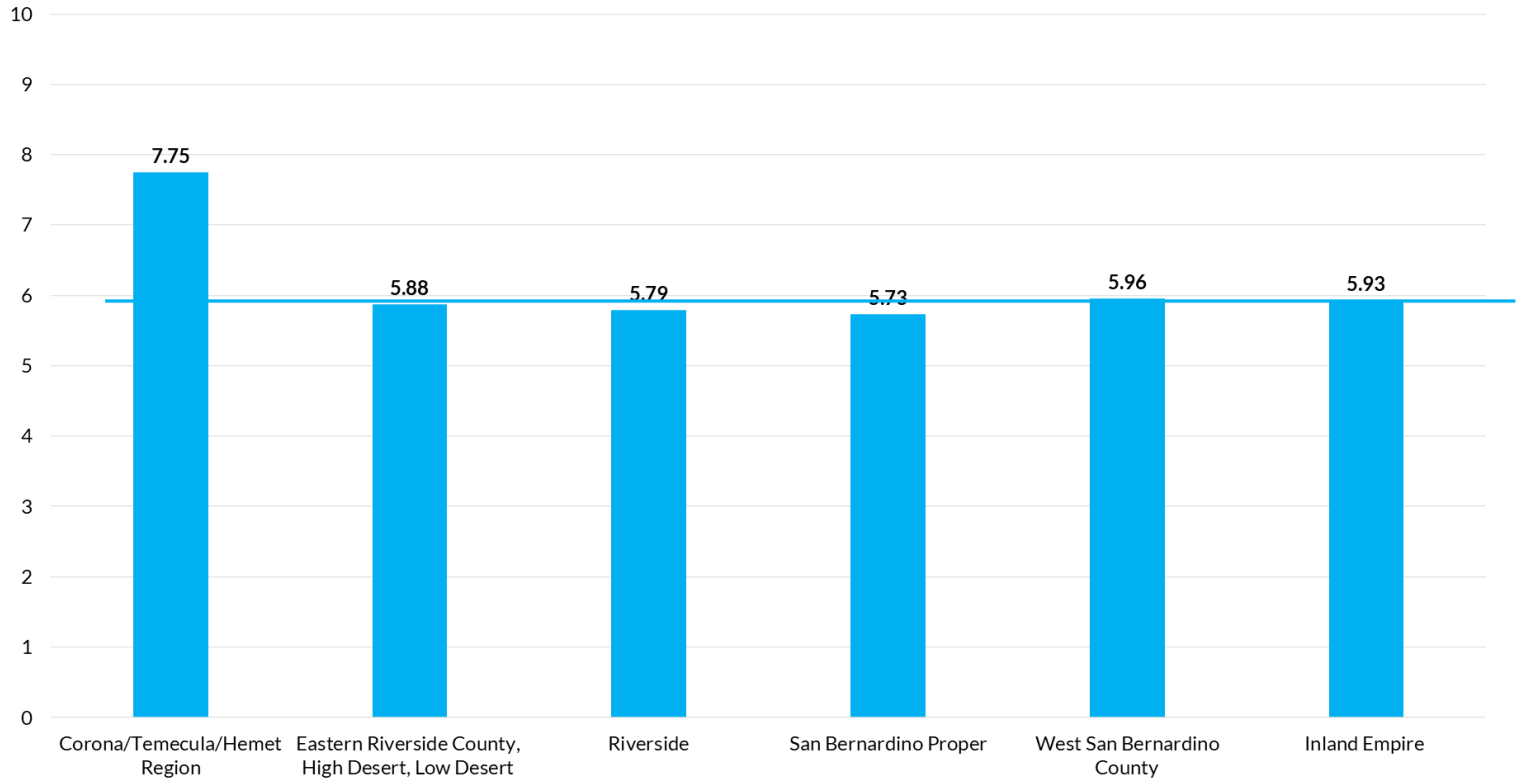
- ❑ 0 – Never
- ❑ 10 – Always

Negative Emotions by Demographic Data

Question: During the past two weeks, how often have you experienced negative emotions such as sadness, worry, or despair?

- Region
- Age
- Race/ethnicity
- Household income
- Educational attainment
- Gender
- Sexual orientation

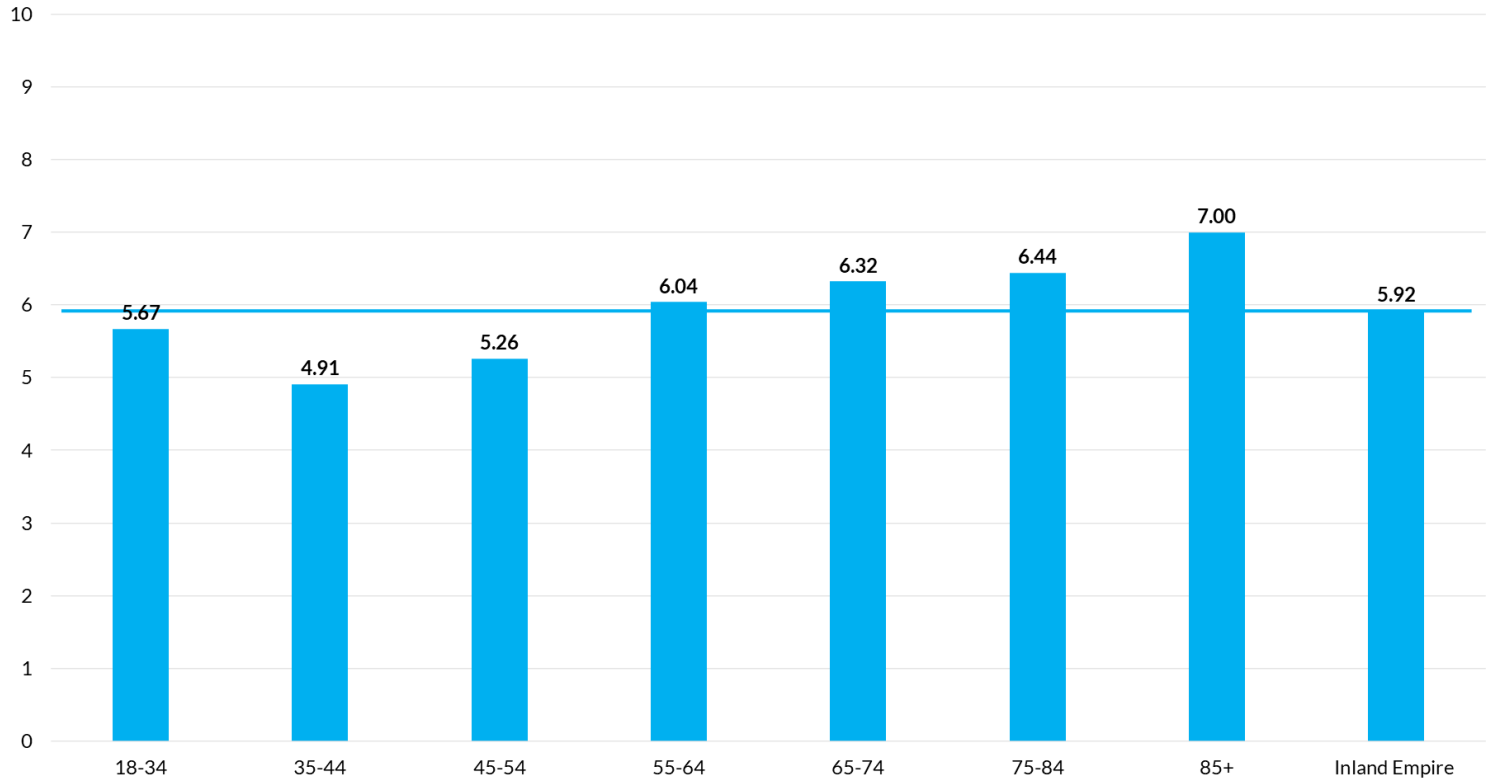
Negative Emotions by Region



Key:

- 0 – Always
- 10 – Never

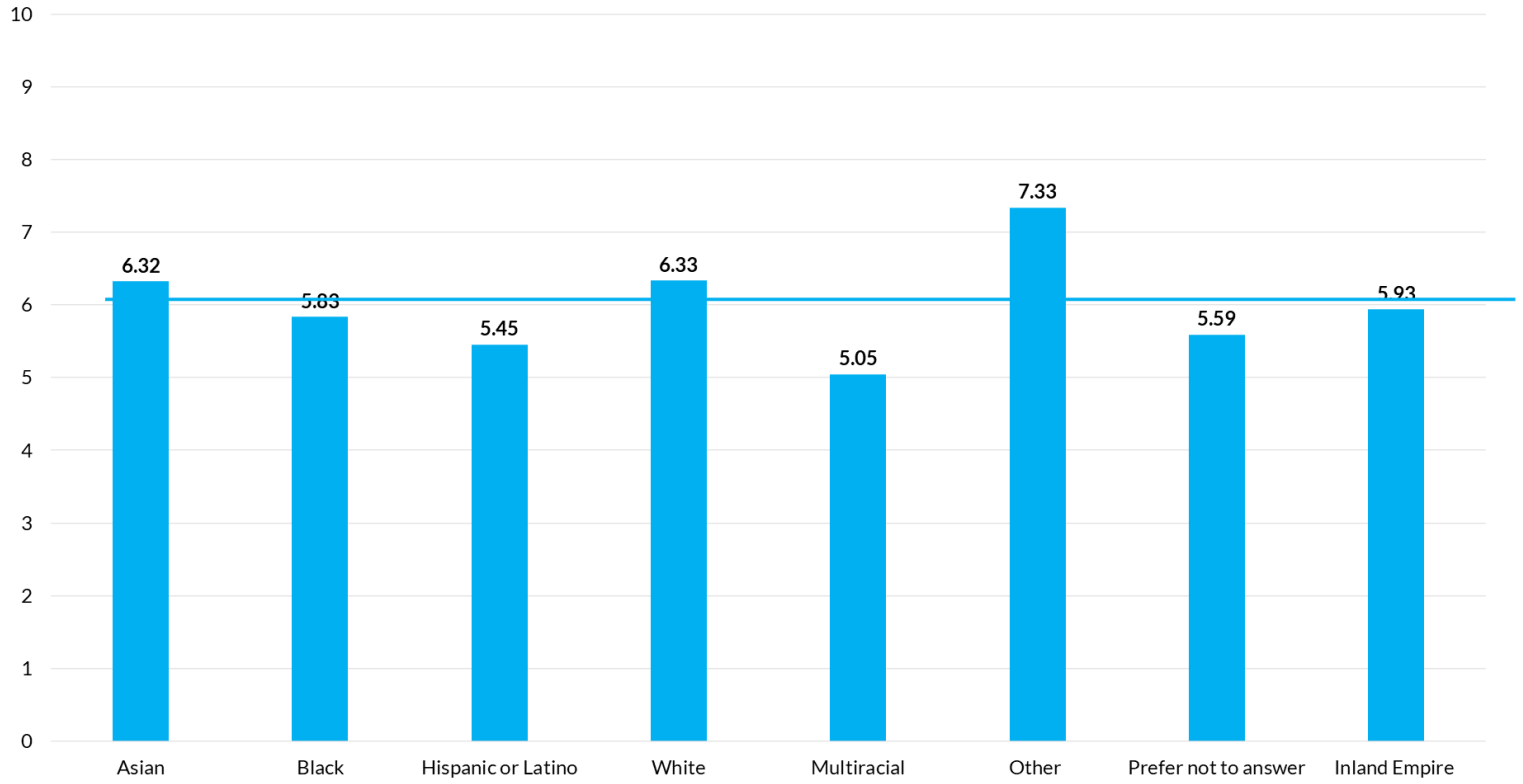
Negative Emotions by Age



Key:

- 0 – Always
- 10 – Never

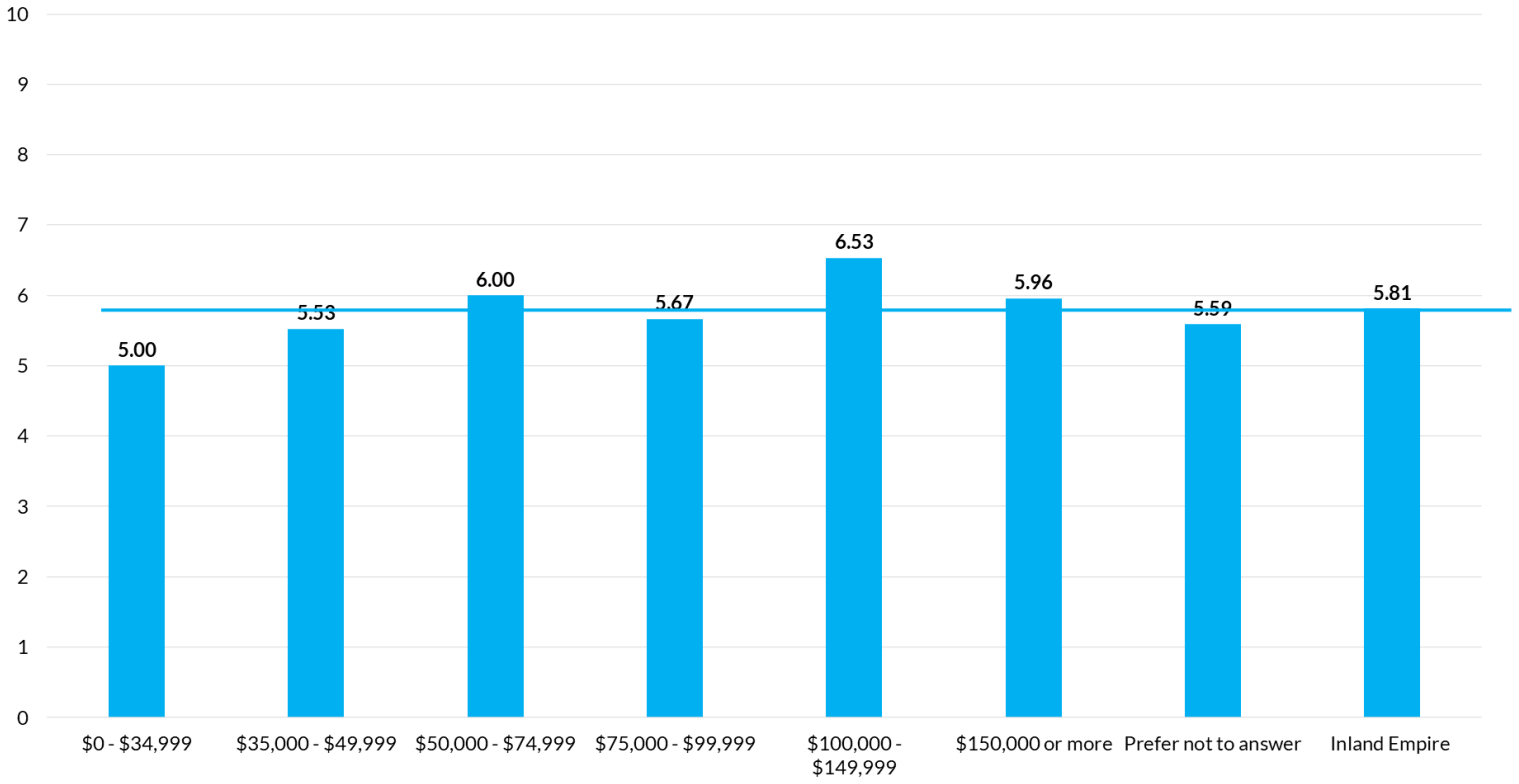
Negative Emotions by Race/Ethnicity



Key:

- 0 – Always
- 10 – Never

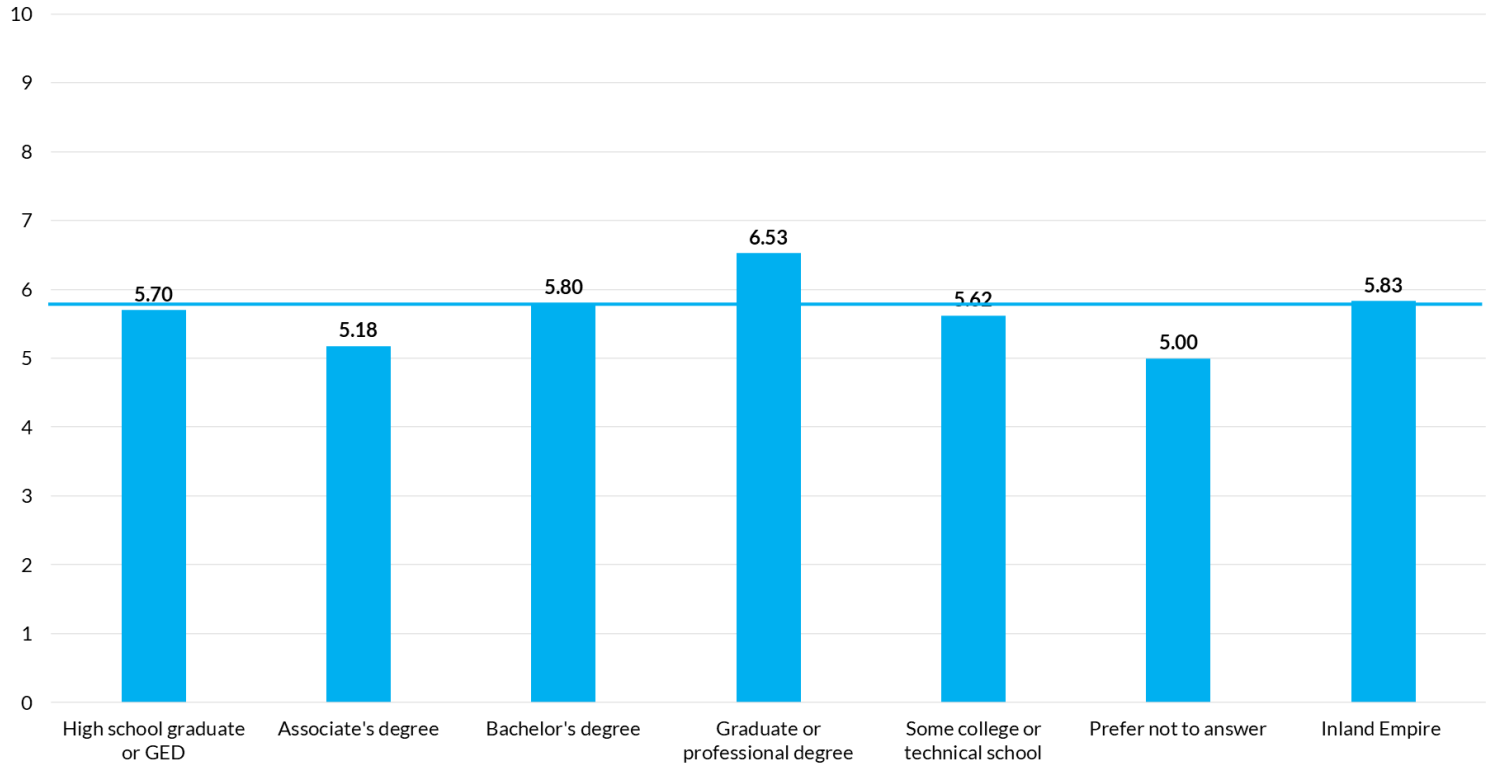
Negative Emotions by Household Income



Key:

- 0 – Always
- 10 – Never

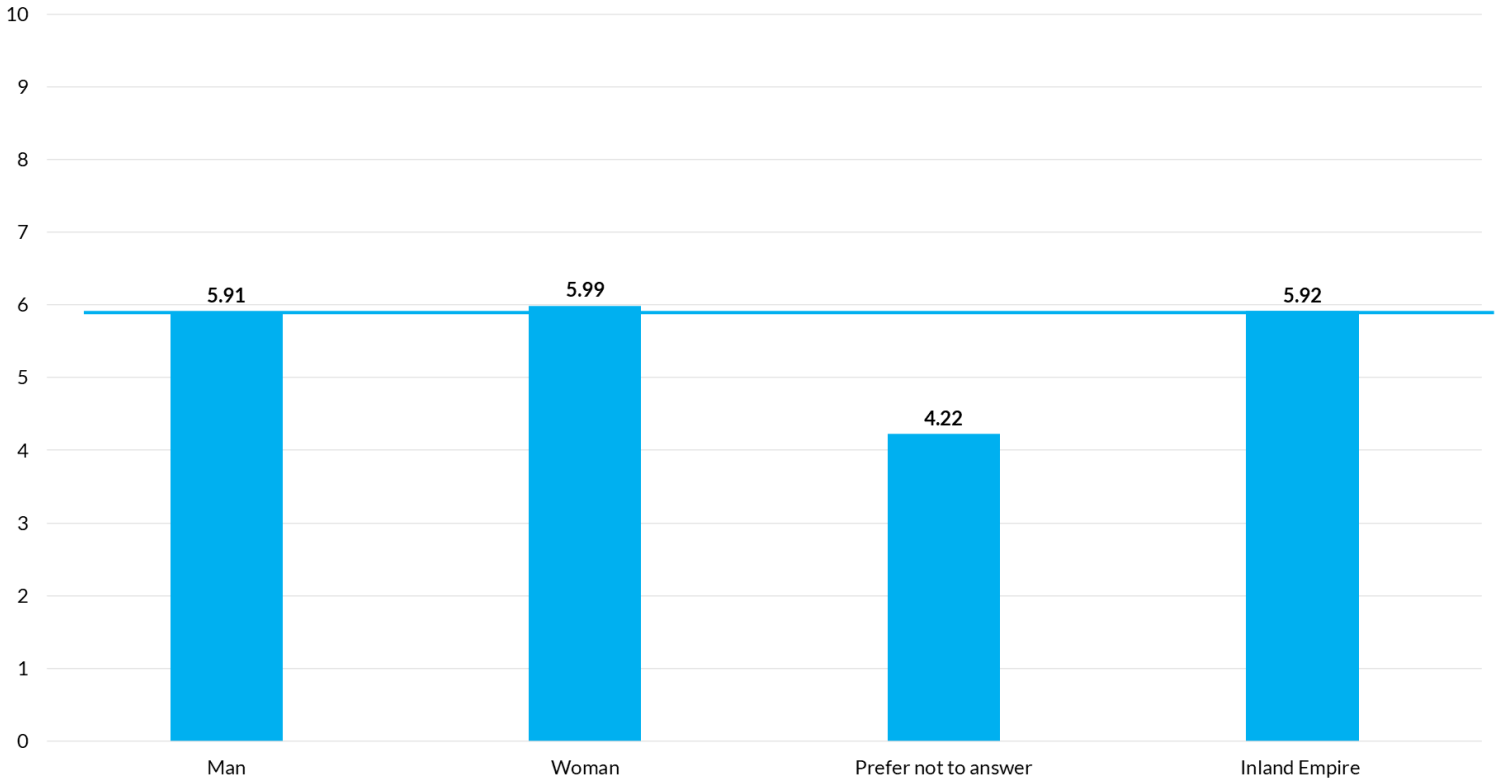
Negative Emotions by Educational Attainment



Key:

- 0 – Always
- 10 – Never

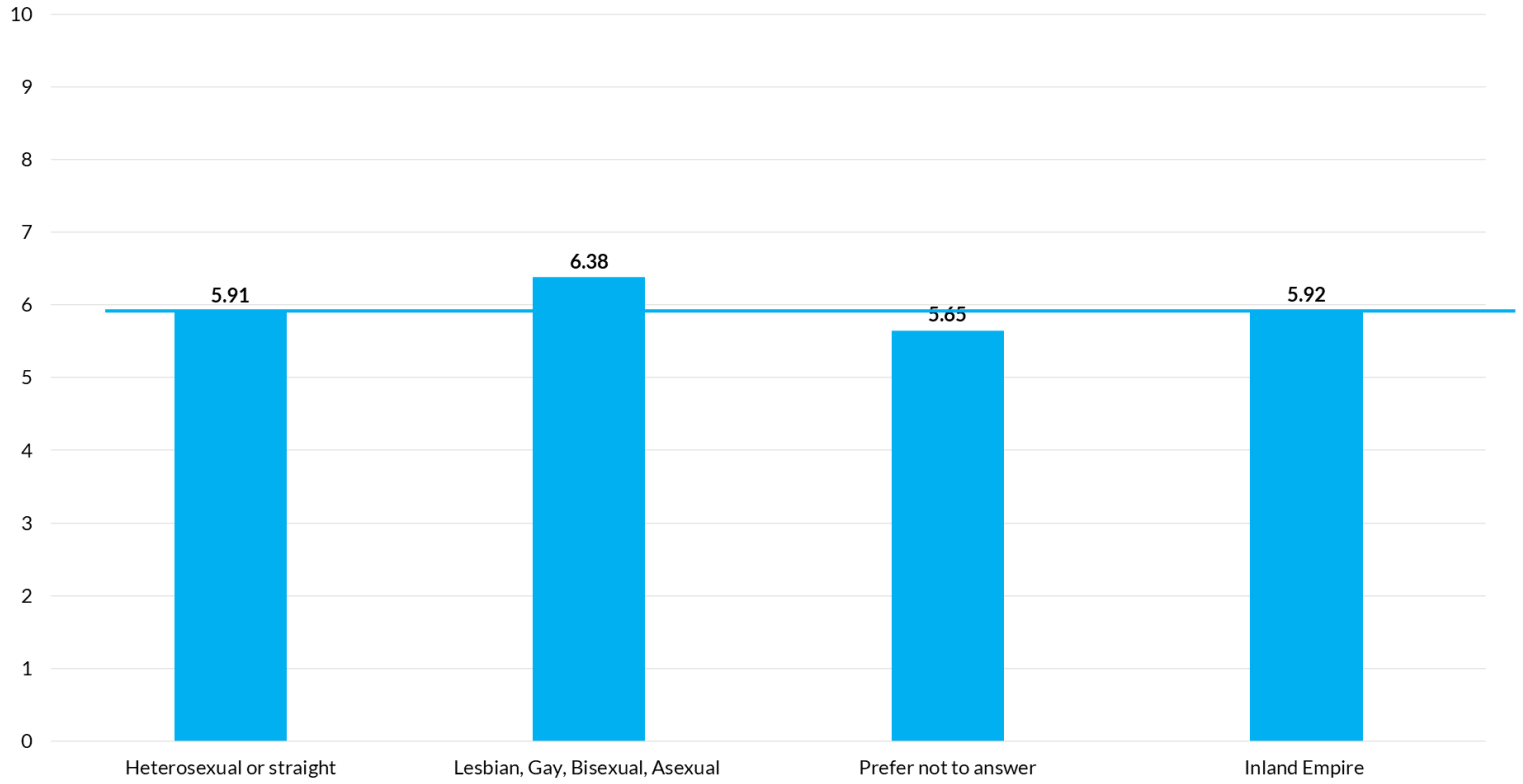
Negative Emotions by Gender



Key:

- 0 – Always
- 10 – Never

Negative Emotions by Sexual Orientation



Key:

- 0 – Always
- 10 – Never

Appendix G: Prioritization Survey Methods and Results

Prioritization Methods

The Prioritization Survey

After reviewing the data, the 2025 Stakeholder Committee used a survey with five questions to select priority areas for collective action in the Inland Empire. Participants were asked to select the top 3 Burden of Disease and top 2 Vital Conditions. In addition, participants were asked the following five questions for each selection:

1. How severe is this health issue in terms of its impact on your community (e.g., mortality, morbidity, quality of life)?

2. Define the level of community interest, energy and organizational capacity to take action on this issue.

3. Rate the level of opportunities to partner with local Medi-Cal managed care plans (MCPs), county agencies, community-based organizations (CBOs), and/or health systems to address this issue.

4. Assess the availability of evidence-based or promising practices to guide community partners in addressing this issue.

5. OPTIONAL: Rate the potential for a measurable return on investment and/or sustainable funding opportunities to address this issue

Additionally, stakeholders were asked to **list up to three populations** that are disproportionately impacted for each priority area.

Prioritization Input

Hospitals distributed the survey to key community partners and collaboratives throughout the Inland Empire. Additional feedback on priorities was gathered through informal conversations and incorporated into the validation and consensus.

Prioritization Methods

Votes for each Burden of Disease and Vital Conditions were counted and totaled. Responses to each of the five questions for each category were averaged, and a total score across all five questions was calculated. Populations were themed based on the following categories: homeless and economically disadvantaged, insurance and access barriers, age, race and ethnicity, identity and social groups, women, other vulnerabilities.

Validation and consensus

Hospitals validated and reached consensus on the final priority areas. The top 3 Burden of Disease and top 2 Vital Conditions with the highest votes were selected as the priority areas. Recognizing diabetes as an emerging concern, Cardiovascular Disease and Diabetes were combined into a single priority area.

Prioritization Results – Votes and Populations

Homeless and Economically Disadvantaged

Includes people with low income, unemployment, unstable housing,
and persons with disabilities living on limited income.

Age

Includes children, youth, young and transitional-age adults, working-age adults, and older adults/seniors (65+), with unique needs across life stages.

Insurance and Access Barriers

Includes uninsured and system navigation barriers

Race and Ethnicity

Responses included Hispanic/Latino, Black/African-American, Asian, White, multiracial, and other communities of color, with older Black communities facing particular challenges.

Identity and Social Groups

Includes people of color, LGBTQ+ communities, and individuals marginalized by gender, sexuality, or single status.

Women

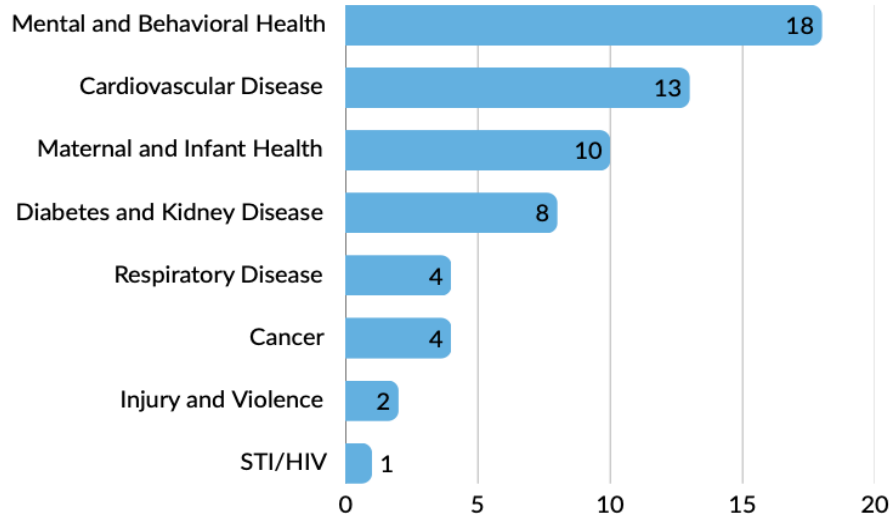
Includes women and females, mothers in their early to mid-20s, families, children, and individuals navigating pregnancy, postpartum, or pregnancy loss.

Other Vulnerabilities

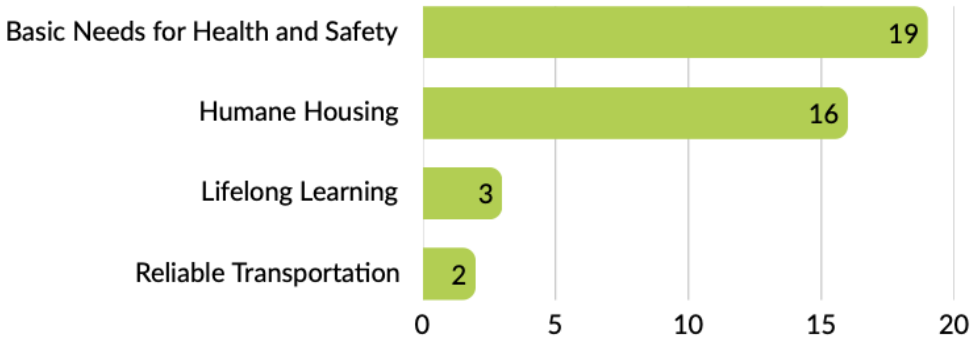
Includes people with disabilities, mental or behavioral health conditions, substance use, or chronic illnesses (e.g., diabetes, obesity). Also includes non-citizens, undocumented immigrants, and underserved populations in rural, urban, mountainous, desert, or warehouse districts.

Prioritization results

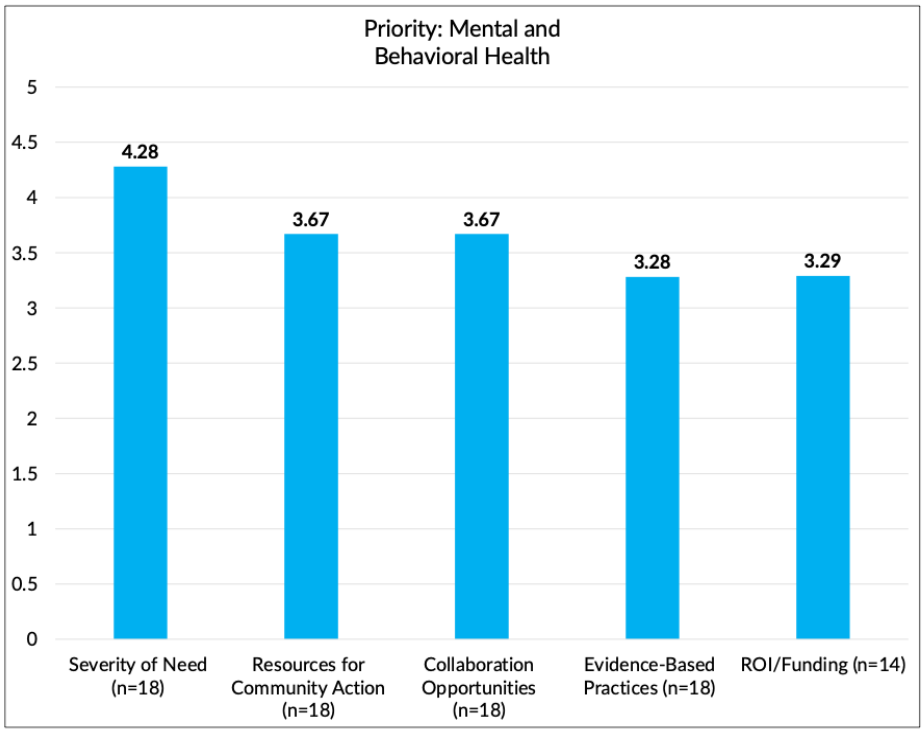
Burden of Disease by Vote:



Vital Conditions by Vote:



Priority 1: Mental Health and Substance Use



Factors contributing to inequities:

Homeless and Economically Disadvantage

Low income/Socioeconomic status (poverty, employment, housing)
Unemployed
Homeless

Insurance and Access Barriers

Uninsured

Age Groups

Older adults/seniors
Adolescents/youth/young adults/transitional age youth (TAY)
Adults

Race and Ethnicity

Hispanic/Latino
Older Black communities
People of color

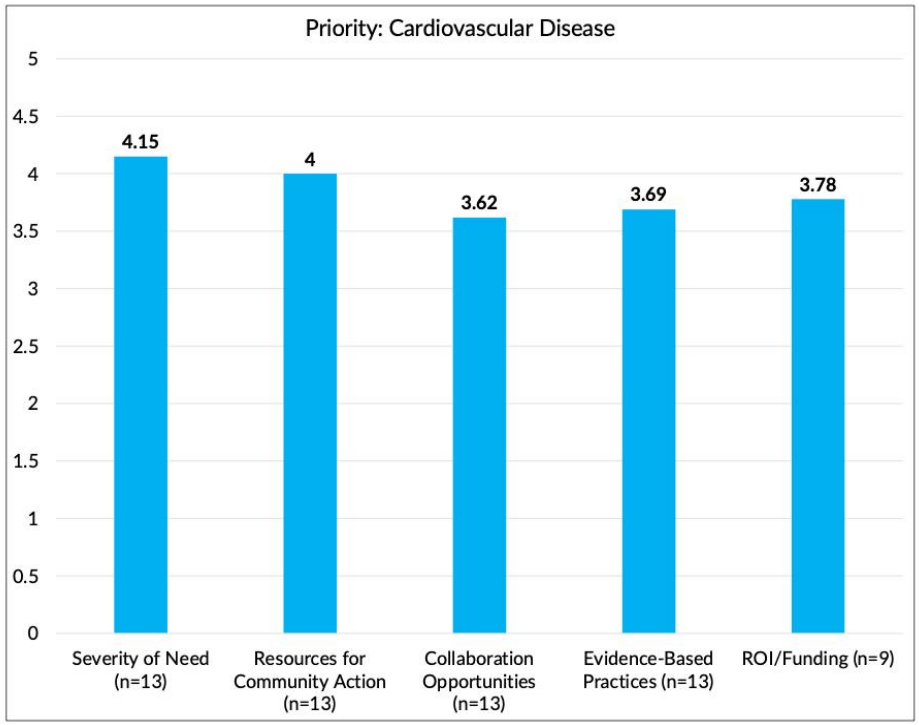
Identity and Social Groups

LGBTQ+
Sexuality
Single females, single males

Other Vulnerabilities

Disability status
Citizenship status (non-citizen, undocumented)
Underserved populations/regions

Priority 2: Cardiovascular Disease



Factors contributing to inequities:

Housing and Economically Disadvantage
- Low income
- Socioeconomic status (poverty, employment, housing)

Insurance and Access Barriers
- People without insurance

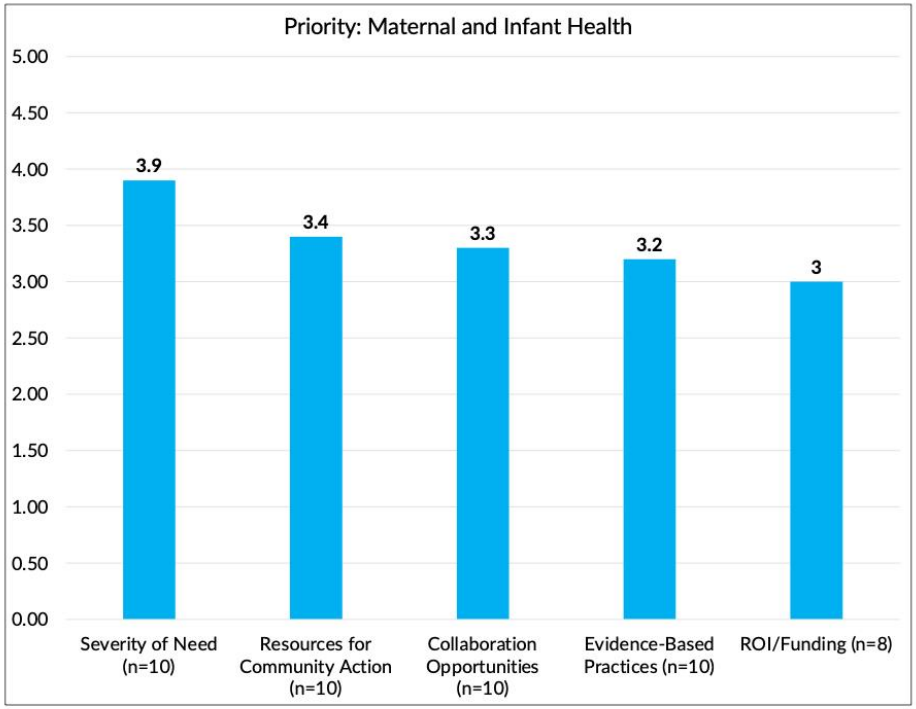
Age Groups
- Elderly/seniors (65+)
- Younger generations
- Age (general)

Race and Ethnicity
- Hispanic/Latino
- Black/African-American
- White
- Most racial and ethnic groups

Identity and Social Groups
- Gender

Other Vulnerabilities
- Obese
- Diabetic
- Underserved/underserved regions
- Commonly overlooked populations

Priority 3: Maternal and Infant Health



Factors contributing to inequities:

Economically Disadvantage

Low socioeconomic status (SES)/fixed income

Insurance and Access

People without insurance/uninsured
Access to professional services

Race and Ethnicity

Black/African-American
Hispanic
Asian

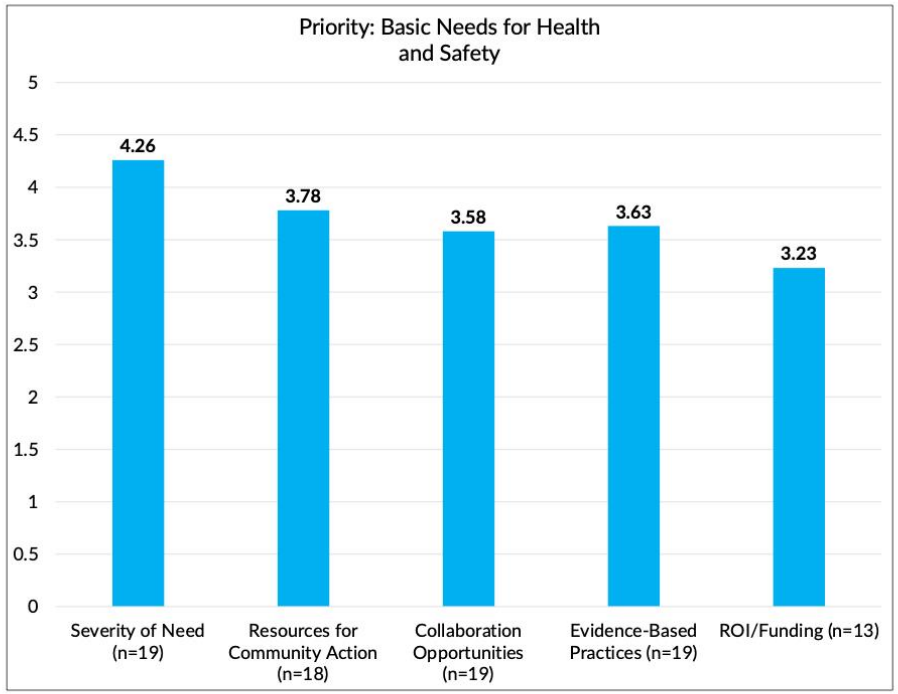
Women/Female

Women/female
Children
Families
Mothers in their early to mid-20s
Individuals trying to become pregnant, are pregnant, have a loss and postpartum

Other Vulnerabilities

Citizenship status
Underserved populations

Priority 4: Basic Needs for Health and Safety



Factors contributing to inequities:

Housing and Economically Disadvantage
- Socioeconomic status (poverty, employment, housing, insurance, cost of living, etc.)
- Low income/economically disadvantaged
- Income vs. cost to live
- Skilled vs. unskilled workers
- Homeless/unhoused
- Disabled persons with low income
- Low-income families

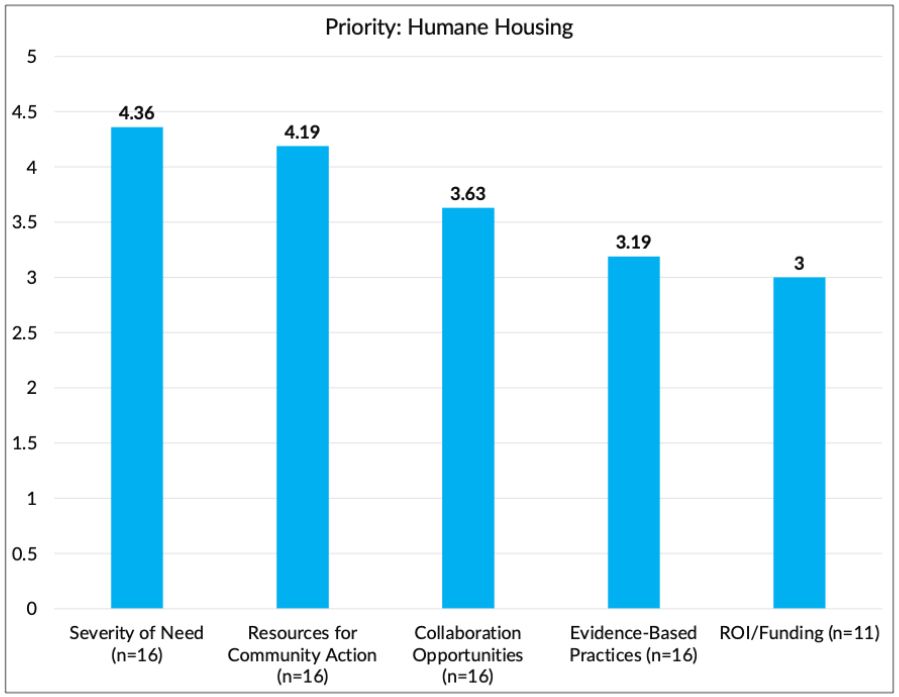
Insurance and Access Barriers
- People without insurance

Race and Ethnicity
- Black/African-American
- Hispanic/Latino
- White
- People of color
- Multiracial/ethnic groups

Other Vulnerabilities
- Non-citizens
- Undocumented populations
- Immigrants
- Underserved regions

Age Groups
- Youth/adolescents
- Age (general)
- Older adults/seniors (65+)
- Senior community

Priority 5: Humane Housing



Factors contributing to inequities:

Housing And Economically Disadvantages

- Socioeconomic status (poverty, employment, housing, insurance, financial means)
- Low income
- Homeless/unhoused
- Those lacking financial means or navigations skills to secure housing

Other Vulnerabilities

- Undocumented populations
- Citizenship status (non-citizen, undocumented, etc.)
- People with mental/behavioral health conditions
- Disability status
- Those using substances
- Underserved populations/regions/communities (including rural, mountainous, desert, urban)

Race and Ethnicity

- White
- Hispanic/Latino
- Black/African American

Age groups

- Older adults/seniors (65+)
- Young adults
- Working adults

Prioritization Survey – Questions and Population Results

Combined Total of the 5 Questions

This number reflects the total score across all five factors: severity, capacity, collaboration, evidence-based practices, and funding.