Bear Valley Community Hospital

Big Bear Lake, California

BEAR VALLEY
COMMUNITY HEALTHCARE DISTRICT

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution November 9, 2016

Dear Community Member:

At Bear Valley Community Hospital (BVCH), we have spent more than 40 years providing high-quality compassionate healthcare to the greater Big Bear Lake community. The “2016 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how BVCH will respond to such needs. This document suggests areas where other local organizations and agencies might work with us to achieve desired improvements and illustrates one way we are meeting our obligations to efficiently deliver medical services.

We do not have adequate resources to solve all the problems identified. Some issues are beyond the mission of the hospital and action is best suited for a response by others. Some improvements will require personal actions by individuals rather than the response of an organization. We view this as a plan for how we, along with other area organizations and agencies, can collaborate to bring the best each has to offer to support change and to address the most pressing identified needs.

I invite your response to this report. As you read, please think about how to help us improve health and medical services in our area. We all live in, work in, and enjoy this wonderful community together. Together, we can make our community healthier for every one of us.

Thank You,

John Friel
Chief Executive Officer
Bear Valley Community Hospital

TABLE OF CONTENTS

EXECUTIVE SUMMARY

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Bear Valley Community Hospital ("BVCH" or the "Hospital") has performed a Community Health Needs Assessment to determine the health needs of the local community and develop an implementation plan to outline and organize how to meet those needs.

Data was gathered from multiple well-respected secondary sources to build an accurate picture of the current community and its health needs. A survey of a select group of Local Experts was performed to review the prior CHNA and provide feedback, and to ascertain whether the previously identified needs are still a priority. A second survey was distributed to the same group that reviewed the data gathered from the secondary sources and determined the Significant Health Needs for the community.

The Significant Health Needs for San Bernardino County are:

1. Accessibility
2. Mental Health
3. Substance Abuse

The Hospital has developed implementation strategies for all three of the needs including activities to continue/pursue, community partners to work alongside, and leading and lagging indicators to track.

APPROACH

APPROACH

A Community Health Needs Assessment (CHNA) is part of the required hospital documentation of "Community Benefit" under the Affordable Care Act (ACA), required of all not-for-profit hospitals as a condition of retaining tax-exempt status. ***While Bear Valley Community Hospital is not a not-for-profit hospital, this study is designed to comply with standards required of a not-for-profit hospital,[2] and helps assure BVCH identifies and responds to the primary health needs of its residents.***

Further explanation and specific regulations are available from Health and Human Services (HHS), the Internal Revenue Service (IRS), and the U.S. Department of the Treasury.[3]

Project Objectives

BVCH partnered with Quorum Health Resources (Quorum) to:[4]

- Complete a CHNA report, compliant with Treasury – IRS
- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response

Overview of Community Health Needs Assessment

Typically, non-profit hospitals qualify for tax-exempt status as a Charitable Organization, described in Section 501(c)(3) of the Internal Revenue Code; however, the term 'Charitable Organization' is undefined. Prior to the passage of Medicare, charity was generally recognized as care provided to the less fortunate who did not have means to pay. With the introduction of Medicare, the government met the burden of providing compensation for such care.

In response, IRS Revenue ruling 69-545 eliminated the Charitable Organization standard and established the Community Benefit Standard as the basis for tax-exemption. Community Benefit determines if hospitals promote the health of a broad class of individuals in the community, based on factors including:

- An Emergency Room open to all, regardless of ability to pay
- Surplus funds used to improve patient care, expand facilities, train, etc.
- A board controlled by independent civic leaders
- All available and qualified physicians granted hospital privileges

Specifically, the IRS requires:

- Effective on tax years beginning after March 23, 2012, each 501(c)(3) hospital facility is required to conduct a CHNA at least once every three taxable years and to adopt an implementation strategy to meet the community needs identified through such assessment.

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[2] Federal Register Vol. 79 No. 250, Wednesday December 31, 2014. Part II Department of the Treasury Internal Revenue Service 26 CFR Parts 1, 53, and 602

[3] As of the date of this report all tax questions and suggested answers relate to 2014 Draft Federal 990 schedule h instructions i990sh—dft(2) and tax form

[4] Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice

- The assessment may be based on current information collected by a public health agency or non-profit organization and may be conducted together with one or more other organizations, including related organizations.
- The assessment process must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise of public health issues.
- The hospital must disclose in its annual information report to the IRS (Form 990 and related schedules) how it is addressing the needs identified in the assessment and, if all identified needs are not addressed, the reasons why (e.g., lack of financial or human resources).
- Each hospital facility is required to make the assessment widely available and downloadable from the hospital website.
- Failure to complete a CHNA in any applicable three-year period results in an excise tax to the organization of $50,000. For example, if a facility does not complete a CHNA in taxable years one, two, or three, it is subject to the penalty in year three. If it then fails to complete a CHNA in year four, it is subject to another penalty in year four (for failing to satisfy the requirement during the three-year period beginning with taxable year two and ending with taxable year four).
- An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.[5]

Community Health Needs Assessment Subsequent to Initial Assessment

The Final Regulations establish a required step for a CHNA developed after the initial report. This requirement calls for considering written comments received on the prior CHNA and Implementation Strategy as a component of the development of the next CHNA and Implementation Strategy. The specific requirement is:

> *"The 2013 proposed regulations provided that, in assessing the health needs of its community, a hospital facility must take into account input received from, at a minimum, the following three sources:*
>
> *(1) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community;*
>
> *(2) members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations; and*
>
> *(3) written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy.*[6]

[5] Section 6652

[6] Federal Register Vol. 79 No. 250, Wednesday December 31, 2014. Part II Department of the Treasury Internal Revenue Service 26 CFR Parts 1, 53, and 602 P. 78963 and 78964

…the final regulations retain the three categories of persons representing the broad interests of the community specified in the 2013 proposed regulations but clarify that a hospital facility must ''solicit'' input from these categories and take into account the input ''received.'' The Treasury Department and the IRS expect, however, that a hospital facility claiming that it solicited, but could not obtain, input from one of the required categories of persons will be able to document that it made reasonable efforts to obtain such input, and the final regulations require the CHNA report to describe any such efforts."

Representatives of the various diverse constituencies outlined by regulation to be active participants in this process were actively solicited to obtain their written opinion. Opinions obtained formed the introductory step in this Assessment.

To complete a CHNA:

"… the final regulations provide that a hospital facility must document its CHNA in a CHNA report that is adopted by an authorized body of the hospital facility and includes:

(1) A definition of the community served by the hospital facility and a description of how the community was determined;

(2) a description of the process and methods used to conduct the CHNA;

(3) a description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;

(4) a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and

(5) a description of resources potentially available to address the significant health needs identified through the CHNA.

… final regulations provide that a CHNA report will be considered to describe the process and methods used to conduct the CHNA if the CHNA report describes the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA."[7]

Additionally, a CHNA developed subsequent to the initial Assessment must consider written commentary received regarding the prior Assessment and Implementation Strategy efforts. We followed the Federal requirements in the solicitation of written comments by securing characteristics of individuals providing written comment but did not maintain identification data.

"…the final regulations provide that a CHNA report does not need to name or otherwise identify any specific individual providing input on the CHNA, which would include input provided by individuals in the

[7] Federal Register Op. cit. P 78966 As previously noted the Hospital collaborated and obtained assistance in conducting this CHNA from Quorum Health Resources.

form of written comments."[8]

Quorum takes a comprehensive approach to the solicitation of written comments. As previously cited, we obtained input from the required three minimum sources and expanded input to include other representative groups. We asked all participating in the written comment solicitation process to self-identify themselves into any of the following representative classifications, which is detailed in an Appendix to this report. Written comment participants self-identified into the following classifications:

(1) Public Health – Persons with special knowledge of or expertise in public health

(2) Departments and Agencies – Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility

(3) Priority Populations – Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs in the community served by the hospital facility. Also, in other federal regulations the term Priority Populations, which include rural residents and LGBT interests, is employed and for consistency is included in this definition

(4) Chronic Disease Groups – Representative of or member of Chronic Disease Group or Organization, including mental and oral health

(5) Broad Interest of the Community – Individuals, volunteers, civic leaders, medical personnel and others to fulfill the spirit of broad input required by the federal regulations

Other (please specify)

Quorum also takes a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with Local Expert Advisor[9] opinions, and resolve any data inconsistency or discrepancies by reviewing the combined opinions formed from local experts. We rely on secondary source data, and most secondary sources use the county as the smallest unit of analysis. We asked our local expert area residents to note if they perceived the problems or needs identified by secondary sources existed in their portion of the county.

Most data used in the analysis is available from public Internet sources and Quorum proprietary data from Truven. Any critical data needed to address specific regulations or developed by the Local Expert Advisor individuals cooperating with us in this study are displayed in the CHNA report appendix.

[8] Federal Register Op. cit. P 78967

[9] "Local Expert" is an advisory group of at least 15 local residents, inclusive of at least one member self-identifying with each of the five Quorum written comment solicitation classifications, with whom the Hospital solicited to participate in the Quorum/Hospital CHNA process.

Data sources include:[10]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of San Bernardino compared to all State counties	May 31, 2016	2014
www.cdc.gov/communityhealth	Assessment of health needs of San Bernardino compared to its national set of "peer counties"	May 31, 2016	2011
Truven (formerly known as Thompson) Market Planner	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics	May 31, 2016	2015
www.capc.org and www.getpalliativecare.org	To identify the availability of Palliative Care programs and services in the area	May 31, 2016	2015
www.caringinfo.org and iweb.nhpco.org	To identify the availability of hospice programs in the county	May 31, 2016	2015
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	May 31, 2016	2010
www.cdc.gov	To examine area trends for heart disease and stroke	May 31, 2016	2010
http://svi.cdc.gov	To identify the Social Vulnerability Index value	May 31, 2016	2010

[10] The final regulations clarify that a hospital facility may rely on (and the CHNA report may describe) data collected or created by others in conducting its CHNA and, in such cases, may simply cite the data sources rather than describe the ''methods of collecting'' the data. Federal Register Op. cit. P 78967

Website or Data Source	Data Element	Date Accessed	Data Date
www.CHNA.org	To identify potential needs from a variety of resources and health need metrics	May 31, 2016	2015
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	May 31, 2016	2015
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	May 31, 2016	2015

Federal regulations surrounding CHNA require local input from representatives of particular demographic sectors. For this reason, Quorum developed a standard process of gathering community input. In addition to gathering data from the above sources:

- We deployed a CHNA “Round 1” survey to our Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital’s desire to represent the region’s geographically and ethnically diverse population. We received community input from 14 Local Expert Advisors. Survey responses started March 21, 2016 and ended with the last response on June 6, 2016. All written comments are presented verbatim in the Appendix to this report.
- Information analysis augmented by local opinions showed how San Bernardino relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups (“Priority Populations”) need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following “take-away” bulleted comments
  - Low-income residents experience a lack of education, lack of services, and lack of accessibility
  - Big Bear Valley has limited access to mental health and specialty services
  - The community has seen a large influx of racial and ethnic minority groups, particularly the Hispanic population, that require access to multilingual speaking services

When the analysis was complete, we put the information and summary conclusions before our Local Expert Advisors who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need, and new needs did emerge from this exchange. Consultation with 12 Local Experts occurred again via an internet-based survey (explained below) beginning June 6, 2016 and ending August 1, 2016.

Having taken steps to identify potential community needs, the Local Experts then participated in a structured communication technique called a "Wisdom of Crowds" method. The premise of this approach relies on a panel of experts with the assumption that the collective wisdom of participants is superior to the opinion of any one individual, regardless of their professional credentials.

In the BVCH process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, the vast majority of comments agreed with our findings. We developed a summary of all needs identified by any of the analyzed data sets. The Local Experts then allocated 100 points among the potential significant need candidates, including the opportunity to again present additional needs that were not identified from the data. A rank order of priorities emerged, with some needs receiving none or virtually no support, and other needs receiving identical point allocations.

We dichotomized the rank order of prioritized needs into two groups: “Significant” and “Other Identified Needs.” Our criteria for identifying and prioritizing Significant Needs was based on a descending frequency rank order of the needs based on total points cast by the Local Experts, further ranked by a descending frequency count of the number of local experts casting any points for the need. By our definition, a Significant Need had to include all rank ordered needs until at least fifty percent (50%) of all points were included and to the extent possible, represented points allocated by a majority of voting local experts. The determination of the break point — “Significant” as opposed to “Other” — was a qualitative interpretation by Quorum and the BVCH executive team where a reasonable break point in rank order occurred.

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital

Bear Valley Community Hospital, in conjunction with Quorum, defines its service area as San Bernardino County in California, which includes the following ZIP codes:[11]

91701 – Rancho Cucamonga	91708 – Chino	91709 – Chino Hills	91710 – Chino
91730 – Rancho Cucamonga	91737 – Rancho Cucamonga	91739 – Rancho Cucamonga	91759 – Mt Baldy
91761 – Ontario	91762 – Ontario	91763 – Montclair	91764 – Ontario
91784 – Upland	91786 – Upland	92242 – Earp	92252 – Joshua Tree
92256 – Morongo Valley	92267 – Parker Dam	92277 – Twentynine Palms	
92278 – Twentynine Palms	92280 – Vidal	92284 – Yucca Valley	92285 – Landers
92301 – Adelanto	92304 – Amboy	92305 – Angelus Oaks	92307 – Apple Valley
92308 – Apple Valley	92309 – Baker	92310 – Fort Irwin	92311 – Barstow
92313 – Grand Terrace	**92314 – Big Bear City**	**92315 – Big Bear Lake**	92316 – Bloomington
92317 – Blue Jay	92318 – Bryn Mawr	92321 – Cedar Glen	92322 – Cedarpines
Park 92324 – Colton	92325 – Crestline	92327 – Daggett	92332 – Essex
92333 – Fawnskin	92335 – Fontana	92336 – Fontana	92337 – Fontana

[11] The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below

92338 – Ludlow	92339 – Forest Falls	92341 – Green Valley Lake	92342 – Helendale
92344 – Hesperia	92345 – Hesperia	92346 – Highland	92347 – Hinkley
92350 – Loma Linda	92352 – Lake Arrowhead	92354 – Loma Linda	92356 – Lucerne Valley
92358 – Lytle Creek	92359 – Mentone	92363 – Needles	92364 – Nipton
92365 – Newberry Springs	92368 – Oro Grande	92371 – Phelan	92372 – Pinon Hills
92373 – Redlands	92374 – Redlands	92376 – Rialto	92377 – Rialto
92378 – Rimforest	92382 – Running Springs	92385 – Skyforest	**92386 – Sugarloaf**
92391 – Twin Peaks	92392 – Victorville	92394 – Victorville	92395 – Victorville
92397 – Wrightwood	92399 – Yucaipa	92401 – San Bernardino	92404 – San Bernardino
92405 – San Bernardino	92407 – San Bernardino	92408 – San Bernardino	92410 – San Bernardino
92411 – San Bernardino	93562 – Trona		

In 2014, the Hospital received 79.9% of its patients from San Bernardino County.[12] BVCH receives 76.6% of its patients from zip codes 92315 (Big Bear Lake) and 92314 (Big Bear City).

NOTE:

The community of Big Bear Lake finds itself a part of the largest county in California, San Bernadino County. Because healthcare and other statistical data is primarily collected at the county level, much of the information in this report focuses on the county as a whole. Where possible, zip code-level data has been included to better focus on the Hospital's primary service area.

Furthermore, Local Experts were specifically selected to represent Big Bear Lake and were asked to review the provided data to determine if it is an accurate reflection of the community. While the data proposes all potential health needs, the Local Experts are ultimately responsible for ranking and prioritizing the significant health needs of the area.

[12] Truven MEDPAR patient origin data for the hospital

Demographic of the Community[13]

	Big Bear Lake	County	State	U.S.
2016 Population[14]	**18,109**	**2,135,383**	**39,356,473**	**322,431,073**
% Increase/Decline	**3.3%**	**4.5%**	**4.8%**	**3.7%**
Estimated Population in 2021	**18,713**	**2,231,656**	**41,248,721**	**334,341,965**
% White, non-Hispanic	**72.3%**	**29.7%**	**37.7%**	**61.3%**
% Hispanic	**22.2%**	**52.4%**	**39.1%**	**12.3%**
Median Age	**44.6**	**33.5**	**36.4**	**38.0**
Median Household Income	**$41,097**	**$56,665**	**$62,973**	**$55,072**
Unemployment Rate	**N/A**	**5.6%**	**5.4%**	**5.0%**
% Population >65	**19.7%**	**10.8%**	**13.3%**	**15.1%**
% Women of Childbearing Age	**15.4%**	**21.3%**	**20.5%**	**19.6%**

[13] The tables below were created by Truven Market Planner, a national marketing company
[14] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner

Demographics Expert 2.7
2016 Demographic Snapshot
Area: San Bernardino County
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	2,032,979	308,745,538
2016 Total Population	2,135,383	322,431,073
2021 Total Population	2,231,656	334,341,965
% Change 2016 - 2021	4.5%	3.7%
Average Household Income	$70,966	$77,135

	2016	2021	% Change
Total Male Population	1,063,548	1,111,192	4.5%
Total Female Population	1,071,835	1,120,464	4.5%
Females, Child Bearing Age (15-44)	453,812	465,706	2.6%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2016	% of Total	2021	% of Total	USA 2016 % of Total
0-14	474,929	22.2%	475,233	21.3%	19.0%
15-17	102,375	4.8%	101,722	4.6%	4.0%
18-24	241,492	11.3%	239,542	10.7%	9.8%
25-34	308,472	14.4%	328,520	14.7%	13.3%
35-54	542,046	25.4%	550,954	24.7%	26.0%
55-64	235,220	11.0%	253,845	11.4%	12.8%
65+	230,849	10.8%	281,840	12.6%	15.1%
Total	2,135,383	100.0%	2,231,656	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2016 Household Income	HH Count	% of Total	USA % of Total
<$15K	78,350	12.4%	12.3%
$15-25K	64,858	10.2%	10.4%
$25-50K	152,340	24.0%	23.4%
$50-75K	117,820	18.6%	17.6%
$75-100K	79,360	12.5%	12.0%
Over $100K	141,138	22.3%	24.3%
Total	633,866	100.0%	100.0%

EDUCATION LEVEL

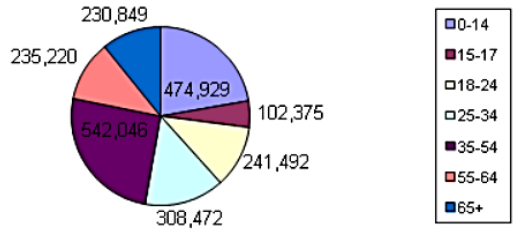
	Education Level Distribution		
2016 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	130,095	9.9%	5.8%
Some High School	151,407	11.5%	7.8%
High School Degree	342,455	26.0%	27.9%
Some College/Assoc. Degree	444,835	33.8%	29.2%
Bachelor's Degree or Greater	247,795	18.8%	29.4%
Total	1,316,587	100.0%	100.0%

RACE/ETHNICITY

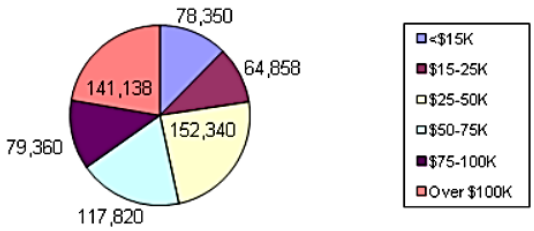
	Race/Ethnicity Distribution		
Race/Ethnicity	2016 Pop	% of Total	USA % of Total
White Non-Hispanic	633,198	29.7%	61.3%
Black Non-Hispanic	172,545	8.1%	12.3%
Hispanic	1,119,195	52.4%	17.8%
Asian & Pacific Is. Non-Hispanic	149,076	7.0%	5.4%
All Others	61,369	2.9%	3.1%
Total	2,135,383	100.0%	100.0%

2016 Demographic Snapshot Charts

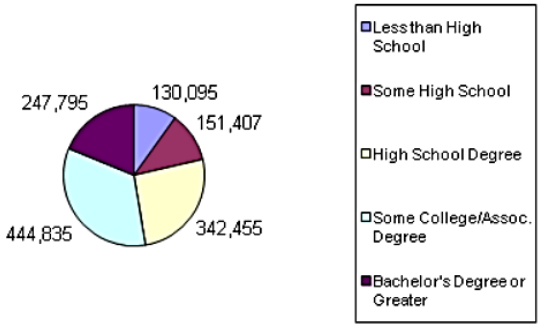
Population Distribution by Age Group



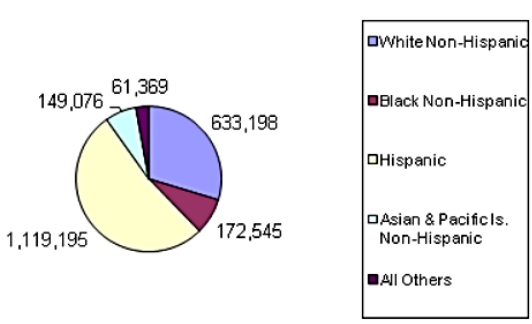
Current Households by Income Group



Population Age 25+ by Education Level



Population Distribution by Race/Ethnicity



2016 Benchmarks
Area: San Bernardino County
Level of Geography: ZIP Code

Area	2016-2021 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2016-2021	Females 15-44 % of Total Population	Females 15-44 % Change 2016-2021	Median Household Income	Median Household Wealth	Median Home Value
USA	3.7%	38.0	15.1%	17.6%	19.6%	1.5%	$55,072	$54,224	$192,364
California	4.8%	36.4	13.3%	19.0%	20.5%	1.8%	$62,973	$41,270	$432,066
Selected Area	4.5%	33.5	10.8%	22.1%	21.3%	2.6%	$56,665	$58,079	$280,026

Demographics Expert 2.7
DEMO0003.SQP

Demographics Expert 2.7
2016 Demographic Snapshot
Area: Big Bear Lake
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	17,642	308,745,538
2016 Total Population	18,109	322,431,073
2021 Total Population	18,713	334,341,965
% Change 2016 - 2021	3.3%	3.7%
Average Household Income	$56,019	$77,135

	2016	2021	% Change
Total Male Population	9,190	9,459	2.9%
Total Female Population	8,919	9,254	3.8%
Females, Child Bearing Age (15-44)	2,785	2,925	5.0%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2016	% of Total	2021	% of Total	USA 2016 % of Total
0-14	3,082	17.0%	3,119	16.7%	19.0%
15-17	662	3.7%	686	3.7%	4.0%
18-24	1,623	9.0%	1,528	8.2%	9.8%
25-34	1,897	10.5%	2,212	11.8%	13.3%
35-54	4,200	23.2%	3,920	20.9%	26.0%
55-64	3,070	17.0%	2,999	16.0%	12.8%
65+	3,575	19.7%	4,249	22.7%	15.1%
Total	18,109	100.0%	18,713	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2016 Household Income	HH Count	% of Total	USA % of Total
<$15K	1,334	17.8%	12.3%
$15-25K	1,059	14.1%	10.4%
$25-50K	1,990	26.5%	23.4%
$50-75K	1,343	17.9%	17.6%
$75-100K	744	9.9%	12.0%
Over $100K	1,039	13.8%	24.3%
Total	7,509	100.0%	100.0%

EDUCATION LEVEL

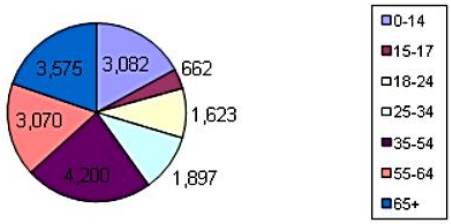
	Education Level Distribution		
2016 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	532	4.2%	5.8%
Some High School	1,372	10.8%	7.8%
High School Degree	3,666	28.8%	27.9%
Some College/Assoc. Degree	4,883	38.3%	29.2%
Bachelor's Degree or Greater	2,289	18.0%	29.4%
Total	12,742	100.0%	100.0%

RACE/ETHNICITY

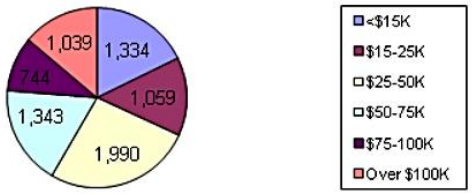
	Race/Ethnicity Distribution		
Race/Ethnicity	2016 Pop	% of Total	USA % of Total
White Non-Hispanic	13,095	72.3%	61.3%
Black Non-Hispanic	92	0.5%	12.3%
Hispanic	4,012	22.2%	17.8%
Asian & Pacific Is. Non-Hispanic	235	1.3%	5.4%
All Others	675	3.7%	3.1%
Total	18,109	100.0%	100.0%

2016 Demographic Snapshot Charts

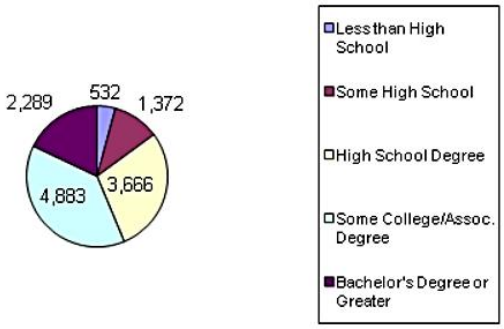
Population Distribution by Age Group



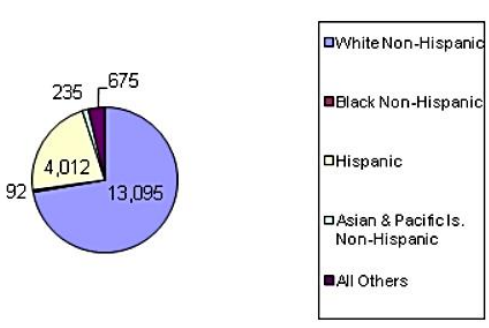
Current Households by Income Group



Population Age 25+ by Education Level



Population Distribution by Race/Ethnicity



2016 Benchmarks
Area: Big Bear Lake
Level of Geography: ZIP Code

Area	2016-2021 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2016-2021	Females 15-44 % of Total Population	Females 15-44 % Change 2016-2021	Median Household Income	Median Household Wealth	Median Home Value
USA	3.7%	38.0	15.1%	17.6%	19.6%	1.5%	$55,072	$54,224	$192,364
California	4.8%	36.4	13.3%	19.0%	20.5%	1.8%	$62,973	$41,270	$432,066
Selected Area	3.3%	44.6	19.7%	18.9%	15.4%	5.0%	$41,097	$42,123	$304,563

Demographics Expert 2.7
DEMO0003.SQP

Customer Segmentation

The population was also examined according to characteristics presented in the Claritas Prizm customer segmentation data. This system segments the population into 66 demographically and behaviorally distinct groups. Each group, based on annual survey data, is documented as exhibiting specific health behaviors. The top three segments in San Bernadino County are:

Claritas Prizm Segments	Characteristics – San Bernardino County
Segment #1 (7%)	Segment #1 is a living example of how ethnically diverse the nation has become: just under half the residents are Hispanic, Asian, or African-American. In these multilingual neighborhoods, middle-aged immigrants and their children live in upper-middle-class comfort.
Segment #2 (7%)	An immigrant gateway community, Segment #2 is the urban home for a mixed populace of Hispanic, Asian, and African-American singles and families. With nearly a quarter of the residents foreign born, this segment is a mecca for first-generation Americans who are striving to improve their lower-middle-class status.
Segment #3 (6%)	Segment #3 is known as a comfortable lifestyle for ethnically-diverse, young, sprawling families with well-paying blue-collar and service jobs. The segment's aging neighborhoods feature compact, modestly priced homes surrounded by commercial centers that cater to child-filled households.

The makeup of the service area, according to the mix of Prizm segments and its characteristics, is contrasted to the national population averages to determine probable lifestyle and medical conditions present in the population. The national average, or norm, is represented as 100%. Where San Bernardino County varies more than 5% above or below that norm (that is, less than 95% or greater than 105%), it is considered significant.

Items in the table with red text are viewed as statistically important adverse potential findings—in other words, these are health areas that need improvement in the San Bernardino County area. Items with blue text are viewed as statistically important potential beneficial findings—in other words, these are areas in which San Bernardino County is doing better than other parts of the country. Items with black text are viewed as either not statistically different from the national norm or neither a favorable nor unfavorable finding—in other words more or less on par with national trends.

Cluster Profile – San Bernardino County

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	98.1%	31.7%	Mammography in Past Yr	92.1%	45.1%
Vigorous Exercise	93.8%	57.7%	Cancer Screen: Colorectal 2 yr	92.0%	24.9%
Chronic Diabetes	90.1%	12.3%	Cancer Screen: Pap/Cerv Test 2 yr	95.0%	60.9%
Healthy Eating Habits	91.8%	29.2%	Routine Screen: Prostate 2 yr	93.5%	32.0%
Ate Breakfast Yesterday	93.8%	79.8%	**Orthopedic**		
Slept Less Than 6 Hours	91.3%	13.7%	Chronic Lower Back Pain	96.4%	23.7%
Consumed Alcohol in the Past 30 Days	94.1%	54.6%	Chronic Osteoporosis	86.5%	9.0%
Consumed 3+ Drinks Per Session	95.5%	29.6%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	92.8%	88.0%
I Will Travel to Obtain Medical Care	94.0%	23.1%	Used Midlevel in last 6 Months	91.2%	40.4%
I am Responsible for My Health	92.6%	65.1%	OB/Gyn 1+ Visit	96.4%	47.9%
I Follow Treatment Recommendations	92.8%	51.8%	Medication: Received Prescription	91.5%	58.8%
Pulmonary			**Internet Usage**		
Chronic COPD	83.9%	3.6%	Use Internet to Talk to MD	100.8%	13.2%
Tobacco Use: Cigarettes	97.6%	27.0%	Facebook Opinions	97.9%	10.9%
Heart			Looked for Provider Rating	94.9%	14.2%
Chronic High Cholesterol	88.8%	20.3%	**Emergency Service**		
Routine Cholesterol Screening	93.4%	50.7%	Emergency Room Use	93.5%	34.3%
Chronic Heart Failure	82.6%	3.4%	Urgent Care Use	95.9%	23.7%

The top three segments in Big Bear Lake are:

Claritas Prizm Segments	Characteristics – Big Bear Lake
Segment #1 (24%)	America's once-thriving mining and manufacturing towns have aged--as have the residents in Segment #1 communities. Today, the majority of residents are retired singles and couples, living on downscale incomes in pre-1960 homes and apartments. For leisure, they enjoy gardening, sewing, socializing at veterans clubs, or eating out at casual restaurants.
Segment #2 (12%)	Segment #2 is the kind of lifestyle where small-town couples nearing retirement are beginning to enjoy their first empty-nest years. Typically in their fifties and older, these upper-middle-class Americans pursue a kind of granola-and-grits lifestyle. On their coffee tables are magazines with titles like Country Living and Country Home. But they're big travelers, especially in recreational vehicles and campers.
Segment #3 (11%)	America was once a land of small middle-class towns, which can still be found today among Segment #3. This widespread segment consists of older couples with white-collar jobs living in sturdy, unpretentious homes. In these communities of small families and empty-nesting couples, Segment #3 residents pursue a rustic lifestyle where hunting and fishing remain prime leisure activities along with cooking, sewing, camping, and boating.

Cluster Profile – Big Bear Lake

Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle		
BMI: Morbid/Obese	107.6%	32.7%
Vigorous Exercise	91.4%	52.0%
Chronic Diabetes	148.5%	18.4%
Healthy Eating Habits	93.6%	27.8%
Ate Breakfast Yesterday	100.9%	71.4%
Slept Less Than 6 Hours	110.0%	16.5%
Consumed Alcohol in the Past 30 Days	81.9%	44.5%
Consumed 3+ Drinks Per Session	105.5%	29.2%
Behavior		
I Will Travel to Obtain Medical Care	93.1%	21.7%
I am Responsible for My Health	94.5%	61.7%
I Follow Treatment Recommendations	93.5%	48.6%
Pulmonary		
Chronic COPD	138.6%	5.5%
Tobacco Use: Cigarettes	114.9%	29.2%
Heart		
Chronic High Cholesterol	133.0%	29.1%
Routine Cholesterol Screening	93.8%	47.6%
Chronic Heart Failure	139.4%	5.9%

Health Service Topic	Demand as % of National	% of Population Affected
Cancer		
Mammography in Past Yr	103.5%	47.2%
Cancer Screen: Colorectal 2 yr	98.4%	25.1%
Cancer Screen: Pap/Cerv Test 2 yr	88.2%	52.9%
Routine Screen: Prostate 2 yr	99.0%	31.8%
Orthopedic		
Chronic Lower Back Pain	123.2%	28.9%
Chronic Osteoporosis	121.7%	12.0%
Routine Services		
FP/GP: 1+ Visit	103.4%	91.3%
Used Midlevel in last 6 Months	104.2%	43.1%
OB/Gyn 1+ Visit	80.9%	37.4%
Medication: Received Prescription	103.0%	59.3%
Internet Usage		
Use Internet to Talk to MD	67.7%	8.4%
Facebook Opinions	102.1%	10.5%
Looked for Provider Rating	84.5%	12.0%
Emergency Service		
Emergency Room Use	104.5%	35.4%
Urgent Care Use	86.3%	20.1%

Leading Causes of Death

Cause of Death			Rank among all counties in CA (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Compared to U.S.)
San Bernardino Rank	CA Rank	Condition		CA	San Bernardino	
1	2	Heart Disease	4 of 58	142.2	240.6	As expected
2	1	Cancer	15 of 58	144.1	178.8	As expected
3	4	Lung	8 of 58	32.0	60.8	Higher than expected
4	3	Stroke	24 of 58	33.9	49.6	As expected
5	7	Diabetes	4 of 58	20.4	32.1	Higher than expected
6	6	Accidents	51 of 58	29.2	28.9	Lower than expected
7	5	Alzheimer's	16 of 58	30.9	27.4	As expected
8	8	Flu - Pneumonia	25 of 58	14.7	19.6	As expected
9	9	Liver	24 of 58	12.0	13.7	Higher than expected
10	10	Hypertension	6 of 58	11.2	12.7	Higher than expected
11	12	Kidney	11 of 58	7.7	10.8	Lower than expected
12	11	Suicide	37 of 58	10.5	10.6	As expected
13	14	Homicide	11 of 58	4.6	7.4	Higher than expected
14	13	Parkinson's	36 of 58	6.8	5.7	As expected
15	15	Blood Poisoning	39 of 58	3.2	4.2	Lower than expected

Priority Populations[15]

Information about Priority Populations in the service area of the Hospital is difficult to encounter if it exists. Our approach is to understand the general trends of issues impacting Priority Populations and to interact with our Local Experts to discern if local conditions exhibit any similar or contrary trends. The following discussion examines findings about Priority Populations from a national perspective.

We begin by analyzing the National Healthcare Quality and Disparities Reports (QDR), which are annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129). These reports provide a comprehensive overview of the quality of healthcare received by the general U.S. population and disparities in care experienced by different racial, ethnic, and socioeconomic groups. The purpose of the reports is to assess the performance of our health system and to identify areas of strengths and weaknesses in the healthcare system along three main axes: **access to healthcare**, **quality of healthcare**, and **priorities of the National Quality Strategy** (NQS). The complete report is provided in Appendix C.

We asked a specific question to our Local Expert Advisors about unique needs of Priority Populations. We reviewed their responses to identify if any of the above trends were obvious in the service area. Accordingly, we place great reliance on the commentary received from our Local Expert Advisors to identify unique population needs to which we should respond. Specific opinions from the Local Expert Advisors are summarized below:[16]

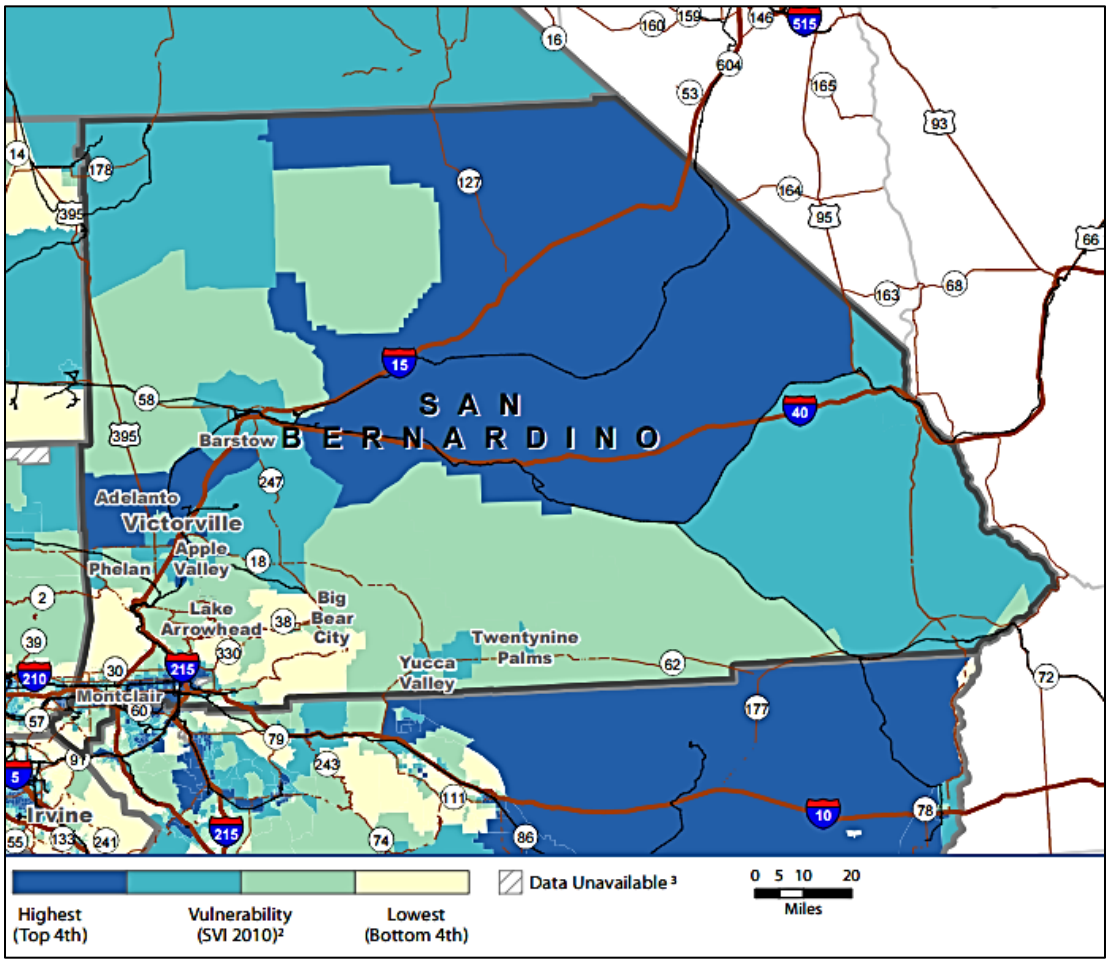
- Low-income residents experience a lack of education, lack of services, and lack of accessibility
- Big Bear Valley has limited access to mental health and specialty services
- The community has seen a large influx of racial and ethnic minority groups, particularly the Hispanic population, that require access to multilingual speaking services

[15] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html
[16] All comments and the analytical framework behind developing this summary appear in Appendix A

Social Vulnerability

Social vulnerability refers to the resilience of communities when confronted by external stresses on human health, stresses such as natural or human-caused disasters, or disease outbreaks.

San Bernardino County zip codes fall into all four quartiles of social vulnerability. However, the northeastern portion is in the highest quartile of vulnerability.



Consideration of Written Comments from Prior CHNA

A group of 14 individuals provided written comment in regard to the 2013 CHNA. Our summary of this commentary produced the following points, which were introduced in subsequent considerations of this CHNA.

Commenter characteristics:

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	3	7	10
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	7	4	11
3) Priority Populations	7	4	11
4) Representative/Member of Chronic Disease Group or Organization	1	8	9
5) Represents the Broad Interest of the Community	10	2	12
Other			
Answered Question			13
Skipped Question			1

Priorities from the last assessment where the Hospital intended to seek improvement were:

- Accessibility
- Diabetes
- Obesity
- Social Factors/Compliance Behavior
- Mental Health

BVCH received the following *verbatim* responses to the question: **"Comments or observations about this set of needs as being the most appropriate for the Hospital to take on in seeking improvements?"**

- **Should the Hospital continue to consider each need identified as most important in the 2013 CHNA report as the most important set of health needs currently confronting residents in the county?**

	Yes	No	No Opinion
Accessibility	12	0	0
Diabetes	9	1	2
Obesity	9	0	3
Social Factors/Compliance Behavior	10	1	1
Mental Health	12	0	0

- **Specific comments or observations about Accessibility as being among the most significant needs for the Hospital to work on to seek improvements?**
    - *Mental Health and Social and Health behaviors need to be a top priority. If we are to look at emerging research and the idea of an "up Stream" approach, then we need to start looking at where health happens. We can address a diabetes program, but unless we address mental and social health, we will*

continue to be treating disease rather than preventing it.

- *Access to care for low income families: 72% district wide poverty (based upon free/reduced meal enrollment) 84% elementary school child poverty (based upon free/reduced meal program enrollment) Increase in Hispanic population and legislation that Medi-Cal is available to undocumented children.*
- *Again, I would like the District to look into obtaining a contract with IEHP at the clinic.*
- *The community needs more dentists who take patients on Medi-Cal. There are no dentists in Big Bear who take adult patients with Medi-Cal insurance and only one dentist that accepts children with Medi-Cal. Children need the example of good dental hygiene from a parent.*
- *1, 2 & 5 I believe are the most important here in our community. I also believe that if you deal with Access to Care, 2DM & Mental Health; Obesity and Social/Health Behaviors will be dealt with as a result.*
- *Increased access to care could be improved with partnering with IEHP for pediatric services. Medi-cal dental services are needed as well.*
- *It is the most important focus of the Healthcare District*
- *I do not see access to care as the duty of a local hospital. There is an Urgent Care in the local area.*
- *yes. Mandatory insurance and poverty in rural communities causes people to choose insurance plans that don't meet their needs. They end up paying for insurance they can't make use of. They then use expensive emergency room care because their pcp is off mountain.*

- **Specific comments or observations about <u>Diabetes</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
  - *Invest in preventative care... invest in education and strategies to improve quality of life, rather then continuing to treat the ailment, maybe look at our population, our needs and how to properly address those needs based on other best practices, and models rather than continuing to do things the same over and over with little to no outcomes.*
  - *Diabetic supplies are very costly. Those community members who have benefits usually have copayments or reach the donut hole where benefits may not be covered. I think through support groups and education, we might better serve our community. I do think Heritage does provide some services, but what about BVCHD?*
  - *Endocrinology could be done via Telehealth to help with provider retention and to keep patient's who already have transportation issues on the mountain for care; it would also help to keep revenue within the district. WIN - WIN - WIN*
  - *Determine if the cost of diabetic supplies is a barrier to managing the disease. Is there assistance for patients that need financial help with costs? Are there discounts available for these patients?*
  - *Don't be so reactive. There was a diabetes clinic at the Chamber which closed due to lack of interest. Concentrate on preventative actions.*
  - *Luckily their aren't many children in our community with type 1 diabetes. But I see many overweight children in school who need to be monitored for pre type 2 diabetes.*

- **Specific comments or observations about <u>Obesity</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
    - *Education and alternative options. I think our dietary staff has been trying to provide the alternative healthy food choices. But let me say, I like the unhealthy options because they are so tasty.*
    - *Important.*
- **Specific comments or observations about <u>Social Factors/Compliance Behavior</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
    - *Our smoking in front of the patients doesn't really set much of an example. I think making this a Smoke Free Campus moved us in the right direction but I always smell cigarette smoke and see people smoking around the hospital. Some people put it out when I mention the signs or comment about our guidelines, others are upset and it's difficult to enforce.*
    - *It is hard for a hospital to change a community's eating habits, especially when fast food is on every corner and its cheap. Promoting good eating habits through community gardens or school garden movements needs dedicated staff at the hospital and in the community to partner....not sure how this can be accomplished at this time.*
    - *I don't believe social behavior is the right space for the Hospital to be in.*
- **Specific comments or observations about <u>Mental Health</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
    - *Since the Hospital added telemedicine to their list of services, this may be an opportunity for some of your mental health clients access psychiatrist services.*
    - *Our society must get our arms around our mental health issues. Big Bear has the same need as does every where else.*
    - *I see this daily. There just isn't enough help for people with mental illness. I don't think this is because of our facility, I see it overall.*
    - *We already have an incredible mental health program at the clinic.*
    - *We have a high number of chronically mentally ill adults and a high rate of onset of mental illness in our children due to poverty, domestic violence and drug/alcohol use. The need for trained psychiatrists for these populations and access to meds would be a great step in meeting this population's needs.*
    - *Having Telemedicine is a good step forward for increased access to mental health services. Could you collaborate with other mental health providers to hire a psychiatrist for Big Bear? At LSS and DMCC children have limited access to psychiatrist for medications. This is creating a HUGE issue with children with behavioral problems.*
    - *There is a distinct lack of assistance for the mentally ill.*

Conclusions from Public Input

Our group of 14 Local Expert Advisors participated in an online survey to offer opinions about their perceptions of community health needs and the potential needs of unique populations. Complete verbatim written comments appear in the Appendix to this report.

BVCH received the following responses to the question: **"Should the Hospital continue to consider each need identified as most important in the 2013 CHNA report as the most important set of health needs currently confronting residents in the county? Please add any additional information you would like us to understand."**

- *Access to care is always an issue when families are not eligible for insurance or if ACA is too expensive...there are many parents who make enough to get by, but not enough to afford medical care, especially for adults. For Spanish speaking families, having access to Spanish speaking providers is a HUGE plus....but families need to know about it. Perhaps outreach to the Spanish community would help reduce that barrier. We have an increased number of children with diabetes in school. How their care is managed is individual to each family. Most are accessing services through the diabetic clinic at Loma Linda. We have two mental health agencies that provide school based children's counseling and family counseling services. Desert Mountain Children's Center provides EPSDT, SART, CIS and other children's mental health supports at school and their clinic. However, they have not had enough therapists nor is their psychiatrist's 1 day per month adequate for our children's needs. Lutheran Social Services provided WRAP, Success First, adult mental health and SAP services in the school district. We find that LSS staff who are local are more receptive to collaboration and coordination of services with school staff. BVCHD's addition of telemedicine has been a great addition to the list of local resources for mental health especially for older students who have parent support. Students who have less parental support are more likely to get consistent services through school based programs. The biggest barrier has been the lack of a pediatric psychiatrist for medications. 1 day per month for DMCC's psychiatrist isn't enough. LSS's psychiatrist has helped fill the gap in emergencies, but parents needing psychiatric services are referred to mental health clinics in Victorville or Rialto.*
- *There appears to be a need for support groups. I believe the ACA addresses the access to medical care. As of 2014, people have access that previously were not receiving care and/ or underserved. I see the problem as a lack of communication and the inability or willingness of some of the individuals to ask the questions that might get them help. I believe there is a high incidence of diabetes in our community. My concern is with the mental health needs of this population. There doesn't seem to be enough help available and even less inpatient beds available.*
- *We need to have Medi-Cal dental services for children and adults. It would be VERY good if the Healthcare District would be a partner with IEHP so that children with Medi-Cal HMOs could receive services on the mountain. Many times, IEHP children will not receive services if the parent needs to take them off the mountain.*
- *Access to health care can be addressed with hosting TAD staff to assist with Medi-Cal insurance. IEHP can also help with child access to health services by providing locally accessible services. Stigma is a barrier for accessing mental health services. An anti-stigma campaign could help increase access to mental health services.*

Summary of Observations: Comparison to Other Counties

Health Outcomes

In a health status classification termed “Health Outcomes," San Bernardino ranks 42 among the 57 ranked California counties (best being #1). Premature Death (deaths prior to age 75) presents worse values (shorter survivability) than the average for the US and California.

Health Factors

In another health status classification “Health Factors," San Bernardino ranks number 47 among the 57 ranked California counties. The following indicators compared to CA average and to national top 10% performance present such poor values it warrants investigating how to improve:

- Adult Obesity – San Bernardino 29% of residents compared to CA 23% and US best of 25%
- Sexually Transmitted Infection – San Bernardino 527 rate per 100,000 compared to CA 440 and US best of 134
- Excessive Drinking – San Bernardino 18% of adults compared to CA 17% and US best of 12%
- Teen Births – San Bernardino 41 births per 1,000 (age 15 to 19) compared to CA 32 and US best of 19
- Access to Exercise Opportunities – San Bernardino 90% compared to CA 94% and US best of 91%

Clinical Care

In the “Clinical Care” classification, San Bernardino County ranks 52 among the 57 ranked California counties. The following indicators compared to CA average and to national top 10% performance present such poor values it warrants investigating how to improve:

- Uninsured – San Bernardino 20% of residents compared to CA 19% and US best of 11%
- Preventable Hospital Stays – San Bernardino 52 which is higher than the CA average of 41 and US best of 38
- Mammography Screening – San Bernardino 51% of female Medicare enrollees compared to CA 59% and US best of 71%
- Diabetic Monitoring – San Bernardino 76% of diabetic Medicare enrollees compared to CA 81% and US best of 90%
- Population to Primary Care Physician – San Bernardino 1,740:1 which is worse than the CA average of 1,270:1 and US best of 1,040:1
- Population to Dentist – San Bernardino 1,540:1 which is worse than the CA average of 1,260:1 and US best of 1,340:1
- Population to Mental Health Provider – San Bernardino 560:1 which is worse than the CA average of 360:1 and US best of 370:1

Social and Economic Factors

In the "Social and Economic Factors" classification, San Bernardino ranks number 41 among the 57 ranked California counties. The following indicators compared to CA average and to national top 10% performance present such poor values it warrants investigating how to improve:

- Children in Poverty – San Bernardino 28% of children compared to CA 23% and US best of 13%
- Children in Single-Parent Households – San Bernardino 36% of children compared to CA 32% and US best of 21%
- Unemployment – San Bernardino 8.1% compared to CA 7.5% and US best of 3.5%
- Violent Crime – San Bernardino 430 offenses per 100,000 compared to CA 425 and US best of 59
- Social Associations – San Bernardino 4.3 associations per 10,000 compared to CA 5.8 and US best of 22.1
- Injury Deaths – San Bernardino 43 deaths per 100,000 compared to CA 46 and US best of 51

Summary of Observations: Peer Comparisons

The Federal Government administers a process to allocate all counties into "Peer" groups. County "Peer" groups have similar social, economic, and demographic characteristics. Health and wellness observations when San Bernardino is compared to its national set of Peer Counties and compared to national rates result in the following:

Mortality

- *Better*
  - Chronic Kidney Disease Deaths
- *Worse*
  - Female Life Expectancy - 80.4 years; 2nd worst among 11 peer counties; US avg. 79.8
  - Cancer Deaths - 175.8 deaths per 100,000; 3rd worst among 11 peer counties; US avg. 185.0
  - Chronic Lower Respiratory Disease (CLRD) Deaths - 59.6 deaths per 100,000; 2nd worst among 11 peer counties; US avg. 49.6
  - Coronary Heart Disease Deaths - 161.0 deaths per 100,000; worst among 11 peer counties; US avg. 126.7
  - Diabetes Deaths - 32.8 deaths per 100.000; worst among 11 peer counties; US avg. 24.7
  - Male Life Expectancy - 76.1 years; 2nd worst among 11 peer counties; US avg. 75.0
  - Motor Vehicle Deaths - 13.4 deaths per 100,000; worst among 10 peer counties; US avg. 19.2
  - Stroke Deaths - 46.5 deaths per 100,000; worst among 10 peer counties; US avg. 46.0

Morbidity

- *Better*
  - Nothing
- *Worse*
  - Adult Overall Health Status - 19.4% of adults; 2nd worst among 9 peer counties; US avg. 16.5%
  - Adult Diabetes - 10.5% of adults; 2nd worst among 10 peer counties; US avg. 8.1%
  - Gonorrhea - 90.0 rate per 100,000; 3rd worst among 11 peer counties; US avg. 30.5

Healthcare Access and Quality

- *Better*
  - Nothing
- *Worse*
  - Uninsured - 21.7% of the population; 3rd worst among 11 peer counties; US avg. 17.7%
  - Cost Barrier to Care - 17.7% of adults who did not see a doctor due to cost; 2nd worst among 9 peer counties; US avg. 15.6%

Health Behaviors

- *Better*
  - Nothing
- *Worse*
  - Teen Births - 43.4 rate per 1,000; 3rd worst among 11 peer counties; US avg. 42.1
  - Adult Female Routine Pap Tests - 76.1% of adult women; 2nd worst among 8 peer counties; US avg. 77.3%

Social Factors

- *Better*
  - Nothing
- *Worse*
  - Inadequate Social Support - 25.9% of adults; worst among 8 peer counties; US avg. 19.6%
  - Poverty - 20.4% of individuals; worst among 11 peer counties; US avg. 16.3%
  - Unemployment - 10.1% of labor force; 2nd worst among 11 peer counties; US avg. 7.1%

Physical Environment

- *Better*
  - Nothing
- *Worse*
  - Air Quality - 16.6 average concentration; worst among 11 peer counties; US avg. 10.7
  - Access to Parks - 37.0% live within a half mile of a park; 3rd worst among 11 peer counties; US avg. 14.0%
  - Limited Access to Healthy Food - 7.5% of low income population do not live close to a grocery store; 2nd worst among 11 peer counties US avg. 6.2%
  - Living Near Highways - 4.8% live within 150 meters of a highway; 3rd worst among 11 peer counties; US avg. 1.5%

Conclusions from Demographic Analysis – San Bernardino County

According to 2016 Truven Health Analytics data, the current population for San Bernardino County is estimated to be 2,135,383 and expected to increase at a rate of 4.5% through 2021. This is lower than California's 4.8% growth rate, but higher than the national average of 3.7%. In 2021, San Bernardino County anticipates a population of 2,231,656.

Population estimates indicate the 2016 median age for the county is 33.5 years, younger than the California average (36.4 years) and the national median age of 38.0. The 2016 Median Household Income for the area is $56,665, lower than the California median income of $62,973 but higher than the national median income of $55,072. Median Household Wealth value is higher than both the national and the California value. Median Home Value ($280,026) for San Bernardino is lower than the California median of $432,066 but higher than the national median of $192,364. San Bernardino's unemployment rate as of March 2016 is 5.6%, which is higher than the 5.4% statewide and the 5.0% national civilian unemployment rate.

The portion of the population in the county over 65 is 10.8%, compared to California (13.3%) and the national average (15.1%). The portion of the population of women of childbearing age is 21.3%, higher than the California average of 20.5% and the national rate of 19.6%. 29.7% of the population is White non-Hispanic. The largest minority is the Hispanic population which comprises 52.4% of the total.

The following areas were identified from a comparison of the county to national averages. Metrics impacting more than 30% of the population and statistically significantly different from the national average include the following. All are considered adverse:

- **Vigorous Exercise** is 6.2% below average, impacting 57.7% of the population
- **Ate Breakfast Yesterday** is 6.2% below average, impacting 79.8% of the population
- **I Am Responsible for My Health** is 7.4% below average, impacting 65.1% of the population
- **I Follow Treatment Recommendations** is 7.2% below average, impacting 51.8% of the population
- **Routine Cholesterol Screening** is 6.6% below average, impacting 50.7% of the population
- **Mammography Screening** in past year is 7.9% below average, impacting 45.1% of the population
- **Routine Prostate Screening** is 6.5% below average, impacting 32.0% of the population
- **1+ Family/General Practitioner Visit** is 7.2% below average, impacting 88.0% of the population
- **Used Midlevel Services** in last 6 months is 8.8% below average, impacting 40.4% of the population

Metrics impacting more than 30% of the population and statistically significantly different from the national average include the following. All are considered beneficial:

- **Consumed Alcohol in the Past 30 Days** is 5.9% below average, impacting 45.3% of the population
- **Received Prescription Medication** is 8.5% below average, impacting 58.8% of the population
- **Emergency Room Use** is 6.5% below average, impacting 34.3% of the population

Conclusions from Demographic Analysis – Big Bear Lake

According to 2016 Truven Health Analytics data, the current population for the Big Bear Lake area (zip codes 92315 and 92314) is estimated to be 18,109 and expected to increase at a rate of 3.3% through 2021. This is lower than California's 4.8% growth rate and the national average of 3.7%. In 2021, the area anticipates a population of 18,713.

Population estimates indicate the 2016 median age for the area is 44.6 years, older than the California average (36.4 years) and the national median age of 38.0. The 2016 Median Household Income for the area is $41,097, lower than the California median income of $62,973 and the national median income of $55,072. Median Household Wealth value is higher than the California value, but lower than the national average. Median Home Value ($304,563) for the area is lower than the California median of $432,066 but higher than the national median of $192,364.

The portion of the population in the county over 65 is 19.2%, compared to California (13.3%) and the national average (15.1%). The portion of the population of women of childbearing age is 15.4%, lower than the California average of 20.5% and the national rate of 19.6%. 72.3% of the population is White non-Hispanic. The largest minority is the Hispanic population which comprises 22.2% of the total.

The following areas were identified from a comparison of the county to national averages. Metrics impacting more than 30% of the population and statistically significantly different from the national average include the following. All are considered adverse:

- **BMI: Morbid/Obese** is 7.6% above average, impacting 32.7% of the population
- **Vigorous Exercise** is 8.6% below average, impacting 52.0% of the population
- **I Am Responsible for My Health** is 5.5% below average, impacting 61.7% of the population
- **I Follow Treatment Recommendations** is 6.5% below average, impacting 48.6% of the population
- **Routine Cholesterol Screening** is 6.2% below average, impacting 47.6% of the population
- **Cervical Cancer Screening** in past two years is 11.8% below average, impacting 52.9% of the population
- **OB/GYN Visit** is 19.1% below average, impacting 37.4% of the population

Metrics impacting more than 30% of the population and statistically significantly different from the national average include the following. All are considered beneficial:

- **Consumed Alcohol in the Past 30 Days** is 18.1% below average, impacting 44.5% of the population

Conclusions from Other Statistical Data

Among the Top 15 Causes of Death in the U.S., 7 of the 15 occurred at expected rates in San Bernardino County. However, **Stroke, Accidents, Kidney Disease, Blood Poisoning,** and **Hypertension** occurred at higher rates than expected, and **Homicide, Suicide,** and **Diabetes** occurred at a lower rate. The Top 10 Causes of Death in San Bernardino County are:

1. **Heart Disease** with San Bernardino ranking #4 among 58 CA counties (where #1 is worst in state)
2. **Cancer** ranking #15 in CA
3. **Lung Disease** ranking #8 in CA
4. **Stroke** ranking #24 in CA
5. **Diabetes** ranking #4 in CA
6. **Accidents** ranking #51 in CA
7. **Alzheimer's** ranking #16 in CA
8. **Flu/Pneumonia** ranking #25 in CA
9. **Liver Disease** ranking #24 in CA
10. **Hypertension** ranking #6 in CA

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 US counties or equivalents applying small area estimation techniques to the most recent county information.

Unfavorable San Bernardino County measures which are *worse than* the US average *and* had an *unfavorable change*:

- **Female Obesity** – As of 2011, 38.8% of females are obese; value increased 7.3 percentage points since 2001

Unfavorable San Bernardino County measures which are *worse than* the US average *but* had a *favorable change*:

- **Female Life Expectancy** – As of 2013, female life expectancy is at 81 years; value increased 3.5 years since 1985
- **Male Life Expectancy** – As of 2013, male life expectancy is at 76.2 years; value increased 5.6 years since 1985

Desirable San Bernardino County measures *better than* the US average *but* had an *unfavorable change*:

- **Female Heavy Drinking** – As of 2012, 5.3% of females are heavy drinkers; value increased 0.4 percentage points since 2005

- **Male Binge Drinking** – As of 2012, 23.7% of males are binge drinkers; value increased 1.2 percentage points since 2002
- **Male Obesity** – As of 2011, 33.6% of males are obese; value increased 6.2 percentage points since 2001

Desirable San Bernardino County measures *better than* the US average *and* had a *favorable change*:

- **Female Smoking** – As of 2012, female smoking is at 14.8%; value decreased 6.1 percentage points since 1996
- **Male Smoking** – As of 2012, male smoking is at 19.9%; value decreased 7.6 percentage points since 1996
- **Male Heavy Drinking** – As of 2012, 9.0% of males are heavy drinkers; value decreased 1.2 percentage points since 2005
- **Female Physical Activity** – As of 2011, physical activity for females is at 55.3%; value increased 9.5 percentage points since 2001
- **Male Physical Activity** – As of 2011, physical activity for males is at 58.3%; value increased 1.8 percentage points since 2001
- **Female Binge Drinking** – As of 2012, 9.4% of females are binge drinkers; value has not changed since 2002

Conclusions from Prior CHNA Implementation Activities

"Community health improvement services" means activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services do not generate inpatient or outpatient revenue, although there may be a nominal patient fee or sliding scale fee for these services.

"Community benefit operations" means:

- *activities associated with community health needs assessments, administration, and*
- *the organization's activities associated with fundraising or grant-writing for community benefit programs.*

Activities or programs cannot be reported if they are provided primarily for marketing purposes or if they are more beneficial to the organization than to the community. For example, the activity or program may not be reported if it is designed primarily to increase referrals of patients with third-party coverage, required for licensure or accreditation, or restricted to individuals affiliated with the organization (employees and physicians of the organization).

To be reported, community need for the activity or program must be established. Community need can be demonstrated through the following:

- A CHNA conducted or accessed by the organization.
- Documentation that demonstrated community need or a request from a public health agency or community group was the basis for initiating or continuing the activity or program.
- The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or program carried out for the express purpose of improving community health.

Community benefit activities or programs also seek to achieve a community benefit objective, including improving access to health services, enhancing public health, advancing increased general knowledge, and relief of a government burden to improve health. This includes activities or programs that do the following:

- Are available broadly to the public and serve low-income consumers.
- Reduce geographic, financial, or cultural barriers to accessing health services, and if they ceased would result in access problems (for example, longer wait times or increased travel distances).
- Address federal, state, or local public health priorities such as eliminating disparities in access to healthcare services or disparities in health status among different populations.
- Leverage or enhance public health department activities such as childhood immunization efforts.
- Otherwise would become the responsibility of government or another tax-exempt organization.
- Advance increased general knowledge through education or research that benefits the public.

EXISTING HEALTHCARE FACILITIES, RESOURCES, & IMPLEMENTATION STRATEGY

Significant Health Needs

We used the priority ranking of area health needs by the Local Expert Advisors to organize the search for locally available resources as well as the response to the needs by BVCH. The following list:

- Identifies the rank order of each identified Significant Need
- Presents the factors considered in developing the ranking
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term
- Identifies BVCH current efforts responding to the need including any written comments received regarding prior BVCH implementation actions
- Establishes the Implementation Strategy programs and resources BVCH will devote to attempt to achieve improvements
- Documents the Leading Indicators BVCH will use to measure progress
- Presents the Lagging Indicators BVCH believes the Leading Indicators will influence in a positive fashion, and
- Presents the locally available resources noted during the development of this report as believed to be currently available to respond to this need.

In general, BVCH is the major hospital in the service area. Bear Valley Community Hospital is a 9-bed, critical access hospital located in Big Bear Lake, California. The next closest facilities are outside the service area and include:

- Mountains Community Hospital in Lake Arrowhead, CA, 28 miles (54 minutes)
- St. Bernardine Medical Center in San Bernardino, CA, 39 miles (63 minutes)
- Community Hospital of San Bernardino in San Bernardino, CA, 43 miles (66 minutes)
- Redlands Community Hospital in Redlands, CA, 42 miles (68 minutes)
- Loma Linda University Medical Center in Loma Linda, CA, 42 miles (69 minutes)
- Desert Valley Hospital in Victorville, CA, 45 miles (83 minutes)

All data items analyzed to determine significant needs are “Lagging Indicators,” measures presenting results after a period of time, characterizing historical performance. Lagging Indicators tell you nothing about how the outcomes were achieved. In contrast, the BVCH Implementation Strategy uses “Leading Indicators.” Leading Indicators anticipate change in the Lagging Indicator. Leading Indicators focus on short-term performance, and if accurately selected, anticipate the broader achievement of desired change in the Lagging Indicator. In the Quorum application, Leading Indicators also must be within the ability of the hospital to influence and measure.

1. **ACCESSIBILITY** – 2013 Significant Need; preventable hospital stays above CA and US average; population to primary care physician ratio worse than CA and US average; used midlevel services 8.8% below average

Public comments received on previously adopted implementation strategy:

- *BVCHD has done very little to address community needs. Many of our employees view the ER as the main priority and therefore we dont need to improve much based on the fact that we are the only ER in the area and people HAVE to come here. I have heard this statement from management as well as employees, which really takes away from quality and pride in what we do. We should want to be the best, and providing the best for our patients, whether they have a choice to come here or not.*
- ** Pediatric dentist for Medi-Cal children * Immunization clinics with no or low cost - Some of our parents with multiple children struggle with costs of immunizations especially since there is no waiver for immunizations for school enrollment as of Jan. 1, 2016. * Spanish language providers - Ensuring that the community knows what services are available and in Spanish is really important since the latest legislation allows for undocumented children to be served. This means communicating to a silent Mexican/Central American population many of whom are not literate in their own language and who are distrustful of any authoritative agency....that's a challenge! * Partner with SB county TAD. It would help families to access Medi-Cal insurance and other supports that families need. We had an office here in 2009-12, when LSS provided offices free of charge for TAD workers to come to Big Bear. It was a great help to families who don't make it off the mountain due to transportation issues. This could also help fill the gap for families who are moving here from off the mountain and find that we have very limited resources compared to what is available off the mountain in urban areas. * Outreach - include flyers in school enrollment packets - what's available and when. Partner with the school district to outreach to our families.*
- *We have been unable to serve the portion of our population that have IEHP medi-cal health plans. I would say I get at least 2 calls a day complaining of changes to health plans and the inability to receive services.*
- *Access to dental care has been a problem since the Rural Health Center closed.*
- *Partner with Medi-Cal HMOs for increased access. Parents don't have to go off the mountain if they belong to an HMO.*
- *House or collaborate with TAD to provide access to these supports in Big Bear. Contract with IEHP for pediatric services.*
- *Unclog the ER*

BVCH services, programs, and resources available to respond to this need include:

- Recruited Primary Care provider for clinic; recruiting additional primary care/family practice providers
- Implemented tele-psychology and tele-psychiatry services
- Vaccines for Children program – provides free/low-cost vaccines to children
- Participate in annual health fair in partnership with local Lion’s Club to provide screenings and education
- FastTrack program within ED to pair lower acuity cases with midlevel providers
- Provide materials in Spanish and provide Spanish interpretation hotline

- Active participant in Hospital Association of Southern California (HASC) to help meet local healthcare needs and address issues

Additionally, BVCH plans to take the following steps to address this need:

- Continue developing agreement with Loma Linda University Medical Center to expand specialty services and provide cross-training for providers
- Upgrading equipment and EHR system in ED to streamline patient flow
- Implementing digital mammography
- Installing new CT scanner
- Looking at adding specialties including general surgery and orthopedics; recruiting for consistent/long-term providers
- Planning to reintroduce dental program through Rural Health Clinic
- Review Private Pay policies for clinic, as well as Financial Assistance Policy and become provider for IEHP
- Explore avenues to expand insurance contracts and keep services local

BVCH evaluation of impact of actions taken since the immediately preceding CHNA:

- Expanded clinic hours to increase access
- Built and opened Brenda Boss Family Resource Center to expand capacity

Anticipated results from BVCH Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency	X	
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate BVCH intended actions is to monitor change in the following Leading Indicator:

- Number of patients seen in ED = 11,184 (7/2015 – 6/2016)
    - Decrease in LWBS = 278 (7/2015 – 6/2016)
- Increase in number patients seen at clinic = 17,939 (7/2015 – 6/2016)

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Population-based Net Physician Need = 47.54 (2016)[17]

BVCH anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Loma Linda University Medical Center	Andrew Hibbert (909) 558-3872	(877) 558-6248 11234 Anderson Street Loma Linda, California 92354 http://medical-center.lomalindahealth.org/
Riverside Community Hospital	Tom Cronin (951) 318-6941	(951) 788-3000 4445 Magnolia Ave, Riverside, CA 92501 www.riversidecommunityhospital.com
Local service organizations (Lion's Club, Rotary, BVCH Auxiliary, BVCHD Foundation, SIBBV)		
Hospital Association of Southern California (HASC)	Jan Remm (951) 222-2284	(213) 347-2002 Manu Life Plaza, 515 S Figueroa St, Los Angeles, CA 90071 www.hasc.org
REACH and Mercy Air (helicopter transport)	Mercy Air: Rock Allen (909) 273-9376 Reach Air: James Cisneros (909) 329-9607	http://www.bigbearchamber.com/Health-Care/Mercy-Air-2152 http://www.bigbearchamber.com/Health-Care/REACH-Air-Medical-Services-2792

[17] See Appendix D. Truven Health Analytics. Net Physician Need by Specialty-Population Based, Big Bear Zip Codes, 2016.

Other local resources identified during the CHNA process that are believed available to respond to this need:

Organization	Contact Name	Contact Information
Mountain Area Regional Transit Authority (MARTA)		(909) 878-5200 41939 Fox Farm Rd, Big Bear Lake, CA 92315 mountaintransit.org/big-bear-routes-and-schedules
Other local physicians		

2. MENTAL HEALTH – 2013 Significant Need; population to mental health provider ratio worse than CA and US average

Public comments received on previously adopted implementation strategy:

- *Partner with DMCC and LSS for collaborative support of a psychiatrist, especially for children. LSS has a psychiatrist for adults, but not for children. This is a barrier if a parent needs to get meds for a child and there is no psychiatrist on the mountain.*
- *if, in fact, we are affiliated with Loma Linda, is there a possibility that we can have better access to 72 hour hold beds? It seems we have more difficulty finding beds for our Mental Health clientele than any other. Some days, I feel like I've gone back to 1970 when I worked at Metropolitan State Hospital doing intakes. We need more and better access to mental health providers.*
- *There needs to be a community effort on mental illness awareness to decrease problems with social stigma.*
- *If we could implement a voucher system at MARTA to help patients with transportation...I believe this would greatly help our attendance. BettyAnn Merrill has already set this up for us, but it has never been approved to be used. Dr. Mueller purchases bus passes for her patients, and it is monitored closely and seems to help the few who need it to attend their weekly appointments.*
- *Could the Hospital partner with Lutheran Social Services to share the cost of a psychiatrist so that we could have med services available for all our mental health clients? Our community doesn't have capacity to meet children and family needs. Anti-Stigma campaign would help enlighten the community about the need for mental health services and access.*
- *Could you contact county Dept. of Behavioral Health or Loma Linda to partner for psychiatrist interns to provide services to our community? The interns need hours and we need services.*
- *I have not seen or heard of any actions that have been taken to improve the situation.*

BVCH services, programs, and resources available to respond to this need include:

- Active participant in Bear Valley Mental Health Alliance to bring together multiple local agencies to address mental health in the community
    - Helped get funding to include case workers on behavioral health calls with the sheriff
- Tele-psychology and tele-psychiatry services provided for adults
- Providing booklets on local resources for mental health and substance abuse

Additionally, BVCH plans to take the following steps to address this need:

- Increase communication and collaboration with all Alliance members
- Continue developing agreement with Loma Linda University Medical Center to expand behavioral health services
- Mental Health First Aid Classes being provided to staff through PRIME Project
- Review additional options for providing transportation services
- Provided matching grant to provide post-partum depression classes as part of MOMs Project (Mothers on Mountains)

BVCH evaluation of impact of actions taken since the immediately preceding CHNA:

- Tele-psychology added

Anticipated results from BVCH Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations		X
4. Enhances public health activities		X
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public		X

The strategy to evaluate BVCH intended actions is to monitor change in the following Leading Indicator:

- Number of tele-psychiatry visits provided = 128 (7/2015 – 6/2016)
- Number of tele-psychology visits provided = 1,154 (7/2015 – 6/2016)

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Number of cases of Depression/Anxiety[18] = 707
- Number of 5150 cases in ED = start tracking in 2016

BVCH anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Hospital Association of Southern California (HASC)	Jan Remm (951) 222-2284	(213) 347-2002 Manu Life Plaza, 515 S Figueroa St, Los Angeles, CA 90071 www.hasc.org

[18] Truven Health Analytics. Estimated 2016 Service Site Utilization by Disease Category, Big Bear Zip Codes, All Ages, 2016.

Organization	Contact Name	Contact Information
Big Bear Mental Health Alliance (LSS, DOVES, Bear Valley Unified School District, Sheriff's Department, Desert Mountain's Children's Collaborative (DMCC), Department of Behavioral Health (DBH))	Eileen Hofer (909) 866-5070	http://bigbearmentalhealthalliance.org/
San Bernardino Sheriff's Department Big Bear Station		(909)866-0100 477 Summit Blvd., Big Bear Lake
Department of Health Care Services (CA) (PRIME Project)	Sheri Mursick (909) 878-8258	http://www.dhcs.ca.gov/provgovpart/Pages/PRIME.aspx
Loma Linda University Medical Center	Andrew Hibbert (909) 558-3872	(877) 558-6248 11234 Anderson Street Loma Linda, California 92354 http://medical-center.lomalindahealth.org/

Other local resources identified during the CHNA process that are believed available to respond to this need:

Organization	Contact Name	Contact Information
Other local physicians		

3. **SUBSTANCE ABUSE** – excessive drinking above CA and US average

Public comments received on previously adopted implementation strategy:

This was not a Significant Need identified in 2013 so no written public comments about this need were solicited

BVCH services, programs, and resources available to respond to this need include:

- Offer chiropractic services in clinic as alternative treatment option for chronic pain
- Collaborate with schools and California Highway Patrol to put on "Every 15 Minutes" to show effects of impaired driving
- Providers have access to CURES program to monitor opioid prescriptions
- Providing booklets on local resources for mental health and substance abuse

Additionally, BVCH plans to take the following steps to address this need:

- Implementing Hospital Association of Southern California's Safe Opioid Prescribing Practices to help manage and control access to narcotics
- Implementing Management of non-malignant Chronic Pain Program (PRIME Project) to encourage use of alternative medicines/modalities to relieve chronic pain
- Expanding chiropractic services in clinic with new provider

Anticipated results from BVCH Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations		X
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate BVCH intended actions is to monitor change in the following Leading Indicator:

- Number of patients participating in PRIME Project = start tracking in 2016

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Age-adjusted ER Rate Due to Alcohol Abuse[19] = 77.9 ER visits/10,000 population 18+ years

BVCH anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Department of Health Care Services (CA) (PRIME Project)	Sheri Mursick (909) 878-8258	http://www.dhcs.ca.gov/provgovpart/Pages/PRIME.aspx
Hospital Association of Southern California (HASC)	Jan Remm (951) 222-2284	(213) 347-2002 Manu Life Plaza, 515 S Figueroa St, Los Angeles, CA 90071 www.hasc.org
Big Bear Mental Health Alliance (LSS, DOVES, Bear Valley Unified School District, Sheriff's Department, Desert Mountain's Children's Collaborative (DMCC), Department of Behavioral Health (DBH))	Eileen Hofer (909) 866-5070	http://bigbearmentalhealthalliance.org/
"Every 15 Minutes" Program	Erin Wilson (909) 878-8220	http://bigbearfire.com/index.php/public-education/school-programs
Local law enforcement agencies		

Other local resources identified during the CHNA process that are believed available to respond to this need:

Organization	Contact Name	Contact Information
Other local physicians		
Local AA Groups		(909)866-2765 http://www.aa.org/pages/en_US/find-aa-resources?zipcode=92315
Al-Anon		(909) 824-1516 1012 E. Cooley Dr., Colton www.cal-inlandempirealanon.org

[19] http://www.healthysanbernardinocounty.org/index.php?module=indicators&controller=index&action=view&indicatorId=128&localeTypeId=3. Average for zip codes 92314, 92315, and 92386; 2012-2014.

Organization	Contact Name	Contact Information
NA Groups		Community Church By The Lake 40946 Big Bear Blvd Big Bear Lake, California 92315

Other Needs Identified During CHNA Process

4. **DIABETES** – 2013 Significant Need
5. **DENTAL**
6. **SOCIAL FACTORS/COMPLIANCE BEHAVIOR** – 2013 Significant Need
7. **AFFORDABILITY**
8. **ACCIDENTS**
9. **OBESITY** – 2013 Significant Need
10. **CANCER**
11. **EDUCATION/PREVENTION**
12. **HEART DISEASE**
13. **ALZHEIMER'S**
14. **HYPERTENSION**
15. **FLU/PNEUMONIA**
16. **STROKE**
17. **LIFE EXPECTANCY**
18. **MATERNAL/INFANT MEASURES**
19. **PHYSICAL INACTIVITY**
20. **LIVER DISEASE**
21. **LUNG DISEASE**
22. **SEXUALLY TRANSMITTED INFECTION**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility

1. Accessibility
2. Mental Health
3. Substance Abuse

Significant needs where hospital did not develop implementation strategy

None

Other needs where hospital developed implementation strategy

None

Other needs where hospital did not develop implementation strategy

4. Diabetes
5. Dental
6. Social Factors/Compliance Behavior
7. Affordability
8. Accidents
9. Obesity
10. Cancer
11. Education/Prevention
12. Heart Disease
13. Alzheimer's
14. Hypertension
15. Flu/Pneumonia
16. Stroke
17. Life Expectancy
18. Maternal/Infant Measures

19. Physical Inactivity
20. Liver Disease
21. Lung Disease
22. Sexually Transmitted Infection

APPENDIX

Appendix A – Written Commentary on Prior CHNA

Hospital solicited written comments about its 2013 CHNA. 14 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

1. **Please indicate which (if any) of the following characteristics apply to you. If none of the following choices apply to you, skip the indication and please continue to the next question.**

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	3	7	10
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	7	4	11
3) Priority Populations	7	4	11
4) Representative/Member of Chronic Disease Group or Organization	1	8	9
5) Represents the Broad Interest of the Community	10	2	12
Other			
Answered Question			13
Skipped Question			1

- **Within the county, do you perceive the local Priority Populations to have any unique needs, as well as potential unique health issues needing attention? If you believe any situation as described exists, please also indicate who you think needs to do what.**
    - *Yes, many of these populations exist in our community and their needs are like any research will tell you about residents of rural communities. There is alack of education, lack of services and lack of access.*
    - *All of these populations exist in our community, but I can only speak to what I know in my role in the school district's support services. We have a growing population of HIspanics, many coming from Mexico with limited English. This population needs to have access to Spanish language services, especially for children's medical care. We also have seen an influx of low income families from urban areas in our district. Their urban culture is different from our rural culture and ensuring that their Medi-Cal and other government supports are transfered are difficult to shift when we have no county TAD office to help with this. As a result, these families have gaps in their aid and supports. We anticipate more families accessing the ER or not getting medical care because of the lapse in services. As our society becomes more inclusive of LGBT population, we have seen an increase in LGBT people in our community. Their specific needs will need to be identified and met.*
    - *Almost if not all are reflected in our community. Low-income, older adult, rural, special needs, LGBT are definitely reflected in our community.*
    - *Yes, the racial and ethnic minority groups, particularly Hispanic minority groups are part of the priority population in our area. The State of California and the County of San Bernardino are currently addressing this population. Senate Bill AB75 focuses on the medical needs of children between ages 0-19 and the DACA and DAPA Acts are also being addressed.*

- *I serve as the school district nurse in Big Bear. The district has a large percentage of students from low income families. Many of these students come from homes where the parents have mental illness or substance use problems. Access to local dentists who take children with Medi-Cal is lacking. I also see a number of neglect issues that are reported but dismissed by CPS.*
- *Our priority populations in BVUSD are low income children needing Medi-Cal covered health, mental health and dental services.*
- *Our rural community has a high poverty level, so Medi-Cal services for children and adults is very important. Health, dental and pediatric services are important. Because our community lacks many county services - no Transitional Assistance Department (TAD) is particulary problematic. In 2009 - 12 TAD had a presence in the community with a collaboration with LSS. They left when LSS couldn't provide the space. If the Healthcare District could provide space to TAD staff in the same way as WIC, we could have residents access food stamps, cash aide and Medi-Cal assistance, increasing local access to supports that could be used at Healthcare facilities. Another point of access would be to contract with IEHP for pediatric services provided on the mountain. Many families can't get their children to IEHP providers off the mountain and children suffer. This would increase patients at the clinic versus the ER.*
- *Large percentage of latinos, a number of undocumented workers, possibly no vaccinations. Mental health is not served. Those needing dialysis cannot be served. There is also a need for oxygen therapy because of the altitude we are at and the need for a full time cardiologist.*
- *We have unique needs for older adults, and residents of rural area. Also we have unique needs for urgent care for the traveling public that visit to our remote area.*
- *mental health and specialty care - such limited resources in Big Bear Valley*
- *Access to healthcare through insurance. People living below poverty level can't afford the insurance or the medical care. Dental needs are very high for children and adults in the Big Bear community. There is only one Medi-Cal dentist for children and none for adults. School screenings have found 1/4 of students needing urgent dental care. It also takes a long time to get on Medi-Cal and immunization noncompliant students are told they can't receive vaccines until their Medi-Cal coverage is effective. That's what vaccines for children is supposed to cover but the hospital clinic turns these families away until their Medi-Cal is active. Mental health and drug rehabilitation services are also greatly needed here. Many families don't have transportation to go off mountain so they don't get the mental health care they need. Many children with asthma don't have adequate plans or education about the condition. The school nurse needs to know the severity to effectively monitor and treat in creating health care plans for school.*

2. **In the last process, several data sets were examined and a group of local people were involved in advising the Hospital. While multiple needs emerged, the Hospital had to determine what issues were of high priority and where it would be a valuable resource to assist in obtaining improvements.**

   Priorities from the last assessment where the Hospital intended to seek improvement were:

   - Accessibility
   - Diabetes
   - Obesity

- Social Factors/Compliance Behavior
- Mental Health

Comments or observations about this set of needs being the most appropriate for the Hospital to take on in seeking improvements?

BVCH received the following **verbatim** responses to the question: "*Comments or observations about this set of needs as being the most appropriate for the Hospital to take on in seeking improvements?"*

- **Should the Hospital continue to consider each need identified as most important in the 2013 CHNA report as the most important set of health needs currently confronting residents in the county?**

	Yes	No	No Opinion
Accessibility	12	0	0
Diabetes	9	1	2
Obesity	9	0	3
Social Factors/Compliance Behavior	10	1	1
Mental Health	12	0	0

- **Specific comments or observations about <u>Accessibility</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
    - *Mental Health and Social and Health behaviors need to be a top priority. If we are to look at emerging research and the idea of an "up Stream" approach, then we need to start looking at where health happens. We can address a diabetes program, but unless we address mental and social health, we will continue to be treating disease rather than preventing it.*
    - *Access to care for low income families: 72% district wide poverty (based upon free/reduced meal enrollment) 84% elementary school child poverty (based upon free/reduced meal program enrollment) Increase in Hispanic population and legislation that Medi-Cal is available to undocumented children.*
    - *Again, I would like the District to look into obtaining a contract with IEHP at the clinic.*
    - *The community needs more dentists who take patients on Medi-Cal. There are no dentists in Big Bear who take adult patients with Medi-Cal insurance and only one dentist that accepts children with Medi-Cal. Children need the example of good dental hygiene from a parent.*
    - *1, 2 & 5 I believe are the most important here in our community. I also believe that if you deal with Access to Care, 2DM & Mental Health; Obesity and Social/Health Behaviors will be dealt with as a result.*
    - *Increased access to care could be improved with partnering with IEHP for pediatric services. Medi-cal dental services are needed as well.*
    - *It is the most important focus of the Healthcare District*
    - *I do not see access to care as the duty of a local hospital. There is an Urgent Care in the local area.*
    - *yes. Mandatory insurance and poverty in rural communities causes people to choose insurance plans that don't meet their needs. They end up paying for insurance they can't make use of. They then use expensive emergency room care because their pcp is off mountain.*

- **Specific comments or observations about <u>Diabetes</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
    - *Invest in preventative care... invest in education and strategies to improve quality of life, rather then continuing to treat the ailment, maybe look at our population, our needs and how to properly address those needs based on other best practices, and models rather than continuing to do things the same over and over with little to no outcomes.*
    - *Diabetic supplies are very costly. Those community members who have benefits usually have copayments or reach the donut hole where benefits may not be covered. I think through support groups and education, we might better serve our community. I do think Heritage does provide some services, but what about BVCHD?*
    - *Endocrinology could be done via Telehealth to help with provider retention and to keep patient's who already have transportation issues on the mountain for care; it would also help to keep revenue within the district. WIN - WIN - WIN*
    - *Determine if the cost of diabetic supplies is a barrier to managing the disease. Is there assistance for patients that need financial help with costs? Are there discounts available for these patients?*
    - *Don't be so reactive. There was a diabetes clinic at the Chamber which closed due to lack of interest. Concentrate on preventative actions.*
    - *Luckily their aren't many children in our community with type 1 diabetes. But I see many overweight children in school who need to be monitored for pre type 2 diabetes.*
- **Specific comments or observations about <u>Obesity</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
    - *Education and alternative options. I think our dietary staff has been trying to provide the alternative healthy food choices. But let me say, I like the unhealthy options because they are so tasty.*
    - *Important.*
- **Specific comments or observations about <u>Social Factors/Compliance Behavior</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
    - *Our smoking in front of the patients doesn't really set much of an example. I think making this a Smoke Free Campus moved us in the right direction but I always smell cigarette smoke and see people smoking around the hospital. Some people put it out when I mention the signs or comment about our guidelines, others are upset and it's difficult to enforce.*
    - *It is hard for a hospital to change a community's eating habits, especially when fast food is on every corner and its cheap. Promoting good eating habits through community gardens or school garden movements needs dedicated staff at the hospital and in the community to partner....not sure how this can be accomplished at this time.*
    - *I don't believe social behavior is the right space for the Hospital to be in.*
- **Specific comments or observations about <u>Mental Health</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

- *Since the Hospital added telemedicine to their list of services, this may be an opportunity for some of your mental health clients access psychiatrist services.*
- *Our society must get our arms around our mental health issues. Big Bear has the same need as does every where else.*
- *I see this daily. There just isn't enough help for people with mental illness. I don't think this is because of our facility, I see it overall.*
- *We already have an incredible mental health program at the clinic.*
- *We have a high number of chronically mentally ill adults and a high rate of onset of mental illness in our children due to poverty, domestic violence and drug/alcohol use. The need for trained psychiatrists for these populations and access to meds would be a great step in meeting this population's needs.*
- *Having Telemedicine is a good step forward for increased access to mental health services. Could you collaborate with other mental health providers to hire a psychiatrist for Big Bear? At LSS and DMCC children have limited access to psychiatrist for medications. This is creating a HUGE issue with children with behavioral problems.*
- *There is a distinct lack of assistance for the mentally ill.*

3. Comments and observations about the implementation actions of the Hospital to seek health status improvement?

- **Should the Hospital continue to allocate resources to assist improving the needs?**

	Yes	No	No Opinion
Accessibility	12	0	0
Diabetes	8	1	3
Obesity	8	0	4
Social Factors/Compliance Behavior	8	1	3
Mental Health	12	0	0

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in Accessibility?**
  - *BVCHD has done very little to address community needs. Many of our employees view the ER as the main priority and therefore we dont need to improve much based on the fact that we are the only ER in the area and people HAVE to come here. I have heard this statement from management as well as employees, which really takes away from quality and pride in what we do. We should want to be the best, and providing the best for our patients, whether they have a choice to come here or not.*
  - ** Pediatric dentist for Medi-Cal children * Immunization clinics with no or low cost - Some of our parents with multiple children struggle with costs of immunizations especially since there is no waiver for immunizations for school enrollment as of Jan. 1, 2016. * Spanish language providers - Ensuring that the community knows what services are available and in Spanish is really important since the latest legislation allows for undocumented children to be served. This means communicating to a silent Mexican/Central American population many of whom are not literate in their own language and who are distrustful of any authoritative agency....that's a challenge! * Partner with SB county TAD. It would help*

*families to access Medi-Cal insurance and other supports that families need. We had an office here in 2009-12, when LSS provided offices free of charge for TAD workers to come to Big Bear. It was a great help to families who don't make it off the mountain due to transportation issues. This could also help fill the gap for families who are moving here from off the mountain and find that we have very limited resources compared to what is available off the mountain in urban areas. * Outreach - include flyers in school enrollment packets - what's available and when. Partner with the school district to outreach to our families.*

- *We have been unable to serve the portion of our population that have IEHP medi-cal health plans. I would say I get at least 2 calls a day complaining of changes to health plans and the inability to receive services.*
- *Access to dental care has been a problem since the Rural Health Center closed.*
- *Partner with Medi-Cal HMOs for increased access. Parents don't have to go off the mountain if they belong to an HMO.*
- *House or collaborate with TAD to provide access to these supports in Big Bear. Contract with IEHP for pediatric services.*
- *Unclog the ER*

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in Diabetes?**
  - *Those who purchase benefits may purchase plans with high deductible, then find they can't afford their medications and supplies (strips and insulin). They don't regularly test, then they go to the ED where they hope to get supplies. People do not always understand that the Emergency Room is not a primary care provider. I try to give patients access to manufacturers who will assist in the cost of supplies.*
  - *I would not use hospital funds for this.*
  - *Just that families have to travel to Loma linda to see their specialist which takes the child out of school a full day for an appointment. Our schools depend on attendance for funding. The less money the district has the more people leave the community for better education and services.*
- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in Obesity?**
  - *Unfortunately, the fruits and vegetables have gone up significantly in price. Many of the Food Banks provide foods that fill the tummy but also fill the gut. It isn't always about the most healthy alternatives. Donations are generally carbohydrates, they are easy to store, less costly, and don't require refrigeration. They don't spoil quickly.*
  - *Lobby the City to prevent any more fast food businesses from starting up.*
- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in Social Factors/Compliance Behavior?**
  - *I believe we need to keep an open door policy and be accessible to our community. I do strive to practice what I preach, hopefully providing an example of being here to help.*

- *Health behavior is where preventative measures can take place. Do you serve or do you lead?*

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in Mental Health?**
  - *Partner with DMCC and LSS for collaborative support of a psychiatrist, especially for children. LSS has a psychiatrist for adults, but not for children. This is a barrier if a parent needs to get meds for a child and there is no psychiatrist on the mountain.*
  - *if, in fact, we are affiliated with Loma Linda, is there a possibility that we can have better access to 72 hour hold beds? It seems we have more difficulty finding beds for our Mental Health clientele than any other. Some days, I feel like I've gone back to 1970 when I worked at Metropolitan State Hospital doing intakes. We need more and better access to mental health providers.*
  - *There needs to be a community effort on mental illness awareness to decrease problems with social stigma.*
  - *If we could implement a voucher system at MARTA to help patients with transportation...I believe this would greatly help our attendance. BettyAnn Merrill has already set this up for us, but it has never been approved to be used. Dr. Mueller purchases bus passes for her patients, and it is monitored closely and seems to help the few who need it to attend their weekly appointments.*
  - *Could the Hospital partner with Lutheran Social Services to share the cost of a psychiatrist so that we could have med services available for all our mental health clients? Our community doesn't have capacity to meet children and family needs. Anti-Stigma campaign would help enlighten the community about the need for mental health services and access.*
  - *Could you contact county Dept. of Behavioral Health or Loma Linda to partner for psychiatrist interns to provide services to our community? The interns need hours and we need services.*
  - *I have not seen or heard of any actions that have been taken to improve the situation.*

- **Do you have opinions about new or additional implementation efforts or community needs the Hospital should pursue?**
  - *I think the partnership with TAD would be a good start that would meet a variety of populations' needs.*
  - *Partnering with Loma Linda in offering High Altitude Training. This segment in our valley is growing and in the long run the hospital needs to provide the medial foundation for the training. I suggest we analyse what is needed and start slowly with the most important components. Over time as Big Bear grows and matures, we will need to have a facility in place to accommodate the athletes who live here and come here to compete and train.*
  - *Yes, I believe we need to seriously revisit Dental Health Services. I was saddened by the closure of our Rural Health Dental Clinic and believe there are ways to make it work, once again.*
  - *Could the HealthCare District partner with the school district for immunization clinics? With new state and federal immunization requirements, many children are not getting their immunizations in a timely nor low cost manner.*
  - *Adult Medi-Cal services. Contract with IEHP to increase child access to medical services*

- *Preventative Care such as: diagnostics, vaccinations, weight loss clinic, cardio stress tests. Dialysis Oxegen Therapy*
- *no*

- **Finally, after thinking about our questions and the information we seek, is there anything else you think important as we review and revise our thinking about significant health needs within the county?**
  - *I think you need to look more at the people doing the work, ask them what they are seeing, get them training to help people and to be able to implement appropriate programs that have positive outcomes.*
  - *Thank you for the survey!*
  - *First and foremost, administration stability! Commitment to Big Bear Valley and looking at the long range vision of what is needed in our community is uppermost of importance. Until our community has that level of commitment from the CEO of our hospital, we will continue to churn and tread water. I'm desiring for our hospital to be looking to the future with consistency, vision and energy!*
  - *I really think we've been focused on the low income, indigent; I'm worried about the people who work hard to get help then find they have done better and are no longer eligible for the help they were getting. We are almost making it impossible for people to earn a decent income because it then affects their ability to get low cost help.*
  - *Participation is a problem in our community. Offering programs to help people who don't recognize or acknowledge their own mental health or substance use problems can seem like a waste of resources but this is the root of the issue that needs addressed.*
  - *The Hospital does a great job in our small community. Collaboration and partnerships would help to reduce the disparity in access and services...start with the agencies we currently have and work with them to ensure that all children and adults have health, mental health and dental services to be prosperous in our community.*
  - *I would be interested in contributing to your strategic planning process.*
  - *Get more beds and stop using the hospital as a senior care facility.*

Appendix B – Identification & Prioritization of Community Needs

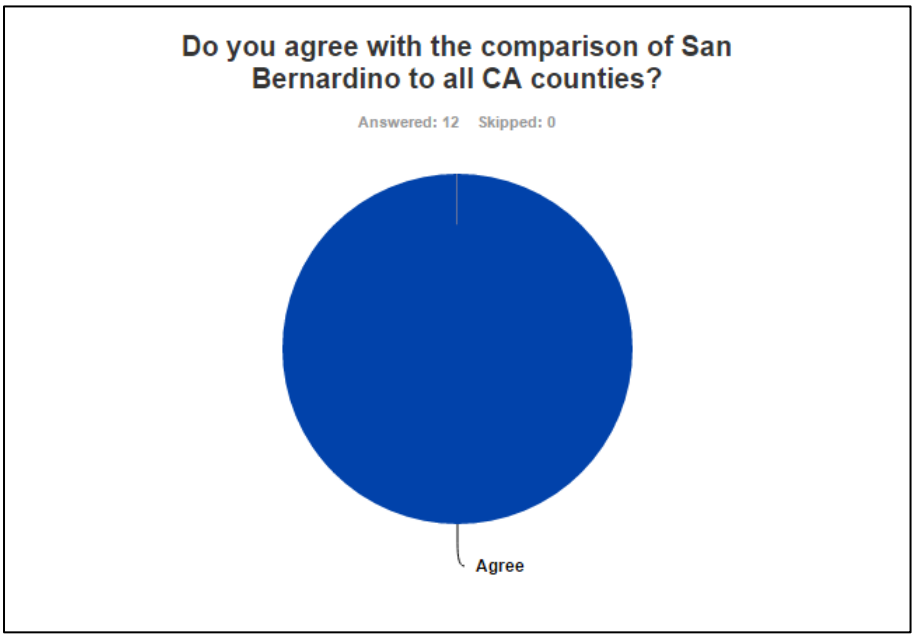
Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Accessibility - 2013 Significant Need	260	9	26.00%	26.00%	Significant Needs
Mental Health - 2013 Significant Need	173	8	17.30%	43.30%	
Substance Abuse	155	1	15.50%	58.80%	
Diabetes - 2013 Significant Need	58	5	5.80%	64.60%	Other Identified Needs
Dental	58	6	5.80%	70.40%	
Social Factors/Compliance Behavior - 2013 Significant Need	56	4	5.60%	76.00%	
Affordability	53	4	5.30%	81.30%	
Accidents	36	2	3.60%	84.90%	
Obesity - 2013 Significant Need	25	3	2.50%	87.40%	
Cancer	20	3	2.00%	89.40%	
Education/Prevention	20	3	2.00%	91.40%	
Heart Disease	20	3	2.00%	93.40%	
Alzheimer's	17	3	1.70%	95.10%	
Hypertension	10	2	1.00%	96.10%	
Flu/Pneumonia	8	2	0.80%	96.90%	
Stroke	7	5	0.70%	97.60%	
Life Expectancy	5	1	0.50%	98.10%	
Maternal/Infant Measures	5	1	0.50%	98.60%	
Physical Inactivity	5	1	0.50%	99.10%	
Liver Disease	3	1	0.30%	99.40%	
Lung Disease	3	1	0.30%	99.70%	
Sexually Transmitted Infection	3	2	0.30%	100.00%	
Total	1000		100.00%		

Individuals Participating as Local Expert Advisors

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	3	5	8
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	4	3	7
3) Priority Populations	6	2	8
4) Representative/Member of Chronic Disease Group or Organization	1	6	7
5) Represents the Broad Interest of the Community	8	2	10
Other			
Answered Question			12
Skipped Question			0

Advice Received from Local Expert Advisors

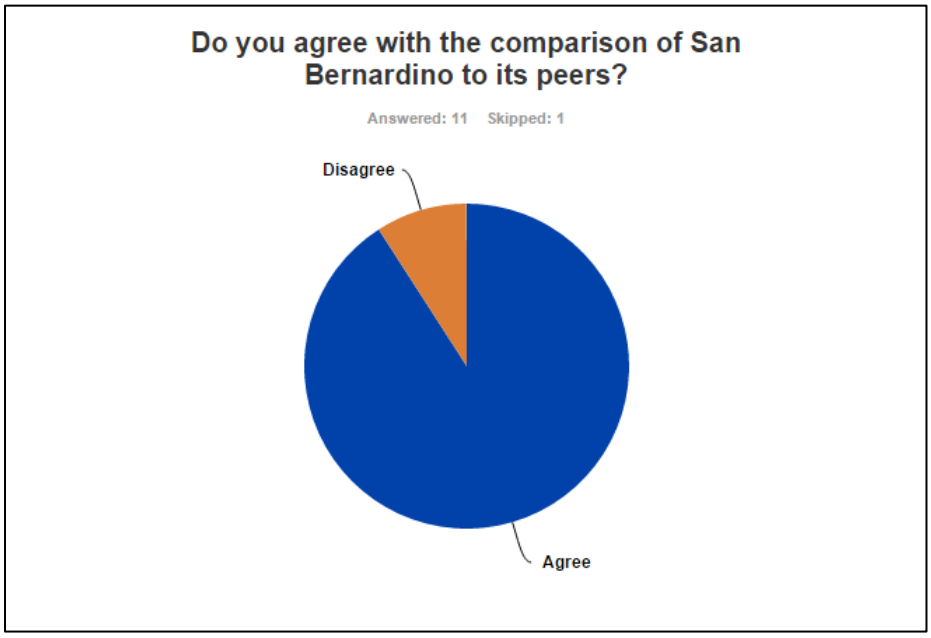
Question: Do you agree with the observations formed about the comparison of San Bernardino to all other California counties?



Comments:

- *We are the largest county serving much of the rural population of the state. Many families do not have the resources to get care, even when they qualify for government assistance. Food banks are rich in carbohydrates, inexpensive bulk items to feed the hungry, not necessarily geared to health.*

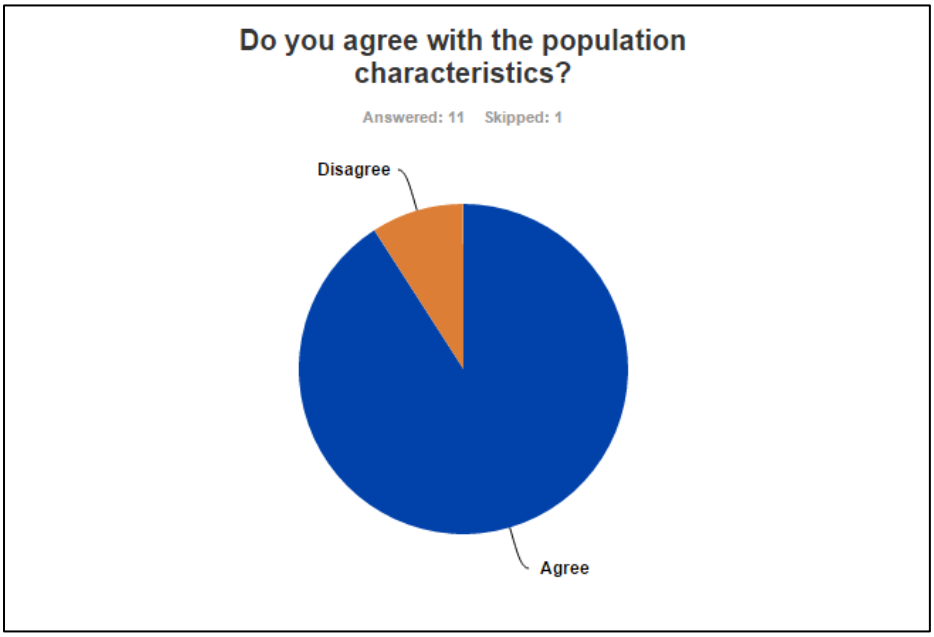
Question: Do you agree with the observations formed about the comparison of San Bernardino County to its peer counties?



Comments:

- *Many children are raised in an environment where prevention is not stressed. Due to lower economic concerns, families often react to an emergency rather than be proactive, working toward prevention of ailments. This is more costly, but they then come to me and say they can't afford whatever it is that is needed. There is a need to make choices based on costs rather than health.*
- *Air Quality in Big Bear cannot be lumped in with the whole county*
- *These statistics are based on adults...the stats for children are worse for those in poverty who need health, mental health and dental access.*

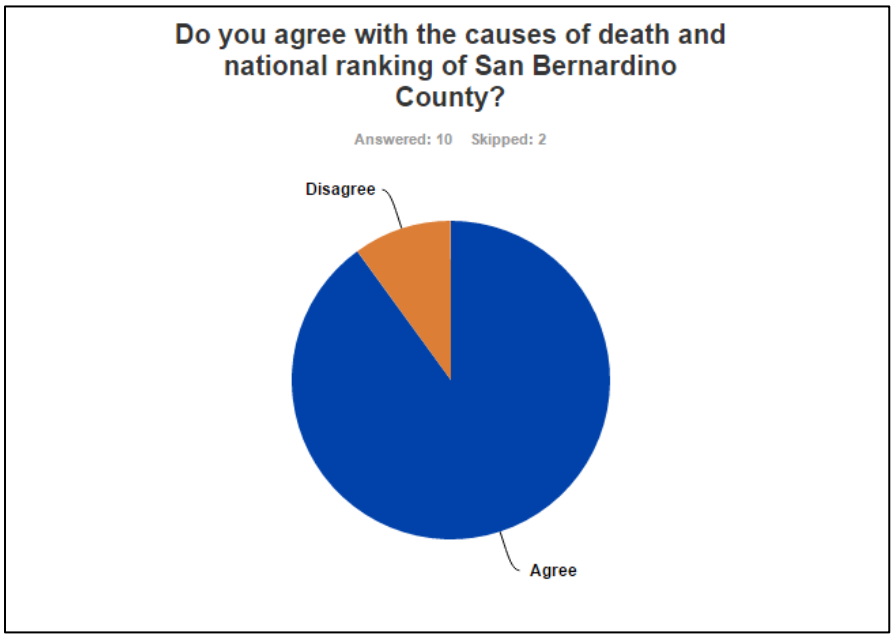
Question: Do you agree with the observations formed about the population characteristics of San Bernardino County?



Comments:

- *I agree with all but the final beneficial health characteristics impacting the population. I believe the emergency room is unfortunately abused as a primary care provider, alcohol is consumed regularly (unless a glass of wine at night is considered medical and not social), and I believe the pain medications are received regularly but the diabetic prescriptions are not filled as ordered.*
- *Additional data on youth health trends can be found through the bi-annual California Healthy Kids Survey (CHKS - grades 5, 7, 9, 11) conducted in 2015-16. Bear Valley youth indicated easy access to alcohol and marijuana, a substantial number using alcohol or binge drinking and a high rate of hopelessness/ suicide ideation. The CHKS reports can be accessed through the school district office and would be helpful in focusing on the drug treatment and mental health issues that the Healthcare district is researching.*

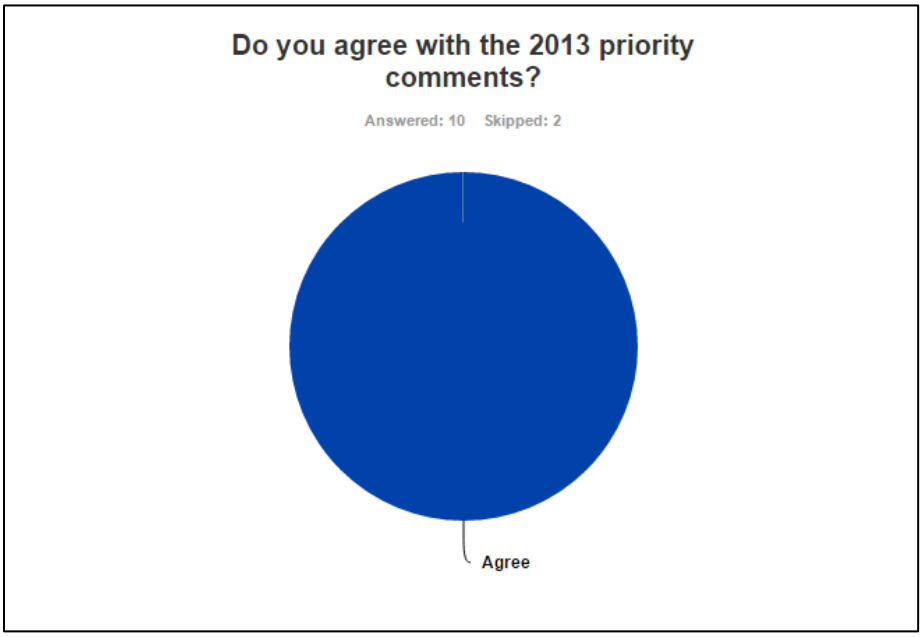
Question: Do you agree with the observations formed from the national ranking and leading causes of death?



Comments:

- *Perhaps I disagree with the terms desirable and undesirable. I think an unfavorable change is not seen in a positive light. I have space here so want to note the correlation between heart disease and dental disease. We need to see the body as a whole, it's difficult to divide when all conditions are interlinked.*

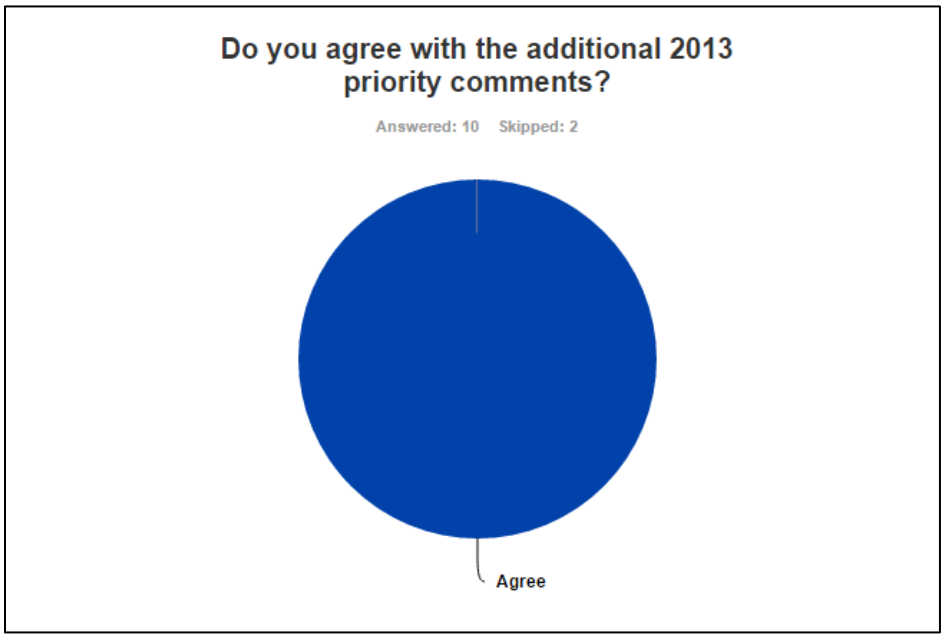
Question: Do you agree with the written comments received on the 2013 CHNA?



Comments:

- *More low income housing and substance abuse and recovery programs are needed.*
- *I believe we need to reinstate the support groups that were once available to our community. These services may be offered by some health plans but would then eliminate people who do not have that coverage. We used to provide immunization clinics for the community during school break. The school nurse was involved, as was the clinic. Physicals were offered at a nominal fee. Yes, to IEHP at the clinic level.*
- *For children: Access to health care, immunizations, dental services and mental health services - IEHP partnership would be advantageous for those with Medi-Cal HMOs. Partnering with TAD would help non-insured get insured....though the ACA has disenfranchised many working poor with LESS coverage than previously, especially for young parents. Their children are covered by Medi-Cal, but they aren't, and many providers no longer take Medi-Cal lessening the options for parents of children. High Altitude Training may be a bonus way to get funding into the Healthcare district, but isn't a community need. It's for elite sport participants...not your poor or average child/parent.*

Question: Do you agree with the additional written comments received on the 2013 CHNA?



Comments:

- *We must keep in mind that we are here to serve our community. These are our friends, neighbors, and family. And our clinic is a clinic, here to serve everyone. We are not the private practice office for our providers. We need to see patients because they are coming here for services. Yes, certain concerns should be scheduled, but not everyone should have to wait until a provider chooses to see them.*

Appendix C – National Healthcare Quality and Disparities Reports

The National Healthcare Quality and Disparities Reports (QDR) are annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129). These reports provide a comprehensive overview of the quality of healthcare received by the general U.S. population and disparities in care experienced by different racial, ethnic, and socioeconomic groups. The purpose of the reports is to assess the performance of our health system and to identify areas of strengths and weaknesses in the healthcare system along three main axes: access to healthcare, quality of healthcare, and priorities of the National Quality Strategy (NQS).

The reports are based on more than 250 measures of quality and disparities covering a broad array of healthcare services and settings. Data is generally available through 2012, although rates of un-insurance have been tracked through the first half of 2014. The reports are produced with the help of an Interagency Work Group led by the Agency for Healthcare Research and Quality (AHRQ) and submitted on behalf of the Secretary of Health and Human Services (HHS).

Beginning with this 2014 report, findings on healthcare quality and healthcare disparities are integrated into a single document. This new National Healthcare Quality and Disparities Report (QDR) highlights the importance of examining quality and disparities together to gain a complete picture of healthcare. This document is also shorter and focuses on summarizing information over the many measures that are tracked; information on individual measures will still be available through chartbooks posted on the Web (www.ahrq.gov/research/findings/nhqrdr/2014chartbooks/).

The key findings of the 2014 QDR are organized around three axes: access to healthcare, quality of healthcare, and NQS priorities.

To obtain high-quality care, Americans must first gain entry into the healthcare system. Measures of access to care tracked in the QDR include having health insurance, having a usual source of care, encountering difficulties when seeking care, and receiving care as soon as wanted. Historically, Americans have experienced variable access to care based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, and residence location.

ACCESS: After years without improvement, the rate of un-insurance among adults ages 18-64 decreased substantially during the first half of 2014.

The Affordable Care Act is the most far-reaching effort to improve access to care since the enactment of Medicare and Medicaid in 1965. Provisions to increase health insurance options for young adults, early retirees, and Americans with pre-existing conditions were implemented in 2010. Open enrollment in health insurance marketplaces began in October 2013 and coverage began in January 2014. Expanded access to Medicaid in many states began in January 2014, although a few had opted to expand Medicaid earlier.

Trends

- From 2000 to 2010, the percentage of adults ages 18-64 who reported they were without health insurance coverage at the time of interview increased from 18.7% to 22.3%.
- From 2010 to 2013, the percentage without health insurance decreased from 22.3% to 20.4%.
- During the first half of 2014, the percentage without health insurance decreased to 15.6%.

- Data from the Gallup-Healthways Well-Being Index indicate that the percentage of adults without health insurance continued to decrease through the end of 2014,[20] consistent with these trends.

ACCESS: Between 2002 and 2012, access to health care improved for children but was unchanged or significantly worse for adults.

Trends

- From 2002 to 2012, the percentage of people who were able to get care and appointments as soon as wanted improved for children but did not improve for adults ages 18-64.

Disparities

- Children with only Medicaid or CHIP coverage were less likely to get care as soon as wanted compared with children with any private insurance in almost all years.
- Adults ages 18-64 who were uninsured or had only Medicaid coverage were less likely to get care as soon as wanted compared with adults with any private insurance in all years.

Trends

- Through 2012, most access measures improved for children. The median change was 5% per year.
- Few access measures improved substantially among adults. The median change was zero.

ACCESS DISPARITIES: During the first half of 2014, declines in rates of un-insurance were larger among Black and Hispanic adults ages 18-64 than among Whites, but racial differences in rates remained.

Trends

- Historically, Blacks and Hispanics have had higher rates of un-insurance than Whites.[21]

Disparities

- During the first half of 2014, the percentage of adults ages 18-64 without health insurance decreased more quickly among Blacks and Hispanics than Whites, but differences in un-insurance rates between groups remained.
- Data from the Urban Institute's Health Reform Monitoring System indicate that between September 2013 and September 2014, the percentage of Hispanic and non-White non-Hispanic adults ages 18-64 without health insurance decreased to a larger degree in states that expanded Medicaid under the Affordable Care Act than in states that did not expand Medicaid.[22]

ACCESS DISPARITIES: In 2012, disparities were observed across a broad spectrum of access measures. People in poor households experienced the largest number of disparities, followed by Hispanics and Blacks.

Disparities

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[20] Levy J. In U.S., Uninsured Rate Sinks to 12.9%. http://www.gallup.com/poll/180425/uninsured-rate-sinks. aspx.

[21] In this report, racial groups such as Blacks and Whites are non-Hispanic, and Hispanics include all races.

[22] Long SK, Karpman M, Shartzer A, et al. Taking Stock: Health Insurance Coverage under the ACA as of September 2014. http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of- September-2014.html

- In 2012, people in poor households had worse access to care than people in high-income households on all access measures (green).
- Blacks had worse access to care than Whites for about half of access measures.
- Hispanics had worse access to care than Whites for two-thirds of access measures.
- Asians and American Indians and Alaska Natives had worse access to care than Whites for about one-third of access measures.

ACCESS DISPARITIES: Through 2012, across a broad spectrum of access measures, some disparities were reduced but most did not improve.

Disparity Trends

- Through 2012, most disparities in access to care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.
- I n four of the five comparisons shown above, the number of disparities that were improving (black) exceeded the number of disparities that were getting worse (green).

QUALITY: Quality of health care improved generally through 2012, but the pace of improvement varied by measure.

Trends

- Through 2012, across a broad spectrum of measures of health care quality, 60% showed improvement (black).
- Almost all measures of Person-Centered Care improved.
- About half of measures of Effective Treatment, Healthy Living, and Patient Safety improved.
- There are insufficient numbers of reliable measures of Care Coordination and Care Affordability to summarize in this way.

QUALITY: Through 2012, the pace of improvement varied across NQS priorities.

Trends

- Through 2012, quality of health care improved steadily but the median pace of change varied across NQS priorities:
  - Median change in quality was 3.6% per year among measures of Patient Safety.
  - Median improvement in quality was 2.9% per year among measures of Person-Centered Care.
  - Median improvement in quality was 1.7% per year among measures of Effective Treatment.
  - Median improvement in quality was 1.1% per year among measures of Healthy Living.
  - There were insufficient data to assess Care Coordination and Care Affordability.

QUALITY: Publicly reported CMS measures were much more likely than measures reported by other sources to achieve high levels of performance.

Achieved Success

Eleven quality measures achieved an overall performance level of 95% or better this year. At this level, additional improvement is limited, so these measures are no longer reported in the QDR. Of measures that achieved an overall performance level of 95% or better this year, seven were publicly reported by CMS on the Hospital Compare website (italic).

- *Hospital patients with heart attack given percutaneous coronary intervention within 90 minutes*
- Adults with HIV and CD4 cell count of 350 or less who received highly active antiretroviral therapy during the year
- *Hospital patients with pneumonia who had blood cultures before antibiotics were administered*
- *Hospital patients age 65+ with pneumonia who received pneumococcal screening or vaccination*
- *Hospital patients age 50+ with pneumonia who received influenza screening or vaccination*
- *Hospital patients with heart failure and left ventricular systolic dysfunction who were prescribed angiotensin-converting enzyme or angiotensin receptor blocker at discharge*
- *Hospital patients with pneumonia who received the initial antibiotic dose consistent with current recommendations*
- *Hospital patients with pneumonia who received the initial antibiotic dose within 6 hours of arrival*
- Adults with HIV and CD4 cell counts of 200 or less who received Pneumocystis pneumonia prophylaxis during the year
- People with a usual source of care for whom health care providers explained and provided all treatment options
- Hospice patients who received the right amount of medicine for pain management

Last year, 14 of 16 quality measures that achieved an overall performance level of 95% or better were publicly reported by CMS. Measures that reach 95% and are no longer reported in the QDR continue to be monitored when data is available to ensure that they do not fall below 95%.

Improving Quickly

Through 2012, a number of measures showed rapid improvement, defined as an average annual rate of change greater than 10% per year. Of these measures that improved quickly, four are adolescent vaccination measures (italic).

- *Adolescents ages 16-17 years who received 1 or more doses of tetanus-diphtheria-acellular pertussis vaccine*
- *Adolescents ages 13-15 years who received 1 or more doses of tetanus-diphtheria-acellular pertussis vaccine*
- Hospital patients with heart failure who were given complete written discharge instructions
- *Adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine*
- *Adolescents ages 13-15 years who received 1 or more doses of meningococcal conjugate vaccine*
- Patients with colon cancer who received surgical resection that included 12+ lymph nodes pathologically examined
- Central line-associated bloodstream infection per 1,000 medical and surgical discharges, age 18+ or obstetric admissions

- Women with Stage I-IIb breast cancer who received axillary node dissection or sentinel lymph node biopsy at time of surgery

Worsening

Through 2012, a number of measures showed worsening quality. Of these measures that showed declines in quality, three track chronic diseases (italic). Note that these declines occurred prior to implementation of most of the health insurance expansions included in the Affordable Care Act.

- Maternal deaths per 100,000 live births
- Children ages 19-35 months who received 3 or more doses of Haemophilus influenzae type b vaccine
- People who indicate a financial or insurance reason for not having a usual source of care
- Suicide deaths per 100,000 population
- Women ages 21-65 who received a Pap smear in the last 3 years
- *Admissions with diabetes with short-term complications per 100,000 population, age 18+*
- *Adults age 40+ with diagnosed diabetes who had their feet checked for sores or irritation in the calendar year*
- Women ages 50-74 who received a mammogram in the last 2 years
- Postoperative physiologic and metabolic derangements per 1,000 elective-surgery admissions, age 18+
- *People with current asthma who are now taking preventive medicine daily or almost daily*
- People unable to get or delayed in getting needed medical care, dental care, or prescription medicines due to financial or insurance reasons

QUALITY DISPARITIES: Disparities remained prevalent across a broad spectrum of quality measures. People in poor households experienced the largest number of disparities, followed by Blacks and Hispanics.

Disparities

- People in poor households received worse care than people in high-income households on more than half of quality measures (green).
- Blacks received worse care than Whites for about one-third of quality measures.
- Hispanics, American Indians and Alaska Natives, and Asians received worse care than Whites for some quality measures and better care for some measures.
- For each group, disparities in quality of care are similar to disparities in access to care, although access problems are more common than quality problems.

QUALITY DISPARITIES: Through 2012, some disparities were getting smaller but most were not improving across a broad spectrum of quality measures.

Disparity Trends

- Through 2012, most disparities in quality of care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.

- When changes in disparities occurred, measures of disparities were more likely to show improvement (black) than decline (green). However, for people in poor households, more measures showed worsening disparities than improvement.

QUALITY DISPARITIES: Through 2012, few disparities in quality of care were eliminated while a small number became larger.

Disparities Trends

- Through 2012, several disparities were eliminated.
  - One disparity in vaccination rates was eliminated for Blacks (measles-mumps-rubella), Asians (influenza), American Indians and Alaska Natives (hepatitis B), and people in poor households (human papillomavirus).
  - Four disparities related to hospital adverse events were eliminated for Blacks.
  - Three disparities related to chronic diseases and two disparities related to communication with providers were eliminated for Asians.
  - On the other hand, a few disparities grew larger because improvements in quality for Whites did not extend uniformly to other groups.
  - At least one disparity related to hospice care grew larger for Blacks, American Indians and Alaska Natives, and Hispanics.
  - People in poor households experienced worsening disparities related to chronic diseases.

QUALITY DISPARITIES: Overall quality and racial/ethnic disparities varied widely across states and often not in the same direction.

Geographic Disparities

- There was significant variation in quality among states. There was also significant variation in disparities.
- States in the New England, Middle Atlantic, West North Central, and Mountain census divisions tended to have higher overall quality while states in the South census region tended to have lower quality.
- States in the South Atlantic, West South Central, and Mountain census divisions tended to have fewer racial/ethnic disparities while states in the Middle Atlantic, West North Central, and Pacific census divisions tended to have more disparities.
- The variation in state performance on quality and disparities may point to differential strategies for improvement.

National Quality Strategy: Measures of Patient Safety improved, led by a 17% reduction in hospital-acquired conditions.

Hospital-acquired conditions have been targeted for improvement by the CMS Partnership for Patients initiative, a major public-private partnership working to improve the quality, safety, and affordability of health care for all Americans. As a result of this and other federal efforts, such as Medicare's Quality Improvement Organizations and the HHS National Action Plan to Prevent Health Care-Associated Infections, as well as the dedication of practitioners, the general trend in patient safety is one of improvement.

Trends

- From 2010 to 2013, the overall rate of hospital-acquired conditions declined from 145 to 121 per 1,000 hospital discharges.
- This decline is estimated to correspond to 1.3 million fewer hospital-acquired conditions, 50,000 fewer inpatient deaths, and $12 billion savings in health care costs.[23]
- Large declines were observed in rates of adverse drug events, healthcare-associated infections, and pressure ulcers.
- About half of all Patient Safety measures tracked in the QDR improved.
- One measure, admissions with central line-associated bloodstream infections, improved quickly, at an average annual rate of change above 10% per year.
- One measure, postoperative physiologic and metabolic derangements during elective-surgery admissions, got worse over time.

Disparities Trends

- Black-White differences in four Patient Safety measures were eliminated.
- Asian-White differences in admissions with iatrogenic pneumothorax grew larger.

National Quality Strategy: Measures of Person-Centered Care improved steadily, especially for children.

Trends

- From 2002 to 2012, the percentage of children whose parents reported poor communication significantly decreased overall and among all racial/ethnic and income groups.
- Almost all Person-Centered Care measures tracked in the QDR improved; no measure got worse.

Disparities

In almost all years, the percentage of children whose parents reported poor communication with their health providers was:

- Higher for Hispanics and Blacks compared with Whites.
- Higher for poor, low-income, and middle-income families compared with high-income families.

Disparities Trends

- Asian-White differences in two measures related to communication were eliminated.
- Four Person-Centered Care disparities related to hospice care grew larger.

[23] Agency for Healthcare Research and Quality. Interim Update on 2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2013. http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2013.html

National Quality Strategy: Measures of Care Coordination improved as providers enhanced discharge processes and adopted health information technologies.

Trends

- From 2005 to 2012, the percentage of hospital patients with heart failure who were given complete written discharge instructions increased overall, for both sexes, and for all racial/ethnic groups.
- There are few measures to assess trends in Care Coordination.

Disparities

- In all years, the percentage of hospital patients with heart failure who were given complete written discharge instructions was lower among American Indians and Alaska Natives compared with Whites.

National Quality Strategy: Many measures of Effective Treatment achieved high levels of performance, led by measures publicly reported by CMS on Hospital Compare.

Trends

- From 2005 to 2012, the percentage of hospital patients with heart attack given percutaneous coronary intervention within 90 minutes of arrival increased overall, for both sexes, and for all racial/ethnic groups.
- In 2012, the overall rate exceeded 95%; the measure will no longer be reported in the QDR.
- Eight other Effective Treatment measures achieved overall performance levels of 95% or better this year, including five measures of pneumonia care and two measures of HIV care.
- About half of all Effective Treatment measures tracked in the QDR improved.
- Two measures, both related to cancer treatment, improved quickly, at an average annual rate of change above 10% per year.
- Three measures related to management of chronic diseases got worse over time.

Disparities

- As rates topped out, absolute differences between groups became smaller. Hence, disparities often disappeared as measures achieved high levels of performance.

Disparities Trends

- Asian-White differences in three chronic disease management measures were eliminated but income-related disparities in two measures related to diabetes and joint symptoms grew larger.

National Quality Strategy: Healthy Living improved in about half of the measures followed, led by selected adolescent vaccines from 2008 to 2012.

Trends

- From 2008 to 2012, the percentage of adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine increased overall, for residents of both metropolitan and nonmetropolitan areas, and for all income groups.

- About half of all Healthy Living measures tracked in the QDR improved.
- Four measures, all related to adolescent immunizations, improved quickly, at an average annual rate of change above 10% per year (meningococcal vaccine ages 13-15 and ages 16-17; tetanusdiphteria-acellular pertussis vaccine ages 13-15 and ages 16-17).
- Two measures related to cancer screening got worse over time.

Disparities

- Adolescents ages 16-17 in nonmetropolitan areas were less likely to receive meningococcal conjugate vaccine than adolescents in metropolitan areas in all years.
- Adolescents in poor, low-income, and middle-income households were less likely to receive meningococcal conjugate vaccine than adolescents in high-income households in almost all years.

Disparities Trends

- Four disparities related to child and adult immunizations were eliminated.
- Black-White differences in two Healthy Living measures grew larger.

National Quality Strategy: Measures of Care Affordability worsened from 2002 to 2010 and then leveled off.

From 2002 to 2010, prior to the Affordable Care Act, care affordability was worsening. Since 2010, the Affordable Care Act has made health insurance accessible to many Americans with limited financial resources.

Trends

- From 2002 to 2010, the overall percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines and who indicated a financial or insurance reason rose from 61.2% to 71.4%.
- From 2002 to 2010, the rate worsened among people with any private insurance and among people from high- and middle-income families; changes were not statistically significant among other groups.
- After 2010, the rate leveled off, overall and for most insurance and income groups.
- Data from the Commonwealth Fund Biennial Health Insurance Survey indicate that cost-related problems getting needed care fell from 2012 to 2014 among adults.[24]
- Another Care Affordability measure, people without a usual source of care who indicate a financial or insurance reason for not having a source of care, also worsened from 2002 to 2010 and then leveled off.
- There are few measures to assess trends in Care Affordability.

Disparities

- In all years, the percentage of people unable to get or delayed in getting needed medical care, dental care, or

[24] Collins SR, Rasmussen PW, Doty MM, et al. The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014. http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/jan/1800_collins_biennial_survey_brief.pdf?la=en

prescription medicines who indicated a financial or insurance reason for the problem was:

- Higher among uninsured people and people with public insurance compared with people with any private insurance.
- Higher among poor, low-income, and middle-income families compared with high-income families.

CONCLUSION

The 2014 Quality and Disparities Reports demonstrate that access to care improved. After years of stagnation, rates of un-insurance among adults decreased in the first half of 2014 as a result of Affordable Care Act insurance expansion. However, disparities in access to care, while diminishing, remained.

Quality of healthcare continued to improve, although wide variation across populations and parts of the country remained. Among the NQS priorities, measures of Person-Centered Care improved broadly. Most measures of Patient Safety, Effective Treatment, and Healthy Living also improved, but some measures of chronic disease management and cancer screening lagged behind and may benefit from additional attention. Data to assess Care Coordination and Affordable Care were limited and measurement of these priorities should be expanded.

Appendix D – Net Physician Need

Net Physician Need by Specialty-Population Based
Area: Big Bear Zip Codes Geography Level: ZIP Code
Ranked on Specialty (Asc)

Specialty	Physician Requirements 2016	Physician Requirements 2021	Current Physician Supply	Net Physician Need 2016	Net Physician Need 2021
Allergy/Immunology	0.24	0.25	0.00	0.24	0.25
Anesthesiology	2.73	2.82	0.00	2.73	2.82
Cardio/Thoracic Surgery	0.34	0.35	0.00	0.34	0.35
Cardiology	2.10	2.17	0.00	2.10	2.17
Clinical Pathology	1.02	1.05	0.00	1.02	1.05
Colorectal Surgery	0.08	0.09	0.00	0.08	0.09
Dermatology	0.81	0.84	0.00	0.81	0.84
Emergency/Critical Care	2.71	2.80	2.00	0.71	0.80
Endocrinology	0.38	0.39	0.00	0.38	0.39
Gastroenterology	0.99	1.02	0.00	0.99	1.02
General Surgery	2.04	2.11	0.00	2.04	2.11
General/Family Practice	7.58	7.83	2.50	5.08	5.33
Hematology/Oncology	1.16	1.20	0.00	1.16	1.20
Hospitalist	0.40	0.41	0.00	0.40	0.41
Infectious Disease	0.40	0.42	0.00	0.40	0.42
Internal Medicine	8.20	8.47	0.00	8.20	8.47
Nephrology	0.55	0.56	0.00	0.55	0.56
Neurology	1.08	1.11	0.00	1.08	1.11
Neurosurgery	0.40	0.41	0.00	0.40	0.41
Obstetrics/Gynecology	2.39	2.47	0.00	2.39	2.47
Ophthalmology	1.52	1.57	0.00	1.52	1.57
Orthopedic Surgery	1.77	1.83	0.00	1.77	1.83
Other Physician	0.45	0.46	0.00	0.45	0.46
Otolaryngology	0.71	0.74	0.00	0.71	0.74
Pain Management	0.23	0.23	0.00	0.23	0.23
Pediatric Cardiology	0.13	0.13	0.00	0.13	0.13
Pediatric EMCC	0.22	0.23	0.00	0.22	0.23
Pediatric Endocrinology	0.07	0.07	0.00	0.07	0.07
Pediatric Medicine	3.14	3.25	0.00	3.14	3.25
Pediatric Pulmonology	0.05	0.06	0.00	0.05	0.06
Pediatric Subspecialties	0.20	0.21	0.00	0.20	0.21
Physical Medicine/Rehab	0.57	0.59	0.00	0.57	0.59
Plastic Surgery	0.46	0.48	0.00	0.46	0.48
Psychiatry	2.72	2.81	0.00	2.72	2.81
Pulmonology	0.77	0.80	0.00	0.77	0.80
Radiology	2.54	2.63	0.50	2.04	2.13
Rheumatology	0.31	0.32	0.00	0.31	0.32
Urology	0.85	0.88	0.00	0.85	0.88
Vascular	0.22	0.22	0.00	0.22	0.22
Total	**52.54**	**54.29**	**5.00**	**47.54**	**49.29**

***** Note: Total line includes listed specialties only and may vary from "All Specialties" in other reports.***
***** Note: "Current Physician Supply" data are collected over time and may not include recent changes in physician work status.***
Source of Current Physician Supply: Market Expert Physicians Database - 07/14/2016
Source of Physician Requirements: Market Expert Physician Population Rates