LOMA LINDA
UNIVERSITY
HEALTH

2013-2015 COMMUNITY HEALTH PLAN

whole.

whole.

2013-2015 COMMUNITY
HEALTH PLAN

We call upon you to imagine a healthier region, and invite you to work with us implementing the solutions outlined in this report. Help us continue to prioritize our health concerns and find solutions across a broad range of health needs.

- LLUMC 2013-2015 Community Heath Plan

LOMA LINDA
UNIVERSITY
HEALTH

LOMA LINDA UNIVERSITY HEALTH

LOMA LINDA UNIVERSITY MEDICAL CENTER

LOMA LINDA UNIVERSITY MEDICAL CENTER – MURRIETA

LOMA LINDA UNIVERSITY BEHAVIORAL MEDICINE CENTER

A look inside

Mission

To continue the teaching and healing ministry of Jesus Christ.

Vision

Innovating excellence in Christ-centered health care.

Values

Compassion

Reflecting the love of God thorough caring, respect, and empathy.

Integrity

Ensuring our actions are consistent with our values.

Excellence

Providing care that is safe, reliable, efficient, and patient centered.

Teamwork

Collaborating to achieve a shared purpose.

Wholeness

Embracing a balanced life that integrates mind, body, and spirit.

Board approval August 27, 2013

Invitation to Create a Healthier Inland Region

Community-based prevention, particularly interventions that look upstream to stop the root causes of disease, can reduce the burden of preventable illnesses. Economic opportunities, access to nutritious foods, green space, and the availability of social networks, are all key determinants in shaping our health. Our hope is to focus beyond the pressing health care challenges to see the resources and assets that exist in our community and how we can align them for better health outcomes as a population.

Building a healthy environment requires multiple stakeholders working together with a common purpose. Developing a shared understanding of the challenges and opportunities is a critical next step in population health improvement. Loma Linda University Health (LLUH) is working with multiple stakeholders to identify collective evaluation measures to work toward key health indicators as a region and not in isolation. LLUH continues to challenge itself and the region to be proactive in understanding the community and become early adopters of interventions that will improve the health status of our region. LLUH has been instrumental in promoting ***The Community Guide***, (www.thecommunityguide.org), a free resource to help communities choose programs and policies to improve health and prevent disease. This resource guides communities toward interventions that have proven to be effective, which are appropriate for our unique community, and evaluate the costs and return on investment.

LLUH continues to provide leadership and expertise within our health system by asking the questions for each initiative and strategy:

1. Are we providing the appropriate resources in the appropriate locations?
2. Do we have the resources as a region to elevate the population's health status?
3. Are our interventions making a difference in improving health outcomes?
4. What changes or collaborations within our system need to be made?
5. How are we using technology to track our health improvements and provide relevant feedback at the local level?

A Community Health Needs Assessment (CHNA) was conducted in 2013. Detailed plans for each licensed hospital were created to meet the identified community needs and address those needs the hospitals are unable to provide. In response to the identified needs in our assessment, LLUH has adopted the following initiatives and strategies for 2013-2015.

whole.

Community Health Needs Assessment Overview Loma Linda University Health

The CHNA was conducted not only in response to California's Community Benefit Legislation (SB 697) and The Affordable Care Act (H.R. 3590) but to truly fulfill the mission of LLUH: to further the teaching and healing ministry of Jesus Christ.

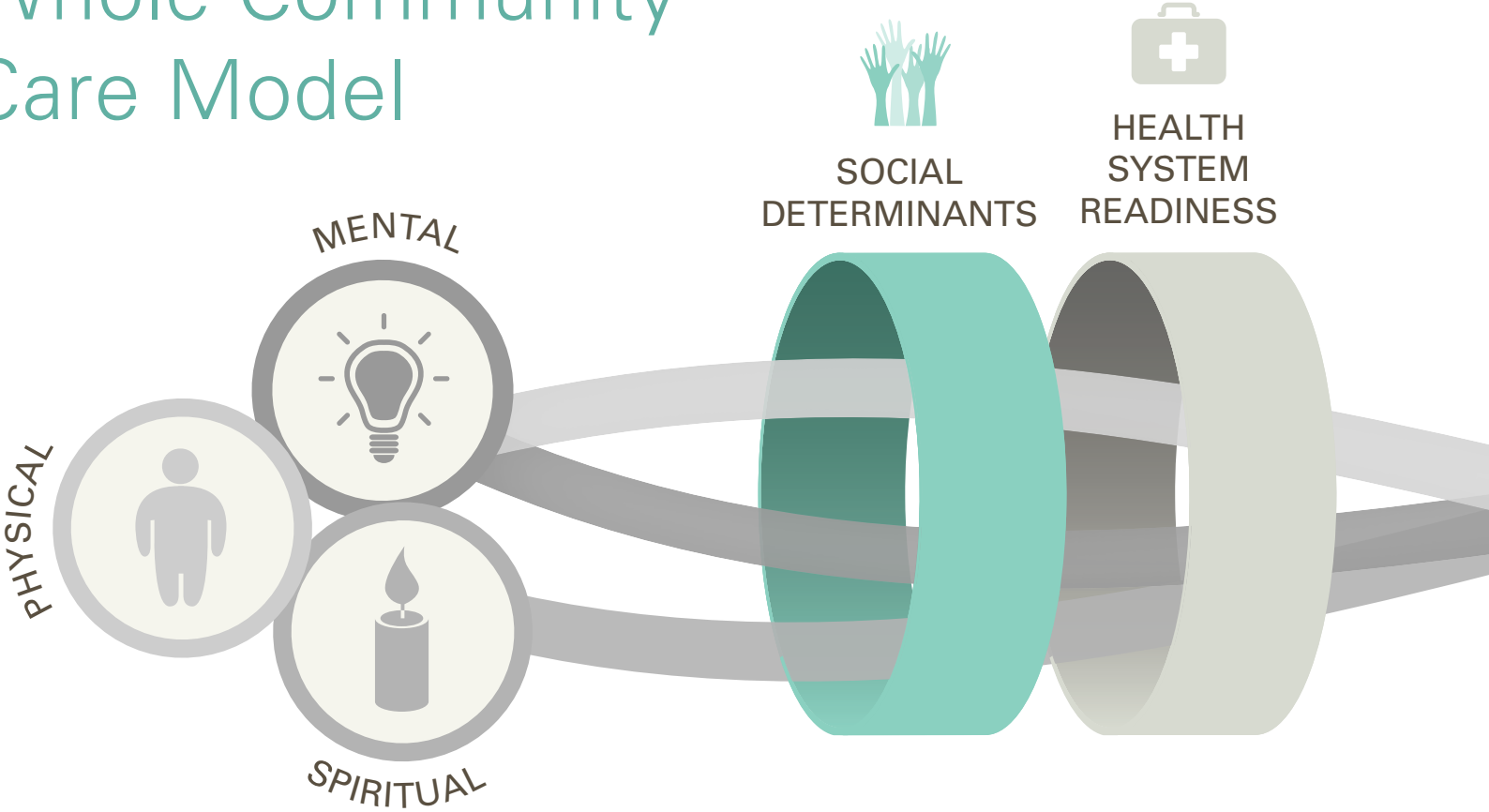
LLUH is rooted in promoting wholeness and the CHNA was modeled after this value with our whole community care model that not only included the health status of our population but the built environment, the social determinants in our community, and the readiness of our health system to truly meet the needs of our community.

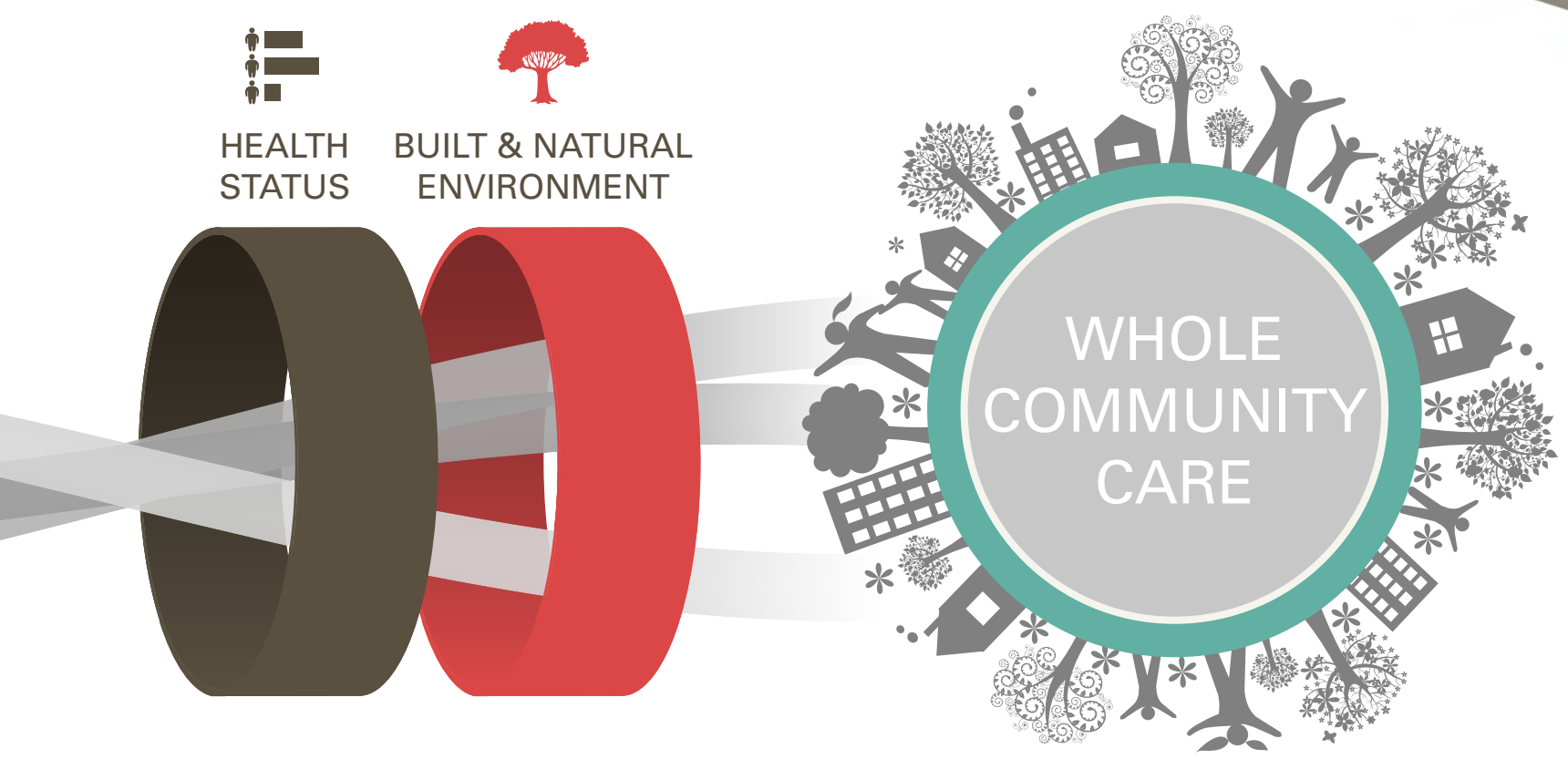
The CHNA was conducted in conjunction with San Bernardino and Riverside County Departments of Public Health. LLUH has played an active role in a countywide health improvement framework, Community Vital Signs (CVS), a community-led effort in partnership with San Bernardino County. This effort developed evidence-based goals and priorities for action that encompasses policy, education, environment, and systems change.

The established goals and priorities will align with national and statewide efforts through Healthy People 2020 and Healthy California 2020. The resources gathered by CVS will assist organizations and agencies in the County to develop or enhance programs and policies to better meet the needs of residents.

This collaborative effort will allow for a collective impact model to address the health challenges in our region. Every effort has been made to align our data with countywide efforts.

Whole Community Care Model




HEALTH STATUS
BUILT & NATURAL ENVIRONMENT
WHOLE COMMUNITY CARE

In March 2012, a cross sector of community leaders and decision makers throughout the County gathered again at the Community Vital Sign (CVS) Stakeholder Summit to discuss and adopt the Vision, Value, and Mission statements developed by their peers.

Purpose

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

Vision

We envision a County where a commitment to optimizing health and wellness is embedded in all decisions by residents, organizations, and government.

Values

- Community-driven: Shared leadership by and for residents, engaging and empowering all voices.
- Cultural competency: Respecting and valuing diverse communities and perspectives.
- Inclusion: Actively reaching out, engaging, and sharing power with diverse constituencies.
- Equity: Access to participation, resources and service, addressing historical inequities and disparities.
- Integrity and accountability: Transparent and cost-effective use of resources.
- Collaboration: Shared ownership and responsibility.
- Systemic change: Transform structures, processes, and paradigms to promote sustained individual and community health and well-being.

As the San Bernardino Countywide Vision progresses, CVS will continue to align individual, state, and national efforts to support collective impact, engage our community, and establish the goals, strategies, and measures for achieving wellness in our County. Additional efforts are being made to include Riverside County in the process and align our efforts throughout the Inland Empire.

LLUH will play a major role in CVS to help with the CHNA, set regional priorities for health, and provide a framework to evaluate the interventions. This will be the basis of our triennial CHNA with additional elements added to help identify specific health care needs of the community served by LLUH. A collective impact indicator will be chosen for each one of our strategies. This indicates that this issue has been identified as a priority for our region and all stakeholders will be engaged toward making a difference.

LLUH feels confident that we are working hard to listen to our community and collectively identify needs and assets in our region. Traditional, publicly available data were included in the assessment, along with qualitative data collected from a broad representation of the community.

Quantitative Data

- Morbidity and Mortality collected from the County Health Profiles.
- Hospitalization and Emergency Department Utilization from OSHPD and LLUMC.
- Social Determinants of Health and Health Indicator data were collected from the U.S. Census Bureau, American Community Survey, Community Commons, and various other local, state, and federal public access databases.

Qualitative Data

- Physician surveys, to identify areas in which the health system can support the health of their patients in our community initiatives.
- Community agencies, serving our primary service area, to assess their needs and to identify areas that LLUMC can be a strategic partner.
- Telephone interviews from consumers in the primary service area.
- Informant interviews from key leaders, to engage them in the development of our interventions and solicit their input to improving the health of our region.
- Focus groups with our patients, providing broad and diverse perspectives.
- Focus groups with our chaplains, fire departments, and nurses.

Community Health Management System (CHMS)

As LLUH matures in its population-based health interventions, metrics to evaluate success and identify areas with the greatest need are critical. A unique aspect of the CHNA included a new Community Health Management System developed by LLUH. CHMS is a geographically enabled system that will provide real-time information to hospital management about health service utilization, availability of community-based health and social care resources, and neighborhood cultural capacities that support desirable health outcomes. This information system will assure our community that geographically relevant data will be generated and consumed at all levels of our health system, enabling system-wide strategic service delivery thinking and acting. Protected, de-identified aggregate data from our patient utilizations will be published in our CHNA to identify areas of highest need in our community. The CHMS is being implemented to enhance the triennial CHNA and to ensure that data is continually being monitored and interventions are evaluated for success.

Objectives for CHMS

- Develop the geospatial analytics competency within LLUH.
- Improve the health status of populations within LLUH primary service area.
- Improve chronic disease management.
- Eliminate unnecessary emergency department visits.
- Reduce unnecessary readmissions.
- Identify strategic locations to implement community- and faith-based interventions to address readmissions and emergency department utilization.

Evaluation Indicators

Developing metrics for population-based interventions are imperative for continued success in elevating the health status of our community. As a regional health system, LLUH is transitioning from a process evaluation-based system to a more inclusive and regional focus of metrics. This requires being in alignment with statewide and national indicators. Healthy People 2020 and The County Health Rankings were used as targets to align our local interventions. Healthy People 2020 provides science-based, ten year national objectives for improving the health of all Americans.

For three decades, the Healthy People initiative has established benchmarks and monitored progress over time in order to:

- Encourage collaborations across communities and sectors.
- Empower individuals toward making informed health decisions.
- Measure the impact of prevention activities.

The County Health Rankings & Roadmaps program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The *Rankings* show the rank of the health of nearly every county in the nation and illustrate that much of what affects health occurs outside of the doctor's office. The *Rankings* help counties understand what influences how healthy residents are and how long they will live. Understanding our County's rankings is only one component of mobilizing action toward community health. The information can be used to create and implement evidence-based policies and programs to improve our community's health. Policies and programs may be designed to target health outcomes directly, or by tackling the variety of factors that determine those outcomes.

LLUH was highlighted in the release of the 2012 *Rankings* for their collaborative work in San Bernardino County. Since 2008 LLUH has been actively involved in the development of a countywide health initiative. We are excited to report an improvement in many of our key indicators in San Bernardino in the release of the 2012 rankings. We are actively working with the County of Riverside to achieve similar results.

Creating a Healthier Community In 2013 — 2015

After conducting the CHNA we asked the following questions:

1. **What is really hurting our communities?**
2. **How can we make a difference?**
3. **What are the high impact interventions?**
4. **Who are our partners?**
5. **Who needs our help the most?**

LLUH assessed their entire service area to strategically identify the areas of greatest need. Poverty, low education levels, and high utilization of emergency department for ambulatory care sensitive conditions for the under and uninsured communities were used as indicators to identify the areas of greatest need. Each indicator was ranked and an index was created. Below you will find the focus areas geographically displayed in red and orange. These areas will be the focus of community health development interventions with target measurable outcomes.

Areas/Cities of Highest Need

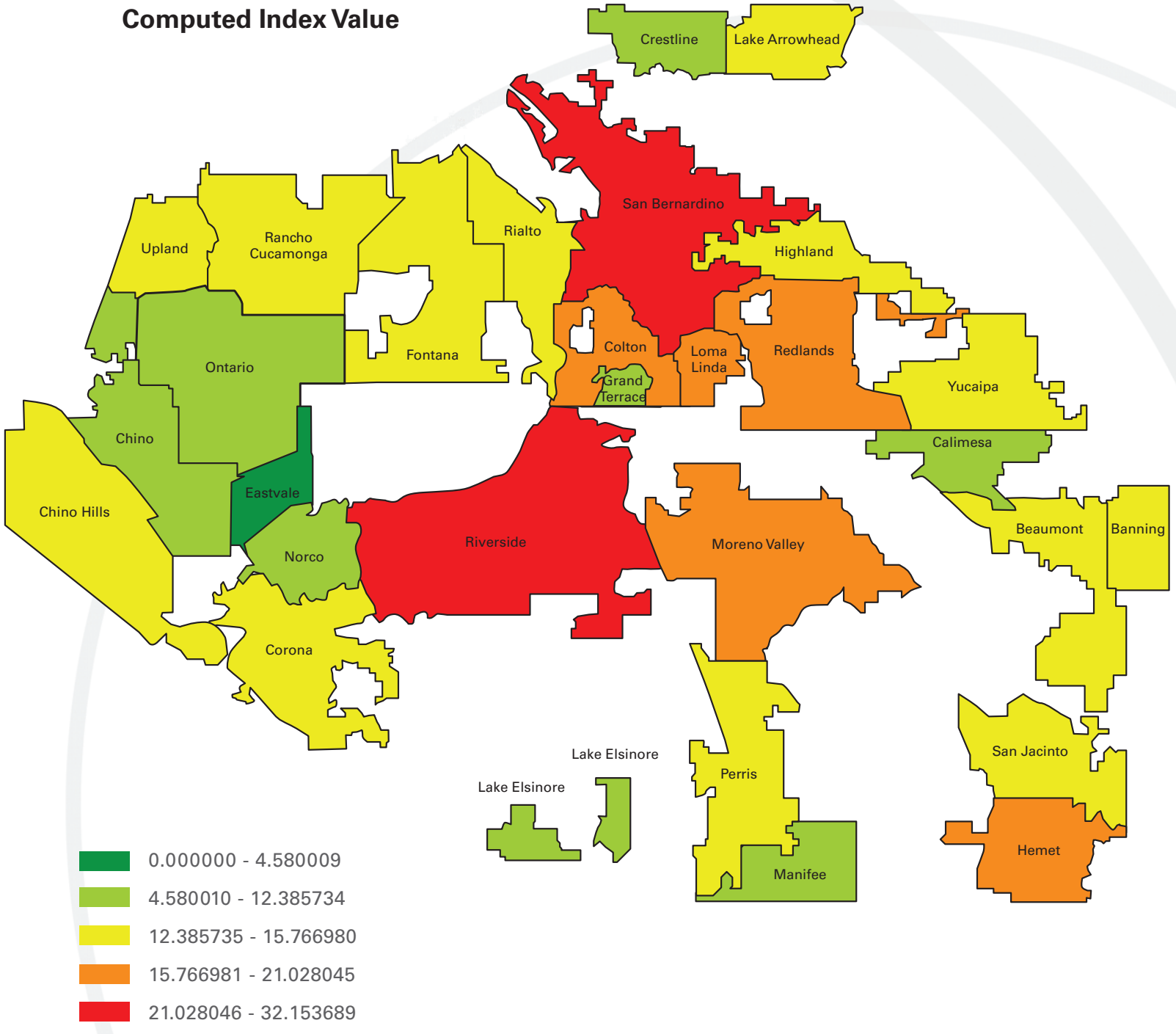
- City of San Bernardino
- City of Riverside

Identified Community Needs

- Lack of access to affordable health care, particularly mental health services.
- High rates of childhood asthma, behavioral problems, and childhood obesity.
- Lack of qualified health care workers to meet emerging community needs.
- Poor coordination of care for heart disease, diabetes, asthma, and sickle cell anemia.
- High prevalence of diabetes, cancer, heart disease, and mental illness.
- Lack of access to prevention and wellness services in the community.
- Disproportionate share of children living in poverty and homelessness.

2010 — 2013 County Health Rankings

	San Bernardino				Riverside			
	2010	2011	2012	2013	2010	2011	2012	2013
Health Outcomes	45	44	41	44	27	29	32	27
Mortality	37	35	36	32	30	27	28	25
Morbidity	48	49	46	51	32	34	36	41
Health Factors	50	50	46	46	40	42	42	36
Health Behaviors	48	48	45	46	36	33	39	33
Clinical Care	54	56	50	52	50	54	43	46
Social & Economic Factors	37	40	39	39	31	29	29	31
Physical Environment	54	55	55	46	52	54	54	41


Computed Index Value
Crestline
Lake Arrowhead
San Bernardino
Rialto
Upland
Rancho Cucamonga
Highland
Ontario
Fontana
Colton
Loma Linda
Redlands
Grand Terrace
Yucaipa
Chino
Calimesa
Chino Hills
Eastvale
Beaumont
Banning
Norco
Riverside
Moreno Valley
Corona
Lake Elsinore
Lake Elsinore
Perris
San Jacinto
Hemet
Manifee
0.000000 - 4.580009
4.580010 - 12.385734
12.385735 - 15.766980
15.766981 - 21.028045
21.028046 - 32.153689

Many factors contribute to chronic disease. Some of these factors are modifiable behaviors; in other words, they reflect individual health behaviors. Half of all deaths in the Inland Empire can be attributed to unhealthy lifestyles or to modifiable behaviors such as tobacco use, sedentary lifestyle, poor diet, and not getting preventive screenings such as mammograms, or blood cholesterol tests. Inactivity, obesity, smoking habits and poor air quality are among the leading risk factors for several chronic diseases prevalent in our region. Poor nutrition and lack of physical activity can lead to obesity, which in turn increases the risk of serious illness, such as diabetes and heart disease. A healthy diet and regular physical activity can help achieve and maintain healthy weight and reduce the risk of developing chronic health conditions.

Health Forecasting — Tools for Improving Population Health

Health Forecasting was founded by UCLA in 2002 to help provide new and valuable information to decision-makers and health advocates about the future health status of the population based on current trends in chronic diseases, socioeconomic and demographic patterns and expected trajectories, and potential changes in policies and programs. Health forecasting can be used as a tool to:

- Analyze chronic disease trends.
- Plan resource distribution to areas or populations with the most need.
- Identify weaknesses in community health and potential areas for improvement.
- Determine corrective actions for improving health and reducing disparities.

LLUH is working in collaboration with UCLA to expand the health forecasting model to the Inland Empire. This work was funded through a grant from UniHealth Foundation. The Inland Empire model will be used by all the participating hospitals in the region. This collaboration will provide LLUH with:

- A tailored community health profile of the hospitals' catchment area by zip code for the hospitals' primary service area and secondary service area for two age groups: children and adolescents, and adults.
- Detailed forecasts of the hospitals' catchment area through the year 2030, including rates and prevalence of chronic conditions, behaviors, mortality, and population projections.
- Capacity to segment their catchment area by ethnicity, gender, income, age, and educational attainment to analyze health disparities among the different sub-groups.
- Suggestions for selected interventions salient to the hospitals' community benefit planning efforts.

This tool will be used to support a forward-thinking decision support tool to assess the current and future health status of our hospitals' service area. This will be critical in moving further upstream in our planned interventions. The strategies outlined below are reflective of this forward-thinking process and will be used as we move through 2013 and beyond.

LLUH has adopted the following system-wide initiatives for 2013-2015 in response to the 2013 CHNA. The system-wide initiatives and individual strategies are outlined in each hospital's community health plan.

Loma Linda University Health: System-Wide Initiatives

- **Healthy Communities Initiative**
- **Faith and Health Initiative**
- **Whole Health System Care Initiative**

Loma Linda University Health: Hospital Strategies

Loma Linda University Medical Center

- **Whole Child Care**
- **Whole Aging Care**
- **Whole Chronic Disease Care**
- **Whole Rehabilitation Care**
- **Whole Cancer Care**
- **Whole Sickle Cell Anemia Care**
- **Health Care Pipelines**

Loma Linda University Medical Center — Murrieta

- **Healthy Communities Initiative**
- **Faith and Health Initiative**
- **Whole Health System Care Initiative**

Loma Linda University Behavioral Medicine Center

- **Whole Behavioral Health Care**

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SYSTEM-WIDE INITIATIVES

Loma Linda University Health: System-Wide Initiatives

Spectrum of Prevention

While individuals are responsible for instituting and maintaining the lifestyle changes necessary to reduce risks and improve health, individual behavior is determined, to a large extent, by social environments, such as community norms and values, regulations, and policies. By altering lifestyle behaviors, the risk of developing heart disease, stroke, cancer, and diabetes can be reduced. Communities, schools, work sites, and health care systems must work together to support and promote healthy behaviors through policies and environmental factors such as smoke-free workplaces, increased access to nutritious foods, increased access to affordable medical care including coverage for preventive services, greater employment opportunities, and creating walkable and bicycle-friendly communities.

Barriers to healthy behaviors are shared among the community as a whole. As these barriers are lowered or removed, behavior change becomes more achievable and sustainable. It becomes easier to "push the ball up the hill." The most effective approach leading to healthy behaviors is a combination of the efforts at all levels – individual, interpersonal, organizational, community, and public policy. LLUH will adopt strategies that meet the community health needs, and all priority areas identified through this assessment will include a spectrum of prevention that will include:

- Influencing policy and legislation.
- Partnering with our community to improve the built environment to enhance health.
- Fostering coalitions, networks and improve systems.
- Changing organizational practices.
- Educating providers.
- Promoting community education.
- Strengthening individual knowledge and skills.

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HEALTH SYSTEM CARE INITIATIVE

Overview of the Whole Health System Care Initiative

With the passage of the Patient Protection and Affordable Care Act (PPACA) of 2010, new health insurance exchanges and Medi-Cal expansions will render health insurance more available, accessible, and expected. To adapt to such changes, health care systems will need to develop innovative delivery systems, electronic enrollment systems, targeted media campaigns, and creative community-based outreach and enrollment. The PPACA also recognizes the important role that prevention and public health play in improving health outcomes, and makes an unprecedented investment in prevention both inside and outside the health care system. In the Inland Empire alone, there are an expected 580,000 individuals eligible for Medi-Cal expansion or the newly formed health exchanges.

Improving the health care system in the Inland Empire will require the system to be better aligned toward population health goals and outcomes. The system should be focused on health, not just illness, and become truly patient centered. To achieve these goals, health care systems and plans across the State are already innovating ways to redesign the health delivery system—which is currently fragmented, geared toward acute services, and at times unsafe.

Community Health Development will support and promote community-based prevention to support the development of a primary care network. There are over 1.5 million residents living in Medically Underserved Areas (MUA) in the Inland Empire. LLUH will provide financial and technical support for the Community Clinic Association of San Bernardino County and financial support to our partner clinic Social Action Community (SAC) Health System.

LLUH will work closely with Covered California to help with outreach and education to providers and community members regarding the newly developed health exchanges. LLUH will help lead the region in the implementation of the PPACA. We will work with our community partners to improve the health infrastructure in the Inland Empire to provide appropriate and affordable care to all residents.

Center for Strategy and Innovation

In 2013, LLUH established a Center for Strategy and Innovation (CSI) to support LLUH's strategic planning process and to innovate new delivery models that engage the community. **The CSI will help create innovative health delivery models that are designed to reduce the overall cost of health care, improve the health of the population, and improve access to affordable health services for the community both in outpatient and community settings**. These models will also improve care for populations with specialized needs, test approaches for specific types of providers to transform their financial and clinical models, and improve the health of populations — defined geographically, clinically, or by socioeconomic class through activities focused on engaging community in prevention, wellness, and comprehensive care that extends beyond the clinical setting. We will also begin to bring community partners together to build these innovative models. This center will be the hub for the interventions outlined in the community health plan.

Purpose:

Establish a Center for Strategy and Innovation to support the LLUH strategic planning process and to innovate new delivery models that engage the community.

Strategy

Strategy Development

Strategic Analysis

Environmental Scan

Strategy Deployment and Alignment

Community Health Needs Assessment

Community Engagement

Community Benefits

Community Health Needs Assessment

Grant Writing

Collaborative Initiatives/ Civic engagement

Innovation

Creating Networks and Multidisciplinary Teams | Informal Networks to Incubate New Ideas

Piloting New Care Models with in the System | Transforming the Experience and Delivery of Health Care.

Enhance Support

Community Health Development

Business Development

Clinical Decision Support

Finance

Philanthropy

Functions

Health Services Utilization/ Data integration

Health Surveillance

Community Engagement

Innovation

Strategic Decision Support

Strategy/Innovation Think Tank

Functions

Community Health Management System ESRI/GIS

Consulting Services

Educational Forums

Innovation Facilitation

Strategic Planning


whole.
FAITH & HEALTH
INITIATIVE

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Faith and Health Initiative

Overview of the Initiative

Faith and Health have long been partners in healing individuals and communities. It makes sense that these two healing institutions should work together in order to ***create new forms of faith-based collaborations for health in our communities***. In order to "continue the teaching and healing ministry of Jesus Christ," it is imperative that we seek to connect strategies and interventions with faith communities in order to make a greater impact for health in our local community.

The Faith and Health Initiative is embedded into the very DNA of Loma Linda Health, and therefore becomes a delivery model for many of the strategies. The corresponding interventions will take place in faith communities through the Faith Community Health Network (FCHN), which is the backbone of the Faith and Health Initiative.

The FCHN is a covenanted relationship between LLUH and Faith Communities in the two-county region in which we serve. The goal of the network is to ***collaborate, innovate***, and provide ***fellowship*** through health interventions. Within the network there seeks to be a "unity of purpose" in working hand-in-hand toward a healthier community, a stronger congregational care, and a better understanding of the resources that LLUH has available for its faith communities.

Ultimately, another goal of the FCHN is to help faith communities care for their congregates as they journey through our health care system by establishing training events for faith community-based liaisons to familiarize them with our particular system, and partnering with patients in order to move them from our system back to their congregational care system with a strong continuum of spiritual care.

Because of the nature of care that Faith Community Leaders give on any given day to their congregants, there are a few strategies that make the most sense to be deeply connected with Faith Community Interventions. Those strategies are Whole Mental Health Care, Whole Aging Care, and working with Covered California in its Education and Outreach to educate providers and community members regarding the newly developed health exchanges.

Goal

Creating new forms of faith-based collaborations for health in our communities.

Interventions

1. Behavioral Health
    a. Mental Health Certificate Training Program
    b. Case Discussion Lunches, Counseling for Clergy
    c. Catholic/VA Intervention
    d. Chaplaincy Training
    e. Mental Health Advisory Council

2. Healthy Aging
    a. Healthy Aging Conference
    b. Drayson Center Membership/Preventative plan for Clergy
    c. Clergy Health and Wellness Day at Drayson
    d. Catholic Healthy Aging Pre-Conference

Evaluation Indicators

- Enroll fifty Faith Communities in the FCHN in 2013. Increase number by 20% in 2014.
- Identify a baseline of referrals to mental health professionals in 2013 and increase by 10% in 2014.
- Increase the number of faith communities interested in health and wellness by a coordinated effort of identifying programs, publicizing programs among the faith communities, and coordinating efforts in geographical locations.

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HEALTHY COMMUNITIES INITIATIVE

Overview of the Initiative

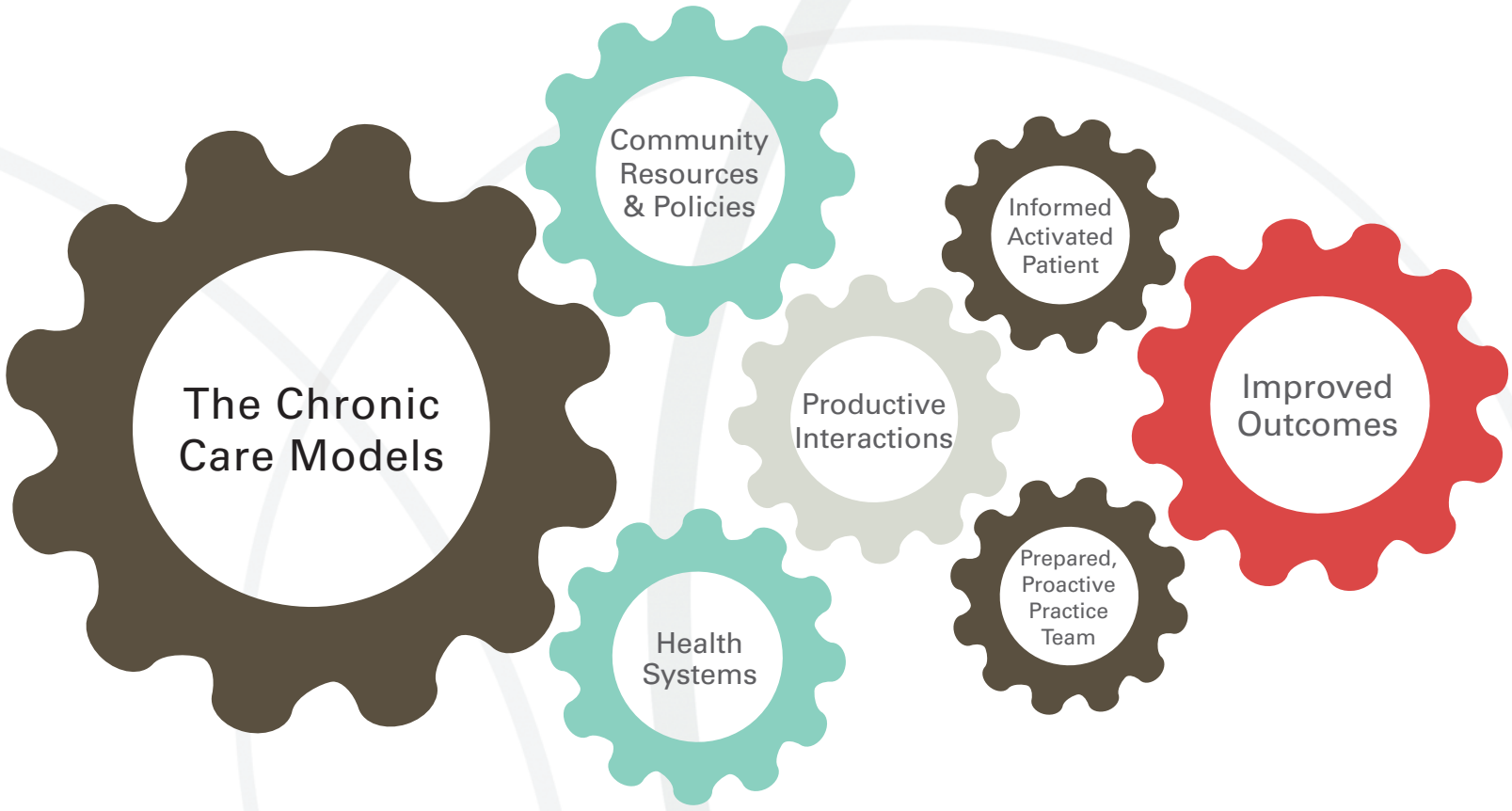
The Institute of Medicine's report, *The Future of the Public's Health in the 21st Century,* calls for significant movement in "building a new generation of inter-sectorial partnerships that draw on the perspectives and resources of diverse communities and actively engage them in health action."

LLUH is committed to elevating the health status of the community. Improving the conditions in which people live, learn, work, and play and addressing the inter-relationship between these conditions, will create a healthier population. Integrating health policy efforts with those related to education, housing, business, transportation, agriculture, media, and other areas outside of the health sector, will ultimately improve the health, safety, and prosperity of the nation.

Building a healthy environment requires multiple stakeholders working together with a common purpose. The health challenges are too large to address in isolation, and a key focus of the community health development interventions will be anchored through a "Healthy Community Model" implemented throughout San Bernardino County. In collaboration with our community, we have collectively prioritized our health concerns, and will seek solutions across a broad range of sectors to create communities we all want for our children and ourselves.

Humans interact with the environment constantly. These interactions affect quality of life, years of healthy life lived, and health disparities. Environmental health consists of preventing or controlling disease, injury, and disability, related to the interactions between people and their environment. An estimated 25% of preventable illnesses worldwide can be attributed to poor environmental quality. Effective chronic disease management must also include a comprehensive approach that addresses the built environment to promote self-management. The chronic care model listed below displays the importance of the health system working with the community to build better systems of care and to bridge both clinical and community prevention.

Healthy Communities of San Bernardino is a countywide strategic initiative to create healthier environments and promote healthful lifestyle choices for all county residents, with a particular emphasis on access to nutritious foods, physical activity, and appropriate health care. The Healthy Communities Program (HCP) was created as an initiative of the San Bernardino County Board of Supervisors in April 2006. After five years, 19 of the County's 24 incorporated jurisdictions have become Healthy Cities. The Healthy San Bernardino Coalition is a by-product of this initiative. Each city develops its own plan and focus areas, which include such diverse topics as: nutrition, active transportation, safety, health care access, facilities, parks and open space, mental health, a green and sustainable city, and education and lifelong learning. Concurrently, city partners are working on policy issues including: 1) updating general plans to reflect their Healthy City commitment; 2) healthy vending policies; 3) joint use agreements; 4) safe routes to schools; 5) community and home garden policies; and 6) farmers market policies.



Organization of Health Care

- Self Management Support
- Delivery System Design
- Decision Support
- Clinical Information System

Participating Cities

- Healthy Adelanto
- Healthy Apple Valley
- Healthy Big Bear Lake and Greater Big Bear Valley
- City of Bloomington
- Healthy Chino
- Healthy Chino Hills
- Healthy Colton
- Healthy Fontana
- Healthy Hesperia
- Healthy High Desert
- Healthy Highland
- Healthy Jurupa Valley
- Healthy Loma Linda
- Healthy Montclair
- Healthy Muscoy
- Healthy Ontario
- Healthy Rancho Cucamonga
- Healthy Redlands
- Healthy Rialto
- Healthy Rim of the Mountain Communities
- Healthy San Bernardino
- Healthy Upland

LLUH is an active partner with Healthy Communities of San Bernardino to further their broad-based, multi-level, multi-sector work in improving the health of our residents. We are providing technical support for policy development, support for their coalitions, resident support in selected cities, and health education and promotion programs.

Evaluation Indicators

- Increase city participation in the Healthy Community Initiative by 20% in 2013.
- Establish a retail food environment index for each city.
- Establish baseline indicators defining a healthy community in both San Bernardino and Riverside County.
- Implement policies to reduce the retail food environment index.

Loma Linda University Medical Center Community Health Plan

Community Health Plan Strategies*

- Whole Child Care
- Whole Cancer Care
- Whole Chronic Disease Care
- Whole Sickle Cell Care
- Whole Aging Care
- Whole Rehabilitation Care
- Health Care Pipelines
- Whole Behavioral Health Care

* *Please see community health plan strategies for full description of program.*

We call upon you to imagine a healthier region, and invite you to work with us implementing the solutions outlined inthis report. Help us continue to prioritize our health concerns and find solutions across a broad range of health needs.

Dear Community,

As Chief Executive Officer of Loma Linda University Medical Center, I would like to thank you for your interest in the health of our community and allowing Loma Linda University Health to be a partner in an effort to improve the health of our region. It is my pleasure to share our current Community Health Plan with you.

In 2012, we invested over **$95,407,460** in community benefits. Loma Linda University Health believes, however, these investments need to be combined with attention to improving health outcomes, shared responsibility from community partners, and careful financial stewardship to ensure continued improvement in our community's health. We continue to make concentrated efforts to shift our investments to more community-based preventive interventions, rather than relying mostly on charity care in our emergency departments, or hospitalizations for advanced and unmanaged health conditions.

The Affordable Care Act has highlighted the importance of designing new and innovative approaches to improving the health of our communities with a significant emphasis on community-based prevention. Loma Linda University Health has been a trusted community asset since 1905, and we are committed to pro actively meeting the diverse health needs of our region through this historic transition.

Improving community health requires expertise and engagement beyond the hospital campus and the health sector. It requires the wisdom of everyone in our community. We are committed to finding innovative ways to work with all sectors of our community to ensure our community health interventions are systematic and sustained.

We call upon you to imagine a healthier region, and invite you to work with us to implement the solutions outlined in this report. Help us continue to prioritize our health concerns and find solutions across a broad range of health needs.

We look forward to our journey together, and thank you for your interest in creating a healthier community for everyone.

Sincerely,

Ruthita J Fike

Ruthita Fike,
Chief Executive Officer , Loma Linda University Medical Center

Loma Linda University Medical Center Service Area

LLUMC's service area is defined as California's Inland Empire region. The Inland Empire region is comprised of the entirety of the Counties of Riverside and San Bernardino. It is home to approximately 4.2 million people as of the 2010 Census. This region contains the census-defined metropolitan statistical area of Riverside-San Bernardino-Ontario, as well as cities in the High Desert extending into the Mojave, the Coachella Valley, and Southwest Riverside County. In the year 2012, 92.8% of LLUMC's inpatient cases originated from the Inland Empire.

This Community Health Plan includes Loma Linda University Medical Center, East Campus, Children's Hospital, and Heart and Surgical Hospital, all whom share one license and are a part of Loma Linda University Health.

Loma Linda University Medical Center
Number of hospital beds: 371
Ruthita J. Fike, CEO
Lowell Cooper, Chair, Board of Trustees
LLUMC, Senior Vice President Managed Care. LLUAHSC

Loma Linda University Children's Center
Number of hospital beds: 348
Zareh Sarrafian, Administrator

Loma Linda University Medical Center East Campus
Number of hospital beds: 134
Lyndon Edwards, Vice President

Loma Linda University Heart and Surgical Hospital
Number of hospital beds: 28
Lyndon Edwards, Vice President

Loma Linda University Medical Center - Murrieta Community Health Plan

Community Health Plan Strategies*

- Whole Child Care
- Whole Chronic Disease Care
- Whole Behavioral Health Care

* *Please see community health plan strategies for full description of program.*

Building a healthy community requires multiple stakeholders working together. We must strive to build lasting partnerships that span across multiple sectors, actively engaging in finding solutions.

Dear Community,

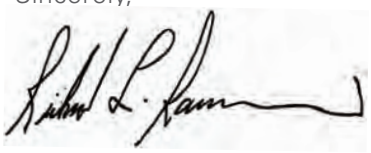
As Chief Executive Officer of Loma Linda University Medical Center-Murrieta (LLUMC – Murrieta), we are pleased to share our first Community Health Plan with you. As you read our plan, please join me in imagining a healthier community while giving us the opportunity to extend our mission of furthering the teaching and healing ministry of Jesus Christ.

As Loma Linda University Health's newest member, LLUMC - Murrieta is proud to make strategic investments in our local community that are aligned with our mission and deep history of community based prevention. We plan to listen to our community, document successes and opportunities for improvement, and provide spiritual, mental, and physical healing to those in need with the intention of becoming a trusted community partner.

The Community Health Plan builds upon the 2013 Community Health Needs Assessment, a report that thoroughly outlines the health in our community. This process gave us new insight into the health of our community highlighting the areas we collectively have identified as priorities and where we could partner and lead for better health outcomes in our region.

Building a healthy community requires multiple stakeholders working together. We must strive to build lasting partnerships that span across multiple sectors, actively engaging in finding solutions. We invite you review our plan and allow us to join you in finding opportunities to partner for a healthier region.

Sincerely,



Rick Rawson,
Chief Executive Officer
Loma Linda University Medical Center - Murrieta

Loma Linda University Medical Center – Murrieta Service Area

LLUMC-Murrieta's market area is defined as the Southwest region of Riverside County. The Southwest Riverside County region is comprised of the communities of Lake Elsinore, Menifee, Murrieta, Sun City, Temecula, Wildomar, and Winchester. It is home to an estimated 477,363 people as of the year 2012.

This Community Health Plan includes Loma Linda University Medical Center- Murrieta: A newly licensed hospital as a part of Loma Linda University Health.

Loma Linda University Medical Center - Murrieta
Number of hospital beds: 106
Rick Rawson, CEO

Cynthia D. Clark, R.N., M.A.
Director Employee & Community Wellness

Murrieta Service Area

Loma Linda University Behavioral Medicine Center Community Health Plan

Community Health Plan Strategies*

- Whole Behavioral Health Care

* *Please see community health plan strategies for full description of program.*

Overcoming the stigma of mental illness, chemical dependency, improving behavioral health in our community requires partnering across multiple sectors to create a continuum of care.

Dear Community Partner,

As Administrator of Loma Linda University Behavioral Medicine Center, it is my pleasure to share our current Community Health Plan. This plan outlines the opportunities to enhance physical, mental, and spiritual healing to those in need.

Optimal behavioral health occurs when individuals have hopeful and productive lives. Our approach is to address the behavioral needs of our community through whole person care, central to the mission of Loma Linda University Health.

Overcoming the stigma of mental illness, chemical dependency, improving behavioral health in our community requires partnering across multiple sectors to create a continuum of care. It requires the collaboration and social support of everyone in our community to provide hope to those in need of behavioral health services and to ensure a healthier future. We are committed to finding innovative ways to engage our community partners in creating sustainable health and building upon on our collective successes.

We hope that through reviewing this document, you find opportunities to partner with us. We aspire to create dynamic strategies aimed at improving the behavioral health of our community. Together, we can imagine a healthier community free from mental illnesses and chronic disease.

Sincerely,

Jill Pollock
Administrator
Loma Linda University Behavioral Medicine Center

Loma Linda University Behavioral Medicine Center Service Area

This Community Health Plan includes Loma Linda University Behavioral Medicine Center, a licensed hospital under Loma Linda University Health.

Loma Linda University Behavioral Medicine Center (LLUBMC) is an 89-bed facility that has provided exemplary mental health care to children, adolescents, adults, and seniors for over 20 years. A full range of services including inpatient and outpatient treatment is provided by a multi-disciplinary treatment team of professional and caring clinicians. LLUBMC specializes in a variety of issues including eating disorders, geriatric psychiatry, chronic pain and medication dependency, anxiety, depression, and other emotional and behavioral issues.

Loma Linda University Behavioral Medicine Center
Number of hospital beds: 89
Jill Pollock, Administrator


Lake
Arrowhead
Crestline
15
Rancho
Cucamonga
210
215
Highland
San Bernardino
Fontana
Colton
Mentone
10
Ontario
Loma Linda
Redlands
Yucaipa
60
Rubidoux
Grand Terrace
10
Calamesa
Mira
Loma
Riverside
Pedley
Norco
Moreno
Valley
Home Gardens
Woodcrest
Corona
El Cerrito
215
15
Nuevo

LLUBMC is the only hospital in San Bernardino and Riverside County that offers inpatient care for children and one of two hospitals in San Bernardino County that offer inpatient care for adolescents. To address the pressing needs in the community, two specialized tracks were designed for youth — an Adolescent Self-Injury Program, and Child and Adolescent Chronic Illness Program.

LLUBMC's market area is defined as California's Inland Empire region. The Inland Empire region is comprised of the entirety of the Counties of Riverside and San Bernardino. It is home to approximately 4.2 million people as of the 2010 Census. This region contains the census-defined metropolitan statistical area of Riverside-San Bernardino-Ontario, as well as cities in the High Desert extending into the Mojave, the Coachella Valley, Murrieta and Southwest Riverside County.

Loma Linda University Behavioral Health Institute (LLUBHI)

In order to address the population health mandate anticipated to roll out as part of health care reform, LLUBMC will need to continue to strengthen its collaborations by aligning closely with Loma Linda University Behavioral Health Institute, Loma Linda University entities, Loma Linda and community physician groups as well as federally qualified health centers (FQHCs). FQHCs primarily treat Medicaid, low income and uninsured patients. Building partnerships with the different levels of providers will position LLUBMC to provide coordinated care that will help to serve its community in a more efficient and effective manner.

LLUBMC is actively partnering with Riverside and San Bernardino Counties and across the LLU Health system, including the Loma Linda University Behavioral Health Institute (LLUBHI).

This Institute was created to not only provide comprehensive outpatient behavioral health services at a confidential and convenient location, but also to integrate academic, research, and clinical practice to improve treatment outcomes as well as focus on prevention.

LLUBHI provides community-oriented comprehensive behavioral health care through the students from the School of Behavioral Health (which represents Social Work, Counseling and Family Sciences, and Psychology) and the residents in the Department of Psychiatry. The collaboration of these behavioral health professionals provides a comprehensive approach for each client's unique behavioral health needs. The Institute has an integrated clinic, which offers services on a sliding scale for those who do not have insurance or are unable to afford behavioral health care.

ACA Task force focused on Behavioral Health

In an effort to address the paradigm shift from curative medicine to population health, the task force was created this year to prepare our behavioral health system to respond to the upcoming health care changes mandated by the PPACA. The group is tasked with not only exploring the intricacies of the various services offered across the LLUH, but also to identify ways to provide a seamless continuum of services within and outside the LLUH enterprise. Second, the group will explore its population's needs and the gaps of service including barriers to care and create community partners and synergies to fill this plan by creating a plan of action.

whole.
STRATEGIES

whole.

CHILD CARE

Identified Need

- High rates of childhood obesity and asthma. High rates of children living in poverty and homelessness.
- Lack of adequate resources for children including behavioral health services, medical services, social services. Fragmentation of the system as a whole.
- Our health system and communities have been unable to respond to children raised in poverty with a lack of resources.

Goal

- Improve health status for children living in the Inland Empire.

LLUMC Strategy

LLUMC-Murrieta Strategy

whole.

CHILD CARE

Children are our most at-risk population in the Inland Empire as they are the smallest voice in a region of minimal resources. In our vast geographic area, children 0-17 years compromise more than 39% of our population, 33% of our families live at poverty level, and 44% live in single parent households. Our children attend schools where educational competency rates are below the national average, yielding high school graduation rates of 60%.

The U.S. Surgeon has identified the obesity epidemic as one of the greatest health problems facing the nation today. Currently, approximately 25 million U.S. children and adolescents are overweight or obese. Since 1980, the percentage of children who are overweight has more than doubled, while rates among adolescents have more than tripled. Although the rising trend in obesity rates is present in all social classes, the risk is greater in lower income and in certain ethnic populations.

Childhood obesity has been associated with a number of problems including health, social, and economic consequences. Childhood obesity is related to numerous chronic adult diseases including type 2 diabetes, cardiovascular disease, several kinds of cancer, and osteoarthritis. Children and adolescents who are overweight are more likely to become overweight or obese adults. If a child is obese at the age of four, he or she will have a 20% likelihood of being overweight as an adult.

Meeting the health needs of our children will require a symphony of care and coordinated response from health care access, access to nutritious foods, family support, access to open space for physical activity, and collaboration with our local schools. Most strategies to prevent or reduce childhood obesity have focused on individual behavior modification and pharmacological treatment, but have been met with limited success.

Our mission at LLUH is to be the voice for our most vulnerable population. We have made children's well-being a priority for our health system by being the premier Children's Hospital in the eastern portion of Southern California.

LLUH recognizes that our children are our future and is committed to improving the health of all children living in the region by promoting lifelong healthy eating patterns through education and behavior change practices, promoting physically active lifestyles, and supporting community programs that promote overall health.

Objectives

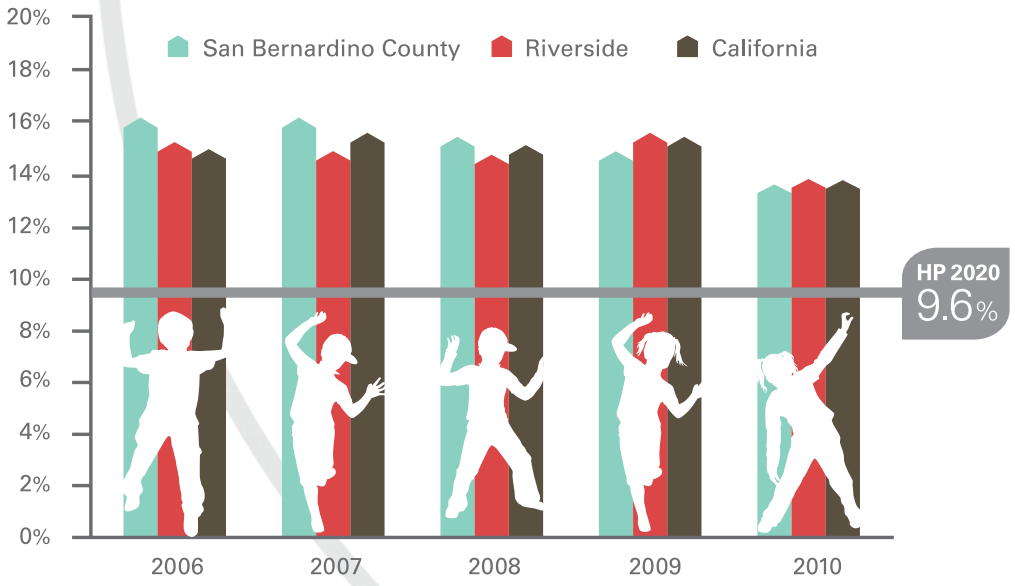
To engage the "collective community" of local, regional, and state agencies, and non-profit entities to create a system of care that stretches from families and communities to the health care system that synergistically improves the wholeness of all the children in our region.

Interventions

Countywide Hospital Collaboration - LLUH continues to collaborate with the Hospital Association of Southern California in connecting with other area hospitals and with the San Bernardino and Riverside County Health Departments in an effort to develop cooperative approaches to improving the health of our community and to evaluate the outcomes of our community benefit programs. In 2013 not-for-profit community hospitals along with other community agencies have joined together with the audacious goal to displace heart disease as the leading cause of death in our county.

Obesity Prevention

- Inland Empire Childhood Obesity Task Force provides a venue for passionate community partners to strategize on possibilities and barriers that affect the challenges of our families, agencies, and policies of our region of service, the Inland Empire.
- Adopt- A-School Model provides a saturation of efforts for success in domains of academics, nutrition, physical activity, and even a school garden.
- Lactation Consultations provide the one-to-one coaching for the new mothers seeking breastfeeding skills to increase the health of their infants with early obesity prevention.
- Lactation Accommodation Policy in local communities is an intervention that targets individual city government entities in efforts to provide education and acceptance of state lactation accommodation laws and to promote understanding and compliance in the business communities of each city.



High rates of child obesity

Proportion of Children Aged 2-5 years considered to be Obese, 2006-2010.

Source: California Department of Health Care Services, Pediatric Nutrition Surveillance System. (2013). Growth indicators by race/ethnicity and age, 2006-2010. Data collected from participants in the Child Health and Disability Prevention Program, which serves Medi-Cal recipients and children/youth with family incomes up to 200% of the federal poverty level (FPL).

- Operation Fit is a five-session summer day camp at the university recreational center that gives children week-long hands on exposure to healthy life through healthy choices of nutrition and physical activity.

- BodyWorks is a national program that provides health education with regards to physical activity, nutritional choices, and goal setting for the well-being of teenagers and parents.

Child Safety and Education

- OK Kids or Outreach to "K"ommunity Kids focuses the integration of young pediatricians in training into communities supportive services focusing on the whole child, specifically addressing the issues of lifestyle living, childhood safety and teen pregnancy and parenting.

- Safe Kids Program is the Loma Linda chapter of the national organization with focuses on safety education of children and parents to reduce the avoidable death statistics. In childhood, accidents and unintentional injuries are ranked as the #1 cause of death.

Social Support and Community Empowerment

- Camp Good Grief is a three-day camp experience for children and teens who have had a family member die due to illness or accident. It provides a place for kids to be with peers who have experienced a similar loss. Camp Good Grief is a relaxed, supportive, open, and safe environment that includes typical activities of a summer camp as well as opportunities to learn how to cope with grief.

- Josh and Friends is a plush puppy toy accompanied by a book titled *I'll Be OK*, which is designed as a therapeutic tool for 3-7 year-old children, to provide comfort and better understanding in an unfamiliar hospital experience.

- Children's Day – A day at a children's hospital for young children to celebrate health through connection with nurses, physicians, and life specialists.

- Walk with the Doc Program, a national physical education program connecting physicians with their community, is promoted through the multiple community efforts, including the California Medical Association, that address the sedentary lifestyle of communities.

- Community-Based Prevention Plus Clinics will provide the opportunity for communities and health care providers to create a rich educational forum for lifestyle transformation.

- Inland Empire Children's Health Initiative is a regional coalition promoting health insurance coverage for children.

- Health prescription for school neighborhoods will create school specific "Health Prescriptions" for families that identify healthy food choices, walkable routes around neighborhoods, safe physical activity areas, and health clinics.

- Baby Basics — Loma Linda University Children's Hospital and affiliated clinics will participate in the national initiative from the American Academy of Pediatrics targeting Baby Basics, parenting, and early reading.

- Think Together is a community partner where engagement is structured for overall wellness providing the framework for health and wellness in the after-school environment as a blended community effort for children and families.

- Healthy Neighborhoods Project is a volunteer student program launched through the graduate programs at Loma Linda University that targets the high-risk children and families in poverty and homeless individuals. The goal is to use the mentoring model to provide friendship, trust, and academic teaching for the children.

    - Project Hope is an intervention working within the San Bernardino City Unified School District programs with pregnant and parenting teens. This addresses the issues of goal setting, parenting skills, nutrition and safety, and nurturing components for teen parents.

    - Special Opportunities is a mentoring outreach for children and teens who have been targeted as extreme academic failure risk due to chaotic families, unsafe environments, and low motivation.

    - Street Medicine is a unique outreach to homeless individuals in the area who are unable to seek medical care at health clinics. This program seeks out isolated, homeless, at-risk individuals to address health care needs, refer for care, and provide health education with regards to basic care.

    - Community Kids Connection provides academic tutoring and music education in a low income part of the community using the mentor model.

    - La Escuelita is a tutoring program for parents, which provides physical activity classes, computer education and "English Language Learner" classes.

Substance abuse prevention

- Youth Hope Substance Abuse is a community drug prevention and intervention program for uninsured young adults who are homeless or with housing insecurity. This program is linked with the community-based program of Youth Hope.

- Prescription Drug Abuse Prevention and Education Program is aimed at the high schools, though reaching down to the elementary schools, providing information for students, teachers, and families of the risks of prescription drugs.

Evaluation Indicators

Short Term

- Enroll and increase the number of children involved in healthy lifestyle interventions with regards to nutrition, activity, academic, and healthy mental domains.

Long Term

- Decrease the number of days missed at school and reduced ambulatory sensitive admissions and emergency room visits.

Collective Impact Indicator

- Improve breastfeeding rates at 6 months.

- Reduce obesity in the community by creating awareness of healthy lifestyle choices.

- Improve families' ability to achieve wellness in their own neighborhoods and schools.

PROGRAM HIGHLIGHTS

The Childhood Obesity Task Force

The Childhood Obesity Task Force is committed to improving health and wellness of all children living in the Inland Empire. Increasing the quality and effectiveness of our partnerships with community organizations, schools, and cities will support lifelong healthy lifestyles. By implementing key interventions the task force will accomplish these goals:

- Education and advocacy on nutrition and obesity prevention
- Promote breastfeeding friendly cities
- Improve health policies and best practices

Breastfeeding Initiative

As part of the CDC's Healthy Communities Program, Healthy Rancho Cucamonga was launched in 2008 encouraging a healthy and sustainable lifestyle for residents and visitors. A key objective is to begin two Lactation Accommodation Rooms: a Workplace Lactation Accommodation Room in City Hall, reducing a barrier for mothers who return to work outside the home but wish to breastfeed; at Central Park. Such an initiative, although low-tech, can address many acute and chronic health issues for both mother and baby, (especially obesity). Based on composite data of epidemiological studies, breastfed babies are 13%-22% less likely to be obese than formula fed infants. Each additional month of breastfeeding decreases a baby's risk of becoming obese. Currently, the Lactation Accommodation Policy Statement has been developed and approved by the city's lawyer.

Adopt-a-School Model

With the rise of chronic diseases and obesity in San Bernardino County LLUMC Community Health Development Department decided to help by making changes at the root of the problem: increase the health within this community by improving the health of the schools. Adopting a local school, allows for the building of sustainable relationships between health systems, schools, and the community. This encourages a substantive long- term improvement in the environment of the learners. Victoria Elementary School was chosen based on criteria that identified it as an at-risk community, with three areas of focus formulated: access to health care, nutrition and physical activity, and mental health. The needs assessment found that 92% of the students were living below the poverty line, 43.1% were English learners and 59% were Hispanic/Latino, making it imperative that information and classes be in both English and Spanish. Because of the area's low socioeconomic status, little transportation is available, making it difficult for, students to access health services, healthy food options, as none are within a mile radius of the school, or some to even getting to the school.

whole.

CANCER CARE

Identified Need

- Higher than average breast cancer mortality in the Inland Empire.
- Higher than average lung cancer rates in the Inland Empire.
- Higher rates of colorectal cancer incidence and mortality rates among Inland Empire males than the statewide average.
- Higher incidence and mortality rates for cervical cancer among Inland Empire women than the statewide average.
- Higher incidence and mortality rate of prostate cancer among Inland Empire African American men than the statewide average.
- Shortage of Medical Oncologists in the community.

Goal

- Reduce the number of new cancer cases, as well as the illness, disability, and death caused by cancer.

LLUMC Strategy

whole.
CANCER CARE

The best cancer care requires highly skilled and compassionate providers who understand the complexity of each patient's needs. Our commitment to whole person care ensures that the entire cancer treatment process is individualized and focused on treating each patient's physical, emotional, and spiritual needs.

The cancer objectives for Healthy People 2020 support monitoring trends in cancer incidence, mortality, and survival to better assess the progress made toward decreasing the burden of cancer in the United States. The objectives reflect the importance of promoting evidence-based screening for cervical, colorectal, and breast cancer by measuring the use of screening tests. For cancers with evidence-based screening tools, early detection must include the continuum of care from screening to appropriate follow-up of abnormal test results and referral to cancer treatment.

At LLUH we are committed to treating interrelated factors that contribute to the risk of developing cancer. These same factors contribute to the observed disparities in cancer incidence and death among racial, ethnic, and underserved groups. The most obvious factors are associated with a lack of health care coverage and low socioeconomic status (SES). SES is most often based on a person's:

1. Income
2. Education level
3. Occupation
4. Social status in the community
5. Geographic location

In the past decade, overweight and obesity have emerged as new risk factors for developing certain cancers, including colorectal, breast, uterine corpus (endometrial), and kidney cancers. The impact of the current weight trends on cancer incidence will not be fully known for several decades. Continued focus on preventing weight gain will lead to lower rates of cancer and many chronic diseases.

Objectives

- Increase the proportion of women who receive cervical cancer screening.
- Increase the proportion of men who receive colorectal cancer screening.
- Increase the number of community events promoting early cancer detection and screening.

Interventions

1. Cancer Screenings
    - Breast cancer
    - Cervical cancer
    - Colorectal cancer
    - Prostate cancer

2. Psychosocial distress — Cancer is a complex disease process that affects patients in a variety of ways that often result in distress. Patients are assessed for psychological, social, financial, spiritual, and physical issues that can interfere with their treatment plan and adversely affect their outcome. Interventions are planned with a goal to relieve the cumulative effect of manageable stressors.

3. Community education and awareness campaign targeting prostate cancer and African American males.

4. Patient navigation to assist with barriers to access and care coordination.

5. Patient Resource Center — Brings cancer-related information to a single location providing a variety of resources to help patients better understand cancer prevention, early detection, the latest treatment options, research and more.

6. Nutrition classes for the community on cancer fighting foods.

7. Medical/Oncology and Hematology Fellowship — To ensure adequate access to appropriate medical care for cancer patients in the Inland Empire.

High rates of all-cause cancer mortality

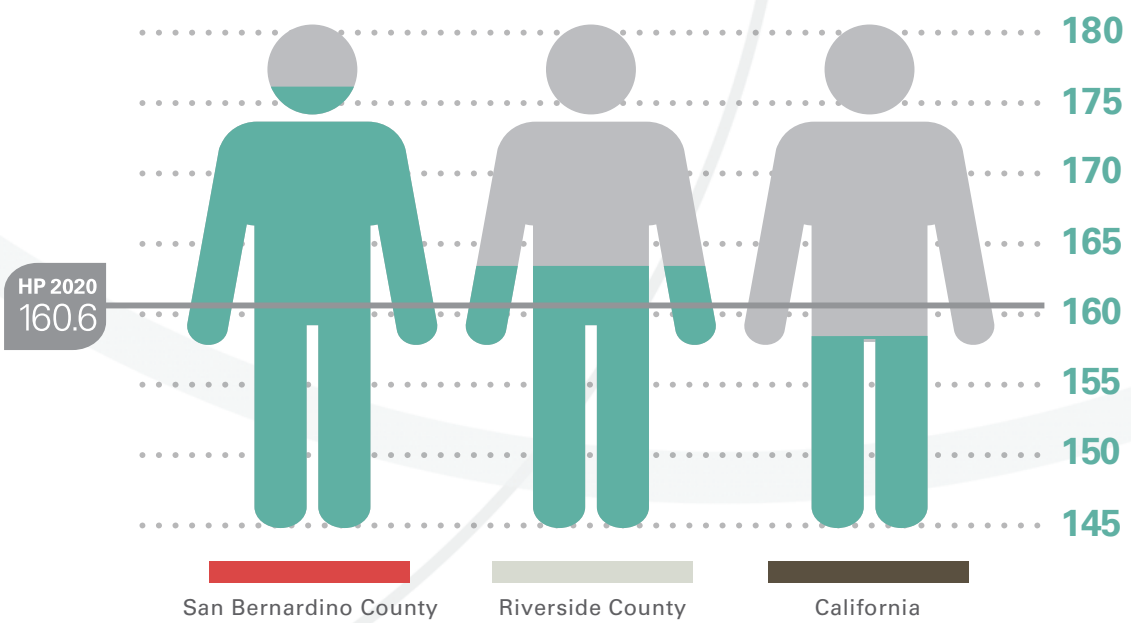
Age-Adjusted All-Cause Cancer Mortality.

Source: Cancer Registry of Greater California (2009).

- The Inland Empire has higher rates of all cause cancer mortality as compared to both California and Healthy People objective.

All Cause

HP 2020: 160.6



8. Wig bank for cancer patients - Losing your hair during treatment for cancer can be one of the most difficult side effects. Providing wigs at no cost to patients under treatment transforms not only how the women look, but also their outlook.

9. Look Good Feel Good — Dedicated to improving self-esteem and quality of life of people undergoing treatment for cancer. The aim is to improve the person's self-image and appearance through complimentary beauty sessions that create a sense of support, confidence, courage, and community.

10. Support Groups
    - Lebed Method Exercise
    - Prostate Cancer
    - Women's Cancer
    - Breast Cancer

Evaluation Indicators

Short Term

- Numbers of community contacts through health education and screenings. To include programs focused on prevention and risk identification.

Long Term

- Increase rates of screenings and earlier stage diagnosis in the region.

Collective Impact Indicator

- Decrease in late-staged diagnosis, morbidity, and mortality related to cancer.

PROGRAM HIGHLIGHTS

Patient Navigation

Patient Navigation in cancer care refers to individualized assistance offered to patients, families, and caregivers to help overcome health care system barriers and facilitate timely access to quality medical and supportive care.

Goals of Patient Navigation

- Save lives from cancer — Ensure that all patients who have a suspicious finding get resolution through more timely diagnosis and treatment.
- Eliminate barriers to care — Make sure that patients get to follow-up appointments and are aware of and can access needed services.
- Ensure timely delivery of services-Assist patients in moving through the health care system as needed in a timely manner.

Too often the positive gains made in finding cancer early are lost because of a lack of clinical follow-up by the patient. Patient navigators, while collaborating with other members of the cancer care team (e.g., physicians, nurses, social workers), guide patients through the health care system and help to prevent and eliminate barriers to quality care and treatment.

whole.

CHRONIC DISEASE CARE

Identified Need

- High rates of ambulatory care, sensitive hospitalizations and ED utilization as related to obesity co-morbidities, heart disease, and diabetes.

Goal

- Improve the continuum of care for individuals experiencing chronic disease.

LLUMC Strategy

LLUMC-Murrieta Strategy

whole.

Chronic Disease Care

The prevalence of chronic diseases is increasing in both the elderly and non-elderly populations, with a significant increase in the number of people with multiple chronic diseases. Increased spending on chronic diseases in Medicare is a significant driver of the overall increase in Medicare spending over the last twenty years.

Chronic disease care is a broad term that encompasses many different models for improving care for people with chronic disease. Elements of a structured chronic disease care program may include a treatment plan with regular monitoring, coordination of care between multiple providers and/or settings, medication management, evidence-based care, measuring care quality and outcomes, community-based interventions supporting healthy behaviors, and support for patient self-management. LLUH is taking an active role to improve the continuum of care for individuals experiencing chronic disease and is committed to an overall emphasis of improving the efficiency of health care and bridging preventive strategies in the clinical setting as well as in the community. Although an overall coordination of multiple chronic diseases will be emphasized, the interventions for this strategy will be geared toward diabetes, heart disease, and obesity related co-morbidities.

Objectives

1. Improve evidence-based protocol adherence for heart disease management within the hospital.

2. Increase community awareness on the importance of identifying their cholesterol, BMI, blood pressure, and glucose levels.

3. Improve the overall self-reported health status as good or excellent.

Interventions

Countywide Hospital Collaboration — LLUH continues to collaborate with the Hospital Association of Southern California in connecting with other area hospitals and with the San Bernardino and Riverside County Health Departments in an effort to develop cooperative approaches to improving the health of our community and to evaluate the outcomes of our community benefit programs. In 2013 not-for-profit community hospitals, along with other community agencies, have joined together with the audacious goal of displacing heart disease as the leading cause of death in our county.

1. Adopt the American Heart Association's "Get with the Guidelines" protocol in the hospital.

2. Develop, pilot, and implement a health coaching/ bridge model for underserved patients that assesses medical adherence treatment, ensuring a medical home, and provides referrals to social services.

3. Develop and implement a Faith Community Health Network that creates a continuum of both spiritual and community care.

4. Implement a Health Connection model that expands the health systems' capacity to address basic resource needs often at the root causes of poor health.

5. Coordinate and integrate nutrition and lifestyle education into existing health education programs, community settings, faith communities, and healthy communities initiative.

6. Develop specialized nutrition education programs for heart failure and diabetic patients.

7. Pilot a community-based chronic care management model utilizing community health workers for diabetic patients managed through the Diabetes Treatment Center.

8. Develop a continuum of care delivery model for diabetic and heart failure patients.

9. Pilot three models of collaborative community -based health promotion, preservation and disease prevention models.

10. Create a benchmark and dashboard to follow our socially complex patients, including homeless patients.

11. Provide flu vaccinations at health fairs and in the community.

Evaluation Indicators

Short Term

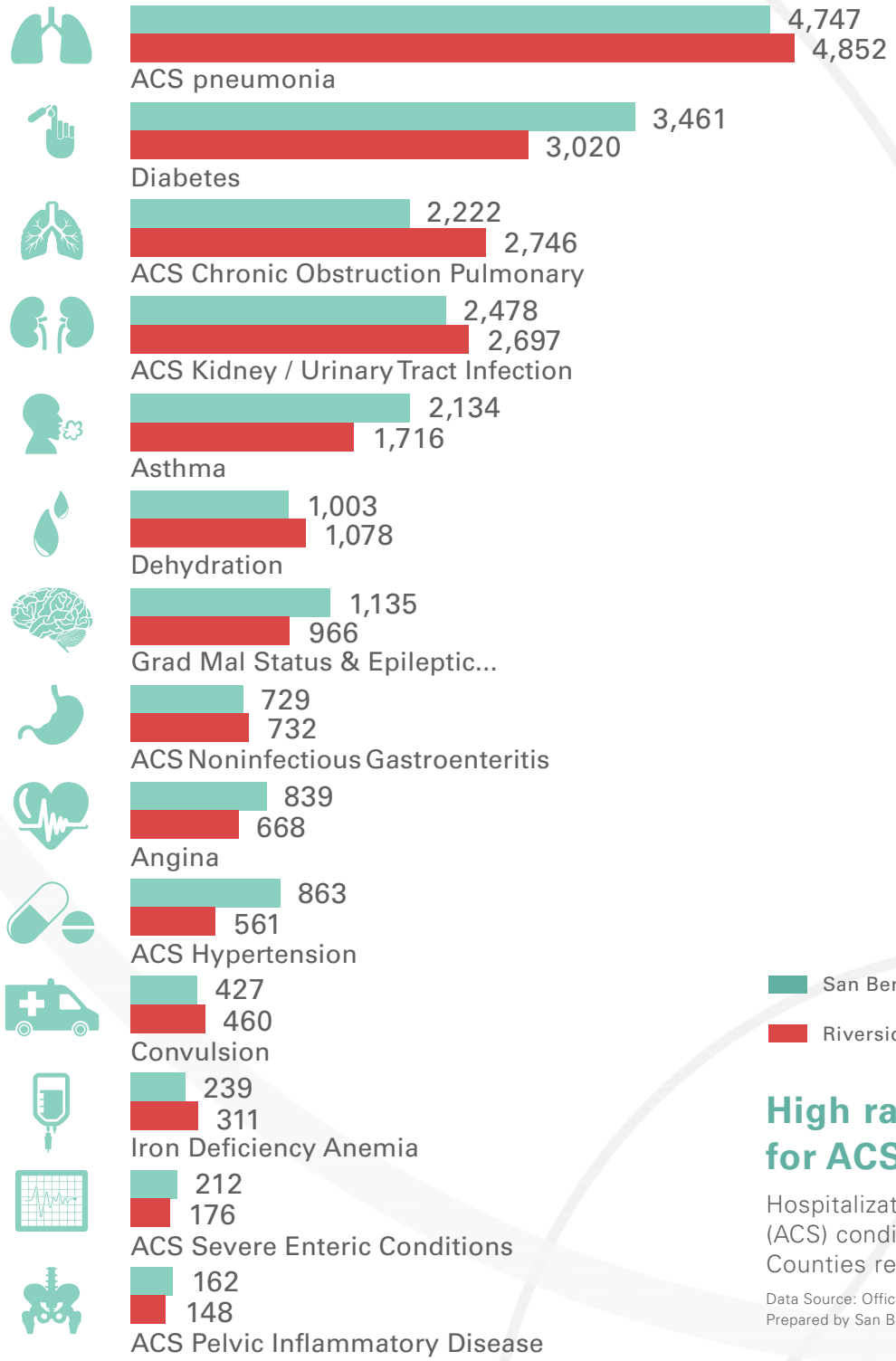
- Decrease rates of readmissions for heart failure, pneumonia, Acute Myocardial Infarctions, and acute diabetes complications.

Long Term

- Increase the sites for community-based management for diabetes.

Collective Impact Indicator

- Displace heart disease as the leading cause of death in San Bernardino County and meet Healthy People 2020 objective.



High rates of hospitalization for ACSC

Hospitalizations for ambulatory care sensitive (ACS) conditions Riverside and San Bernardino Counties residents, 2010.

Data Source: Office of Statewide Health Planning and Development (2010).
Prepared by San Bernardino County Department of Public Health.

PROGRAM HIGHLIGHTS

LLUMC — Service Area

Healthy San Bernardino (HSBC)

Healthy San Bernardino (HSBC) is an active community coalition that promotes healthy eating, lifestyles, and environments. We envision a community with:

- Access to healthy food
- Safe streets and public spaces, schools, parks, and open spaces
- Appropriate health care, wellness, and prevention, including behavioral health
- Economic stability and quality educational and employment opportunities
- Community-driven collaborative leadership
- Personal awareness, motivation, and responsibility with a community-wide sense of hope and purpose

Through the work of our three committees, policy and advocacy, health education and community engagement and health hubs, we are able to connect community members and policy makers to work toward creating a safer and healthier San Bernardino. The San Bernardino Striders was an outcome of our health education and community engagement committee, where community members are able to engage in physical activity, learn health education, and strategize to advocate for a healthier community. Our health hubs are positive centers of gravity throughout San Bernardino where multiple partner organizations are creating a place to support residents to live healthy lifestyles. Finally, our policy and advocacy committee is dedicated to implement and enact policies that support healthy lifestyles and is in the process of developing an innovative food access initiative to make locally grown fruits and vegetables available to low income residents.

LLUMC — Murrieta Service Area

Walk to the Moon with our Community

January of 2014 will "launch" the campaign to cross borders and break down barriers within our community. It is a campaign designed to encourage each community to work together and collaborate for the well-being of all our residents living in the five city area. We will encourage each other toward collaboration and a healthy life style by walking together toward an "impossible goal". Together, as a community of five cities, we will walk to the moon! Collectively, over a four-month period, we will track the distance of each participant. For example: with nearly 500,000 people living in this valley, we only need 12,000 people to walk, or the aerobic equivalent of 20 miles to have traveled the distance to the moon. At the end of the four months we will celebrate together in a multi-city wellness fair with the mantra, "We walked to the moon with our community – now look what more we can do together!"

whole.

SICKLE CELL ANEMIA CARE

Identified Need

- High readmission rates for sickle cell anemia patients.
- Increase length of stay for sickle cell anemia patients.
- Lack of providers and medical homes for sickle cell anemia patients.
- Increase rate of inpatient sickle cell discharge trends in San Bernardino County.
- Lack of adequate disease management for sickle cell anemia patients.
- Increase African-American population in Riverside and San Bernardino County, secondary to outmigration from LA County; trend expected to continue.

Goal

- To decrease morbidity and mortality and improve overall quality of life for sickle cell anemia patients.

LLUMC Strategy

whole.

Sickle Cell Anemia Care

Sickle cell disease (SCD) is a real disease with real consequences — appropriately termed "crisis." Symptoms of this inherited disease begin in early childhood and vary in severity, leading to consequences of frequent hospitalizations, disability, and early death. SCD is the most commonly inherited blood disorder affecting 1 of 500 African Americans and 1 of 1000 Hispanic Americans.

Another reality for patients living with SCD is the lack of available resources in the Inland Empire. Over the past decade there has been a notable outmigration of African Americans from Los Angeles to San Bernardino and Riverside Counties with little attention given to this disease largely exclusive to this population. We believe improving the health outcomes of this group require a focused multidisciplinary effort and health care partnerships connecting community resources, providers, and patients.

Through this focused multidisciplinary effort we will educate Medi-Cal staff regarding the clinical manifestations of the disease, the multiple complications that arise from this disease, and outline the expected appropriate acute and chronic treatment for this disease. We will strive to provide the patients with excellent care regardless of the setting.

With our efforts intact our patients will then be able to responsibly address their needs thru self-awareness, encouragement, peer education and knowledge of not just the limitations that sickle cell disease presents but the possibilities that arise from this or any challenge. We will form partnerships with interested parties in an effort to increase awareness and engage the community so that our efforts may be multiplied. In the end the patients and those surrounding them who are affected by this illness will be the passion of our work.

SCD management aligns with a long history of "mission" at LLUH and provides us an opportunity to engage not only the physical nature of this disease but also the spiritual and emotional aspects of our patients in order to achieve true healing.

Objectives

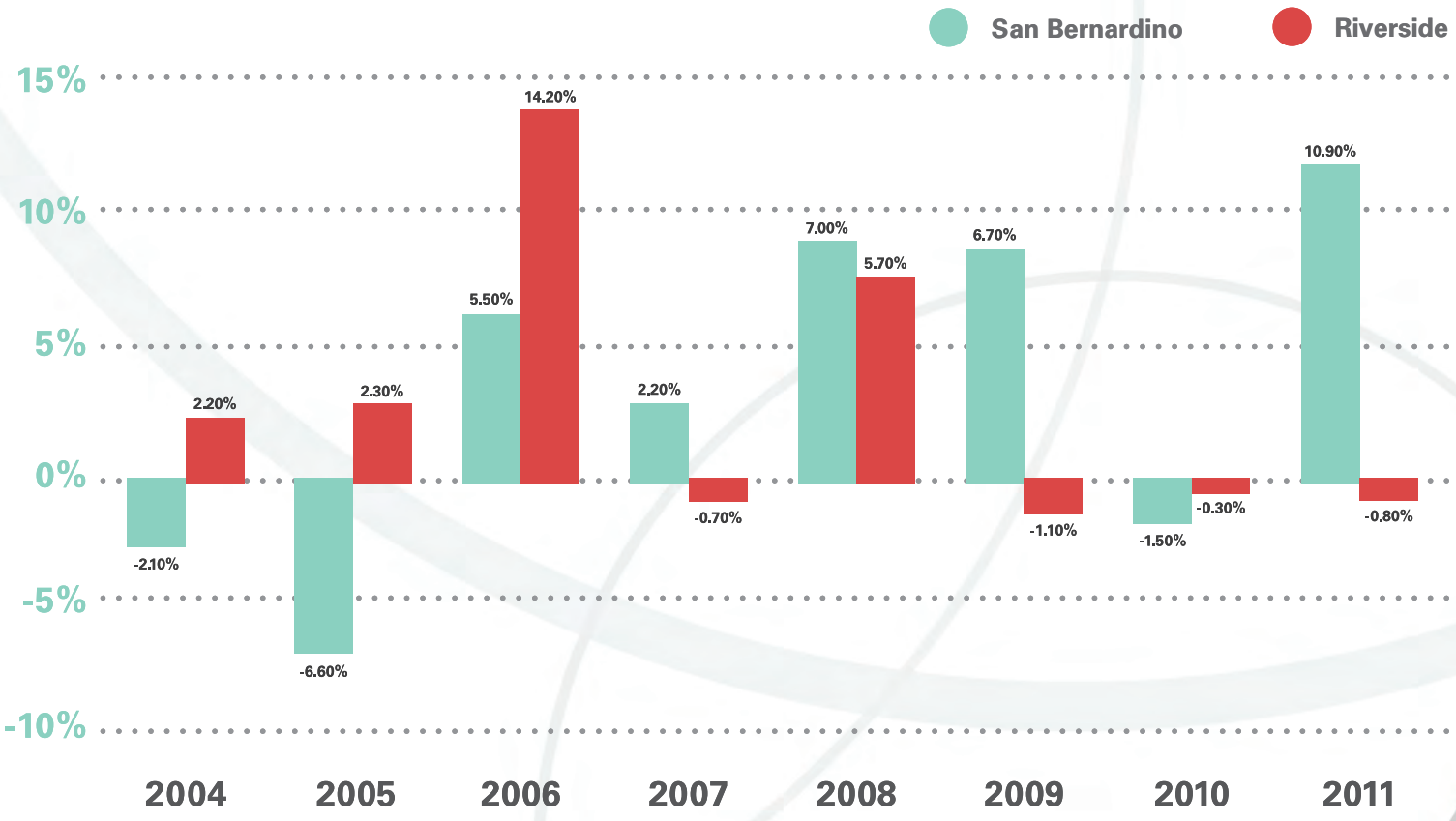
1. Decrease Emergency Department and urgent care utilization rates for adult sickle cell anemia patients.
2. Improve patient satisfaction scores for sickle cell anemia patients.
3. Increase number of health care providers educated on sickle cell anemia patients.

Interventions

Education and Awareness

1. Annual Sickle Cell Symposium.
2. Sickle Cell Anemia provider education program.
3. Community education and awareness campaign for sickle cell anemia to include the faith community.
4. Advocacy and feedback to Covered California on adequate insurance coverage for sickle cell anemia patients.
5. Representation from LLUH on the California Community Engagement Advisory Committee's for Sickle Cell Anemia care representing the Inland Empire.

Inpatient Sickle Cell Discharge Trend by Patient County of Origin, 2004-2011



Access and Care

6. Implementation of a mobile plan of care for sickle cell anemia patients.

7. Recommendations to the Inland Empire Health Information Exchange on data sharing for sickle cell anemia patients throughout the region.

8. Disease management transition program between LLUH pediatrics, hematology/oncology and adult sickle cell program.

9. Development and implementation of a medical home for adult sickle cell anemia patients.

10. Care coordinator for sickle cell anemia patients to include psychosocial services.

11. Develop treatment center models.

Evaluation Indicators

Short Term

- Increase attendance to adult sickle cell support groups.
- Improve patient satisfaction scores for sickle cell anemia served at LLUH.

Long Term

- Reduce ED utilization for sickle cell anemia patients.

Collective Impact Indicator

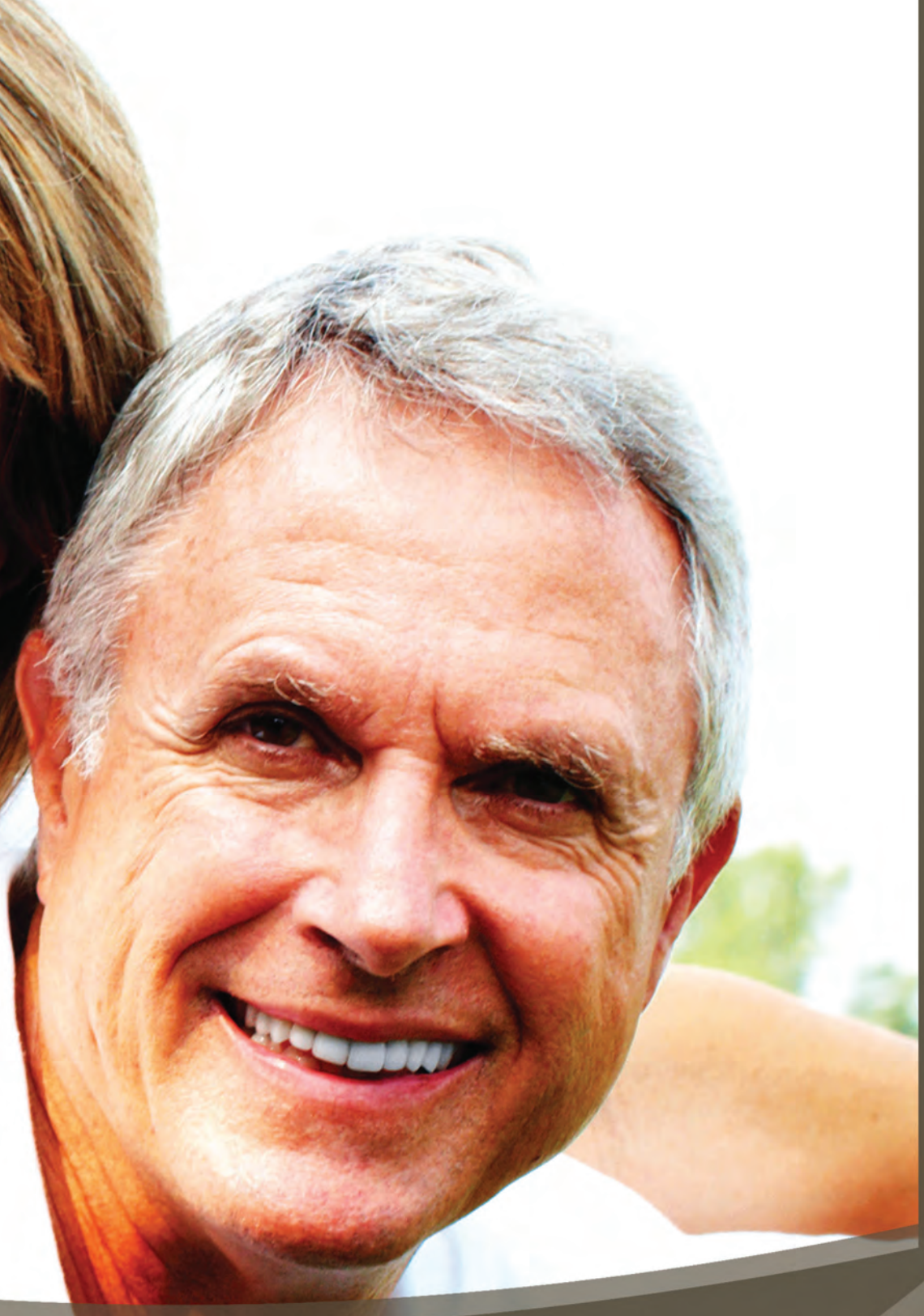
- Increase the number of providers serving sickle cell anemia patients in the Inland Empire.

PROGRAM HIGHLIGHTS

Sickle Cell Support Group

The Loma Linda University East Campus Sickle Cell support group began in 2011 with the help of the PossAbilities Program, East Campus administration, and Dr. Carolyn Rowley. This support group meets on a monthly basis to educate patients, family members, and interested persons about diverse issues related to sickle cell disease. Some of these issues include exercise, health and nutrition, and navigating the medical system. The group is currently facilitated by a sickle cell patient and a resident of the Inland Empire. The group plans to continue to grow by forming relationships with local houses of worship, advertisement via print and radio media, and fostering close ties to the local community.

whole.
AGING CARE



Identified Need

- The growth of the elderly population has outpaced the growth of any other demographic group, coupled with the increase of chronic diseases affiliated with aging.

Goal

- Empower community and community partners toward a collaborative healthy aging model for the region.

LLUMC Strategy

whole.

AGING CARE

The way we define healthy living, wellness, and aging has become increasingly significant over the past decade as the growth of the aging population has continued to outpace that of any other demographic group. Today, as the U.S. health care system prepares to implement sweeping changes brought about by legislative action, the focus on disease prevention and chronic care management has taken center stage, and the aging population is a key player. Aging, however, does not commence at a specific point; it is instead a continuum running across the breadth of the lifespan, and both an individual and communal process. A whole aging care model will engage with multiple stakeholders across the region in order to promote healthy living and aging through preventive health programs, reduction of disparities in education and access, and creation of healthy community initiatives for sustainable healthy aging, serving as an adaptable model for the national stage.

Objectives

1. Identify a common vision for healthy aging with community partners.
2. Implementation of defined models of healthy aging in our region.
3. Improve care coordination for the frail and elderly.

Interventions

Education and Awareness

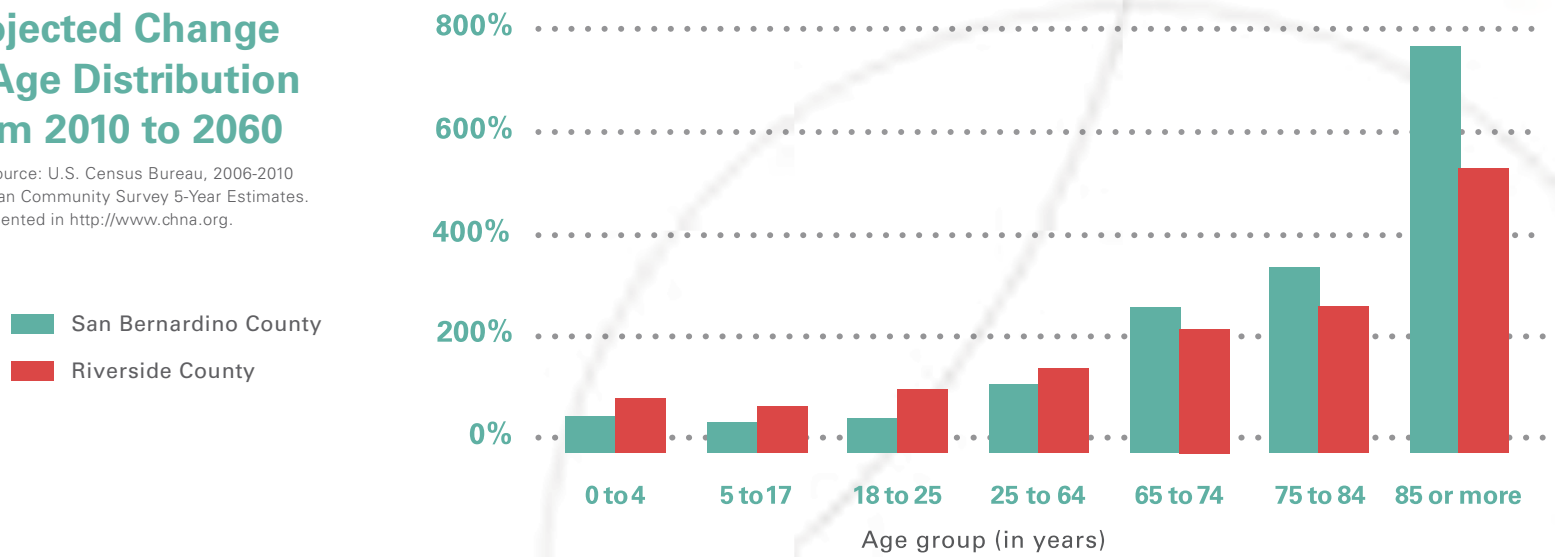
1. Whole Aging Conference – An innovative aging conference.
2. Create models of conversation centered around "Healthy Aging" – Engage community leaders in defining models of healthy aging and metrics for accountability and a collective impact.
3. Just for Seniors – A bi-monthly Well-Being newsletter is mailed to homes and covers relevant topics on preventative health care, travel, family, finances, daily living, and much more. Membership benefits include newsletter, resource directory, seminars on health, social, and financial concerns, life skills education classes, information line 1-877-LLUMC-55, and senior advocates to help navigate the system.

Access and Services

4. Community-Based Aging Model – A transformed community-based delivery model for coordinated care with all-encompassing services for the elderly. A multi sectorial approach to include the faith community, business community, education, and local government.

Projected Change in Age Distribution from 2010 to 2060

Data Source: U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates. As presented in http://www.chna.org.



5. Care Coordination for an Accountable Care Organization (ACO) with community partners.
6. Implement the American Heart Association "Get with the Guidelines" protocol at LLUH.
7. Community-based screenings for dementia.

Evaluation Indicators

Short Term

- Attendance at the Healthy Aging Conference – Increased number of community partners involved in the community conversations model.

Long Term

- Increased number of community-based services available to seniors in the Inland Empire.

Collective Impact Indicator

- An established ACO model for seniors in the Inland Empire.

PROGRAM HIGHLIGHTS

Alzheimer's Community Center for Innovative Care

is a proposed model of care that will address the complex social and medical needs of Alzheimer's patients and their families. This comprehensive, patient-oriented, innovative and sustainablemodel integrates the resources and wisdom of the community, knowledge of the health care partners, and adaptive technological innovation to empower patients and their families in achieving more consistent support and treatment, and most importantly a dignified journey. This effort supports a network of clinical and preventive measures that emphasizes LLUH's whole-person care approach.

whole.

HEALTH CARE PIPELINE

Identified Need

- High poverty rates and low education levels in our region, 1.5 million residents living in Medically Underserved Areas (MUA), and low physician ratios.

Goal

- Create a pathway for students of the Inland Empire region to enter health care occupations and ultimately to care for the residents of the Inland Empire.

LLUMC Strategy

HEALTH CARE PIPELINE

LLUH is working in collaboration with the community to prepare a health care workforce for the 21st century. Investing in our future health care workforce and developing our own local talent is a key strategy for improving the resiliency of our children. Giving our children hope for the future and empowering them with a health career may be one of the keys in improving long-term health. The higher the education levels in a community, the lower the morbidity from many common acute and chronic diseases such as heart disease, respiratory disorders and diabetes. Investing in our health career pipelines can have a positive impact on reducing not only our health care shortages and health disparities, but also the overall academic achievement throughout our region.

Objectives

1. Increase the number of students entering a health professional career in the Inland Empire.
2. Increase the networking and relationships of educational system, health system, and workforce to foster an achievable health career ladder.
3. Increase exposure of students to the career possibilities in the health system.

Interventions

1. Gateway Program — Health care exposure and unique connected summer experiences to foster interest and understand pathway to careers in health delivery systems.
2. Inland Coalition for Health Care Pathways — Regional coalition development and networking, to improve the number and quality of programs in the area. Enrolling the business community in support.
3. Tutoring Programs to strengthen science, math, and literacy.
4. Adopt A School Program — Tutoring programs for children at Victoria Elementary School, reaching into early years.
5. System-wide support of early childhood literacy — Promoting literacy at pediatrician visits and creating a partnership in preschool and school districts for collaboration and support.
6. Participation in Policy Development for Health Care Workforce at the state and local levels.
7. Strategic Planning for Health Care Pipelines in the Inland Empire with all stakeholders of the community and educational sectors.
8. Health Policy Fellows in the Healthy Communities Efforts – This is participatory activity of public health fellows embedded in the healthy community efforts. In addition, this activity places a spotlight on the importance of emerging needs of public health in policy settings.
9. Junior Public Health Policy Interns – High school students being mentored by the health policy fellows designed to expose youth to the field of public health.

Evaluation Indicators

Short Term

- Inventory for a baseline metrics of the San Bernardino and Riverside County activities with regards to education hours, health career lectures, field trips, and internships.

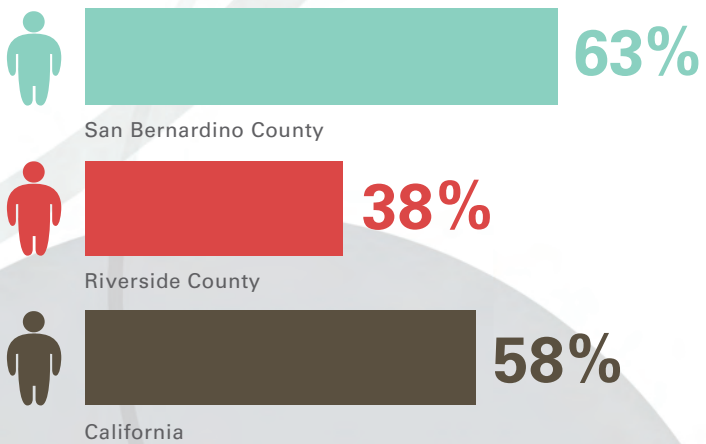
Long Term

- Increase the number of health career connections of local community entities from baseline metrics. Create the network that sponsors these educational ladders by collaborating with businesses, all educational sectors, and the health delivery systems.

Collective Impact Indicator

- Improve high school graduation rates. Third grade literacy scores to increase. Tracking of the health care career numbers.

Percent of Designated Population Underserved.



Data Source: U.S. Health Resources and Services Administration Data Warehouse, Health Professional Shortage Area (Components), May 2013. As shown in http://www.chna.org

Data Source: U.S. Health Resources and Services Administration Data Warehouse, Health Professional Shortage Area (Components), May 2013. As shown in http://www.chna.org

PROGRAM HIGHLIGHTS

Gateway Program

2012 marked the first year that the Institute for Community Partnerships combined the various pipeline programs (College Exodus, Sí Se Puede, and Partners in Progress) into one program. The Gateway to the Health Professions is a 3-week long program aimed toward introducing underrepresented minorities and underprivileged youth to seeking higher education and the health professions. In 2012, 57 students participated in the program, representing 26 local high schools. For 2013, we will be adding two new components to the program, Day of Service and a College Day at La Sierra University.

During the two-week core program, students tour the LLU Schools and receive interactive presentations from departments. In addition to exploring the health careers, students participate in workshops focusing on study skills, SAT preparation, Financial Aid, and Leadership Skills. The core program culminates with a graduation program that their families could attend and students' group presentations on the "lesser known" health professions that they had researched throughout the program.

For the final week of the program, 20 students are chosen to shadow health professionals. Many departments in the LLU Health System granted access to shadow such as: the Emergency Department, Family Medicine, Head & Neck Surgery, Anesthesiology, Obstetrics & Gynecology, Preventive Care, and more.

whole.

REHABILITATION CARE

Identified Need

- Lack of community support for all people, including people with disabilities, to have the opportunity to take part in important daily activities that add to a person's growth, development, fulfillment, and community contribution.

- The following indicator reports the percentage of the total civilian non-institutionalized population with a disability. This indicator is relevant because disabled individuals comprise a vulnerable population that requires targeted services and outreach by providers.

Goal

- Improve the quality of life for individuals with disabilities

LLUMC Strategy

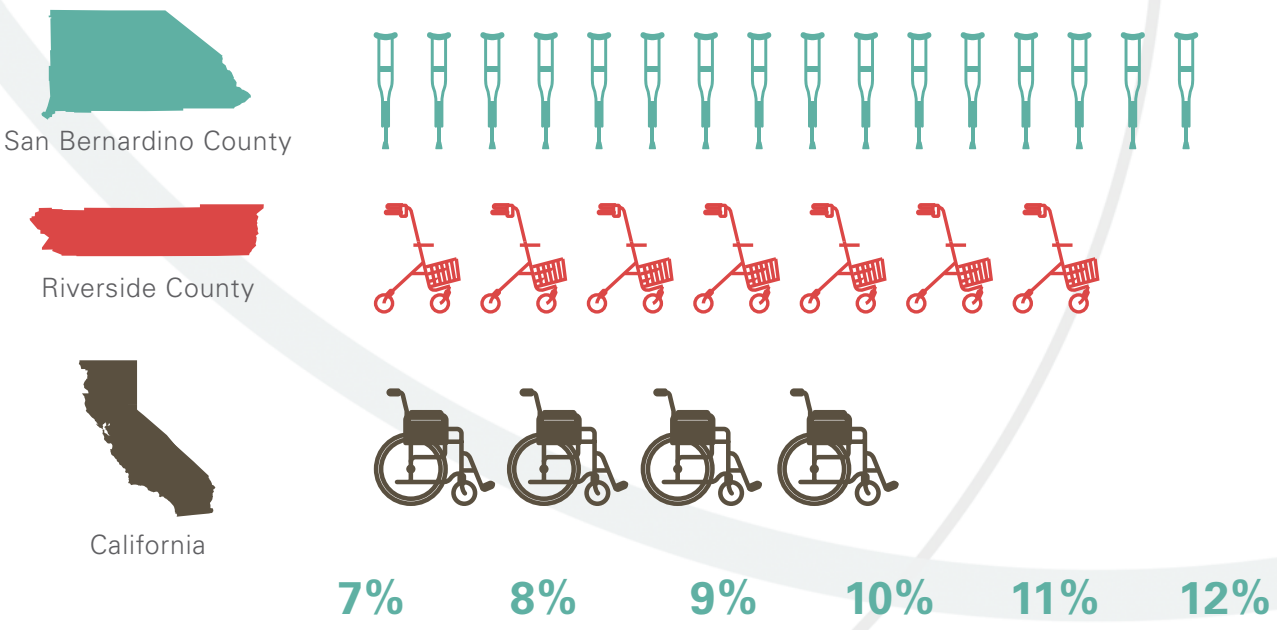
whole.

REHABILITATION CARE

LLUMC EC recognizes that this disenfranchised population is often left without resources or support for dealing with the many adjustments they must make physically, mentally, and emotionally, in order to have fulfilling lives. The mission is to provide a new direction and hope through physical, social, educational and spiritual interaction with peers and their community.

Population with a Disability.

Data Source: U.S Census Bureau, 2009 - 2011 American Community Survey 3 - Year Estimates.



Objectives

1. Increase the proportion of adults with disabilities who report sufficient social and emotional support.
2. Increase the proportion of people with disabilities who participate in social, spiritual, recreational, community and civic activities.

Evaluation Indicators

Short Term

- Attendance at the Healthy Aging Conference — Increased number of community partners involved in the community conversations model.

Long Term

- Improve the overall self-reported health status as good or excellent for the disabled population.

PROGRAM HIGHLIGHTS

Interventions

PossAbilities is a community outreach program developed in 2003 by the Loma Linda University Medical Center East Campus (LLUMCEC). Last year, the program had over 30,000 members, compromised of able-bodied (Support Members) and disabled members. The goal of the program is to provide activities and practical help to disabled individuals who were born with or have suffered a permanent physical injury. The program provides participants a sense of community as they integrate back into life, once again becoming valuable members of society. This free membership program is tailored to persons with physical disabilities such as limb amputations, stroke, spinal cord injuries, traumatic brain injuries, multiple sclerosis, muscular dystrophy, spina bifida, and other disabilities. The various sports leagues, school-sponsored PossAbilities clubs, and the annual triathlon improves the social connectedness and possibility for interaction, particularly for the disabled.

whole.

BEHAVIORAL HEALTH CARE

Identified Need

- Inappropriate utilization of Emergency Departments for 5150s in the Inland Empire.
- Difficulty accessing comprehensive behavioral health services for children, their families, and the underserved and uninsured.

Goal

- To embed behavioral health services in the overall health system in collaboration with community partners.

LLUMC-Murrieta Strategy

LLUBMC Strategy

whole.

BEHAVIORAL HEALTH CARE

Behavioral health includes both mental health and substance use disorders. Optimal mental health is when individuals have productive lives, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Behavioral health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Behavioral issues contribute to a host of problems that may include disability, pain, or death. The resulting disease burden of mental illness is among the highest of all diseases. Behavioral health and physical health are closely connected. Behavioral health plays a major role in one's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors.

LLUH as a faith-based health care leader is building partnerships with its communities to change the health status in our region. One way to support this change is the participation in our faith-based communities to help congregation members become healthy and stay healthy. LLUH is helping faith communities to redefine themselves as 'health centers,' where the whole person is treated: emotionally, spiritually, relationally, and physically. Loma Linda University Medical Center and the Behavioral Medicine Center are teaming up with the Department of Psychiatry and other academic departments in our system, along with faith communities to address the mental health needs in the surrounding community. It is a well-established fact that clergy may often be the first line of treatment for mental health. The purpose of this partnership is to assist in the development of their own faith communities to be truly communities for healing, and to provide resources to clergy and faith leaders to be a more effective outreach to their own members.

Launching initiatives around chronic diseases, within faith communities, is proving to be effective in improving health outcomes. Together, a health care system with advanced medicine and a proven history of prevention, and faith communities centered around hope, love, and trust, can achieve more than either one working alone. Close relationships with faith-based organizations in the area will be at the core of reaching individuals and families by becoming an integral part of their community.

LLUH recognizes that there are many ways to collaborate with our community, form partnerships, and achieve a common purpose. That is why LLUH

recognizes a need to collaborate with not only our faith-based organizations (FBOs) but also all sectors of our community including law enforcement, educators, and parents.

Objectives

1. Increase the proportion of primary care facilities that provide behavioral health treatment on site or by paid referral.
2. Embed behavioral health community services into all aspects of primary care.
3. Increase the proportion of children with mental health problems who receive treatment.

Interventions

Education, Awareness, and Screening

1. Develop thematic conferences (e.g. Addictions and Faith; Domestic Violence; Ministering to those with Severe Mental Illness) to bring national and international experts to further support the work of those in ministry.

2. Create an Affordable Care Act Task Force to address the upcoming policy changes impacting behavioral health.

3. Provide Behavioral Health Education and Awareness – Education aimed at professionals and non-professionals in the community such as clinicians, teachers, case managers, students, and community members. The goal is to provide informational topics within the scope of behavioral health that will reduce stigma, increase knowledge, and assist community members with accessing services.

4. Provide Behavioral Health Screenings – screenings geared toward the general community in the Inland Empire, senior facilities, and/or employer organizations. At least one clinical therapist or program representative handles program specific questions and interprets depression screening and mental health assessment results. Service information is displayed through various collateral pieces such as brochures, flyers, posters, and other promotional items.

5. Provide Senior Behavioral Health Services – Activities addressing senior behavioral health typically are in the form of general education, screenings, and awareness activities as much of the geriatric population are often reluctant to access mental health services because of the stigma and shame they may be feeling. Additionally, the Medical Director collaborates with other providers and educates them on signs and symptoms to look for in their patients so they are better able to detect any underlying psychiatric conditions that need to be addressed.

6. Distribute *Staying with Sobriety* Newsletter – A newsletter that can be accessed through the mail, website or via email. Announcements, mental health education program notices and events, a featured story to honor chemical dependency graduates, are included in the newsletter. Additionally, there are tools that are given to the readers on how to maintain their sobriety.

Building Resource Capacity

7. Develop specialized resources and identification of best practices for the promotion, prevention, and critical interventions that can be delivered by those in direct ministry.

8. Develop formal and informal processes to network, and resource pastors with skills to address the needs of their communities in the area of mental health and addictions.

9. Implement the "Moses Principle Intervention." Even Moses needed someone who would hold his arms when he blessed the people. Spiritual leaders, just like Moses, need to be supported as well. This intervention seeks to facilitate access to mental health resources for ministers (and their spouses), as the success and emotional health of their communities rest on their shoulders.

10. Implement an informal *Case Discussions on Challenging Mental Health Issues in the Faith-Based Communities*, creating a safe place for clergy in the local community to address and discuss the mental health issues and needs of their congregations with peers and licensed mental health professionals.

11. Develop a Faith Community Health Network (FCHN) representing the spectrum of faith traditions receiving health services at LLUH.

12. Provide information and referral services for veterans experiencing PTSD through faith communities.

13. Implement a Faith Community Hotline that connects to our Health Leads Program.

14. Provide Chemical Dependency Children's Program – Chemical Dependency Children's Program is a six-week program that meets once a week for two hours providing treatment to children of addicted parents. The goal is for children to identify with other children and decrease the feeling of isolation. Educating the child of the addiction disease concept, aiding in overcoming the emotional burden of wanting to cure their parents, creating awareness of their own genetic pre-disposition to addiction, and enabling the children to express themselves in a safe environment that empowers them to communicate their feelings with their parents in the presence of their peers and other patients' families is a way to engage children in the healing process.

15. Provide SHIELD Behavioral Health Trainings. Trainings are often geared toward community members, law enforcement, medical providers, teachers, or faith-based leaders, who work with adolescents in some scope. The clinical therapist equips the community with knowledge of adolescent self-injurious behavior and the skills to handle a situation while providing information on what services will best meet the child's needs as it relates to self-injurious behaviors.

16. Continue Substance Abuse Support Groups
    a. Alcoholics Anonymous
    b. Narcotics Anonymous
    c. Pain Pills Anonymous

17. Grow MEND (Master Each New Direction), an outpatient program that helps children with severe chronic illness deal with or avoid stress, understand, accept, and live into adulthood with the unique challenges of chronic disease.

Evaluation Indicators

Short Term

- Number of faith communities involved in the FCHN.

Long Term

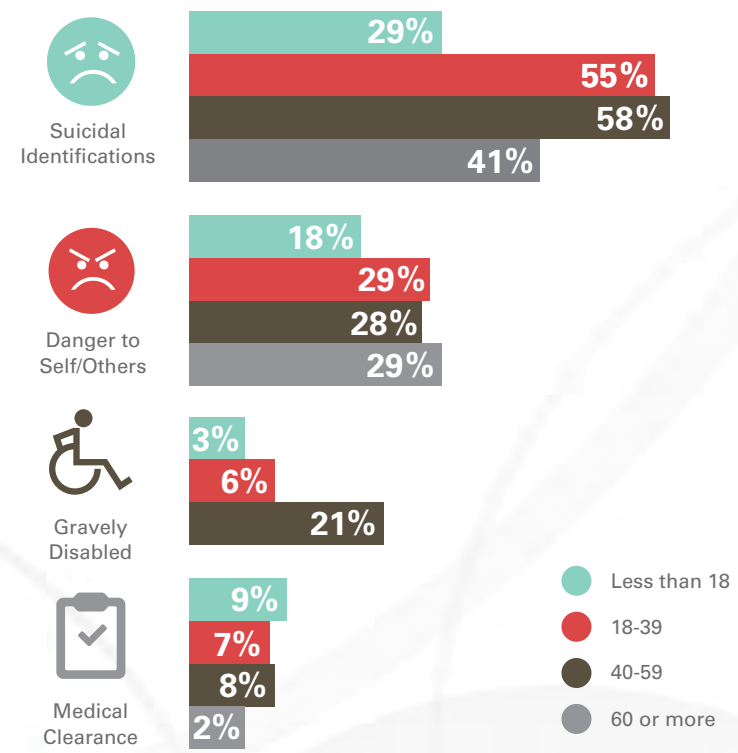
- Increase screenings by primary care providers and provide referrals and/or community resources.

Collective Impact Indicator

- Improve the number of completed referrals for behavioral health services accessing 211.

High Rates of 5150's in Emergency Departments

Data Source: Loma Linda University Medical Center, Community Health Development.



PROGRAM HIGHLIGHTS

Adolescent Self-Injury Program

In November 2008, LLUBMC opened the Shield Program for Adolescent Self-Injury. Shield is one of the only programs of its kind in Southern California that uses Dialectical Behavior Therapy (DBT) as the therapeutic approach for adolescents who self-injure. The treatment team teaches specific skills to stop self-injurious behaviors and manage emotions effectively. This is a grant-funded program sponsored by the UniHealth Foundation. The program helps reduce multiple inpatient hospitalizations, suicide attempts, and self-injurious behaviors and is especially designed for adolescents and their parents.

Master Each New Direction (MEND) - Child and Adolescent Chronic Illness Program

This program is designed to support the patient and his/her family in maintaining or regaining emotional health and balance during the process of a significant medical illness or treatment such as transplantation, diabetes management, or chemotherapy. Patients and their families work together with a team of expert therapists and clinicians on areas including anxiety, body image, medical compliance, and depression. This unique program is a true collaboration between behavioral and medical health disciplines. Providers understand that there are many complexities children face when managing a chronic illness. To ascertain better long-term outcomes, compliance with medical regimens and reduced hospitalizations, addressing the behavioral and emotional issues associated with chronic illnesses is key. By equipping patients with coping skills and helping them to accept and better understand the disease process, patients will manage their illness in a more effective and productive way. Rigorous program evaluation efforts are currently under way to support the positive outcomes seen in our patients. The success of our children's program, which has been growing the past two years, has prompted the development of a similar program for adults.

Community Benefit Administrative Council (CBAC)

In 2009/2010 LLUMC created the Community Benefit Administrative Council (CBAC). CBAC reports to the Mission-Focused subcommittee of the LLUMC Board of Trustees and a Board member serves on CBAC.

The purpose of CBAC is to enhance communication and help create synergy among community benefit interventions, aimed at improving the health of the community and develop interventions. CBAC council members meet quarterly to review the status and progress of LLUMC, LLUBMC, and LLUMC-Murrieta community benefit interventions. Additionally, the council members assure organizational compliance with relevant community benefit legislation.

Core Principles

1. Emphasis on communities with disproportionate unmet health needs.
2. Emphasis on primary prevention care.
3. Build a seamless continuum of care.
4. Emphasis on community capacity building.
5. Emphasis on collaborative governance.

LLUH Community Benefit Administrative Council

Last	First	Title
Barilla	Dora	Assistant VP Strategy and Innovation, LLUH
Baltazar	Angelica	Health and Human Services Industry Support Specialist, ESRI
Baum	Marti	Medical Director, Community Health Development
Belliard	Juan Carlos	Associate Professor in Global Health, School of Public Health Director, Institute for Community Partnerships
Clark	Cynthia	Director, Employee & Community Wellness, LLUMC – Murrieta
Chinnock	Richard	Chair, Department of Pediatrics, LLU School of Medicine
Chrispens	Jere	Member, LLUMC Board of Trustees
Clem	Kathleen	Chair Department of Emergency Medicine, LLUMC
De Luca	Evette	Community Transformation Specialist, LF Leadership
Elwell	Larry	Principal, Victoria Elementary School
Gillespie	Timothy	Faith and Health Liaison, Community Health Development, LLUMC
Mahany	Kevin	Director, Advocacy & Healthy Communities, St. Mary Medical Center
McKenzie	Monica	Perinatal Educator, Staff Development, LLUMC
Payne	Pedro	Manager, PossAbilities & Just for Seniors, LLUMC East Campus
Pruna	Tina	Director, Community-Academic Partnerships (CAPS), LLU
Shah	Huma	Assistant Professor, Loma Linda University- Department of Health Policy and Management Director Research, LLUBMC
Storjfell	Judy	Sr. Vice President for Patient Care Services, Chief Nursing Officer LLUH
Winslow	Gerald	Vice President, Mission and Culture, LLUMC

Community Partners that Care

LLUH supports and enhances regional efforts in place to promote healthier communities. Partnership is not used as a legal term, but as a description of the relationships of connectivity that are necessary to collectively improve the health of our region. One of the objectives is to partner with other not-for-profit and religious organizations that share our values and priorities to improve the health status and quality of life of the community we serve. This is an intentional effort to avoid duplication and leverage the successful work already in existence in the community. Many important systemic efforts are under way in our region and we have been in partnership with multiple not-for-profits to provide quality care to the underserved in our region.

Institute for Community Partnerships (ICP)

In an effort to intentionally partner with our community to elevate the health status in our region, the LLUH hospitals joined together with other entities in the Loma Linda University Health Sciences system forming the Institute for Community Partnerships (ICP). ICP aspires to increase communication, collaboration, and empowerment of all on-campus entities serving the local community as well as their community partners. LLUH's Community Health Development department is also active in channeling student and faculty volunteers from Loma Linda University into service learning projects in the local community.

Last year, the CBAC council grants developed strategic collaborations with the following organizations.

LLUH believes that partnerships are effective tools in improving the health of our community. Together, we are able to leverage our resources and strengths and have a greater impact. We can build a greater sense of community and a shared commitment toward health improvement.

Local Organization	Purpose	Objectives
Health System Learning Group **Stakeholder Health**	Bring together 40 health systems to take advantage of the opportunities presented by national health reform to re-examine health system practices.	• Deliberately embraces a 'learn-in-the-open' approach – sharing transparency, while harvesting lessons from promising practices in the field. • Promotes proactively managing charity care and leveraging community benefit requirements, not only to assess community health, but to invest in community health with a true integrative strategy. • Document its learning in this starting monograph in order to challenge leaders in the field to be the early adopters of an ensemble of practices that will improve health status, both inside and outside of their health systems.
Social Action Community (SAC) Health System	Support the development of a community-based clinic and create an infrastructure for the clinic to become financially sustainable.	• Increase the proportion of persons who have a specific source of ongoing care. • Increase the proportion of persons with health insurance.
Community Clinic Association of San Bernardino County	To support the Community Clinic Association of San Bernardino in building an effective, county-wide association of community clinics that efficiently deliver culturally appropriate quality health care to the medically indigent, underserved, uninsured, and/or underinsured.	• Support the development of a community clinic association to increase the capacity and sustainability of the community clinics in the Inland Empire.
Latino Health Collaborative (LHC)	To support LHC in improving the health of Latinos and our community to address barriers within the public and private systems that impact health and access to health care.	• Increase health equity by strengthening civic engagement, increasing in health professions, building capacity of community-based organizations, strengthening relationships with health systems, and public education and advocacy.

We would like to thank our partners for their service to our community.

- Air Quality Management District (AQMD)
- American Cancer Society
- American College of Cardiology
- American Heart Association
- American Lung Association
- American Red Cross
- AmeriCorps
- Boys and Girls Club
- C.E.R.T. - Community ER Response Team
- California Association of Marriage & Family Therapists
- California Bicycle Coalition
- California Safe Program
- California Thoracic Society
- Catholic Diocese of San Bernardino
- Central City Lutheran Mission
- Chamber of Commerce – Inland Empire
- Childhood Cancer Foundation of Southern California, Inc.

- Community Clinic Association of San Bernardino County
- CVEP Career Pathways Initiative
- First 5 of San Bernardino and Riverside
- Faith-Based Communities
- Inland Coalition for Health Professions
- Inland Empire Children's Health Initiative
- Inland Empire United Way
- Inland Empire Women Fighting Cancer
- Latino Health Collaborative
- Jefferson Transitional Program
- Nu Voice Society Inland Empire
- Omnitrans
- Partners for Better Health
- Reach Out
- Riverside County Emergency Medical Services (RCEMS)
- Riverside County Department of Public Health
- Ronald McDonald House
- Riverside County Department of Public Health
- SAC Health System
- Safe Kids Inland Empire Coalition
- San Bernardino Associated Governments (SANBAG)
- San Bernardino City Schools Wellness Committee
- San Bernardino County Healthy Communities
  - Healthy Adelanto
  - Healthy Apple Valley
  - Healthy Big Bear Lake and Greater Big Bear Valley
  - City of Bloomington
  - Healthy Chino
  - Healthy Chino Hills
  - Healthy Colton
  - Healthy Fontana
  - Healthy Hesperia
  - Healthy High Desert
  - Healthy Highland
  - Healthy Loma Linda
  - Healthy Montclair
  - Healthy Muscoy
  - Healthy Ontario
  - Healthy Rancho Cucamonga
  - Healthy Redlands
  - Healthy Rialto
  - Healthy Rim of the Mountain Communities
  - Healthy San Bernardino
  - Healthy Upland
  - Healthy Victorville
  - Healthy Yucaipa
- San Bernardino County Medical Society
- San Bernardino County Department of Public Health
- San Bernardino Mexican Consulate
- San Manuel Band of Mission Indians
- Think Together

2012 Community Benefit Data/Information

For over a century, Loma Linda University Health (LLUH) has been fulfilling the mission "To Make Man Whole." From a humble beginning LLUH has grown to nearly 900 beds for patient care including beds at LLUMC, LLUMC East Campus, LLU Children's Hospital, and LLU Heart Surgical Hospital, LLUMC- Murrieta, and LLU Behavioral Medicine Center. Each year the institution admits more than 33,000 inpatients and serves over half a million outpatients provided by our 400 + faculty physicians. LLUMC is the only tertiary-care hospital in the area and the only Level 1 regional trauma center for Inyo, Mono, Riverside, and San Bernardino Counties. In 2013 LLUMC-Murrieta converted to a not-for-profit hospital, making them the newest addition to our system. These numbers below do not represent Murrieta in 2012 but we look forward to reporting Murrieta's community contribution for 2013. We are proud to expand our mission to the western region of Riverside County by providing health services to the community.

Community Members Served Annually **234,384**

Medi-Cal and Other Means Tested Government Programs	$15,524,093
Charity Care	$25,289,879
Community Health Development	$5,654,768
Subsidize Health Services	$906,036
Health Professions Education & Research	$48,032,684
Total Community Benefit Economic Value	**$95,407,460**

Community Members Served Annually

234,384

Terms and Definitions – 2012
(Reported May 2013)

Medical Care Services (Charity Care and Un-reimbursed Medi-Cal and Other Means-Tested Government Programs)

Free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are thereby deemed unable to pay for all or portion of the services. Charity Care does not include: a) bad debt or uncollectible charges that the hospital recorded as revenue but wrote-off due to failure to pay by patients, or the cost of providing care to such patients; b) the difference between the cost of care provided under Medicaid or other means-tested government programs, and the revenue derived therefrom; or c) contractual adjustments with any third-party payers. Clinical services are provided, despite a financial loss to the organization, measured after removing losses, and by cost associated with, Charity Care, Medicaid, and other means-tested government programs.

Community Health Improvement

Activities that are carried out to improve community health, extend beyond patient care activities and are usually subsidized by the health care organization. Helps fund vital health improvement activities such as free and low cost health screenings, community health education, support groups, and other community health initiatives targeting identified community needs. Subsidized Health Services – clinical and social services that meet an identified community.

Health Professions Education

Educational programs that result in a degree, certificate, or training that is necessary to be licensed to practice as a health professional, as required by state law; or continuing education that is necessary to retain state license or certification by a board in the individual's health profession specialty. It does not include education or training programs available exclusively to the organization's employees and medical staff, or scholarships provided to those individuals. Costs for medical residents and interns may be included.

There is a new bottleneck effect occurring in medical education. Since the release of the Flexner report a century ago, the "rate limiting step" to a physician's career has been acceptance into a nationally accredited medical school. For decades the second step in medical education, residency training, was relatively perfunctory because of a surfeit of internships (post graduate year -1) positions. Residency directors would clamor to match any United States MD graduate who failed to match on their first attempt. Because the number of new residency positions has not kept pace with the increase in US medical graduates, there has been a recent and dramatic shift in supply and demand. The bottleneck to a career in medicine is now the limited number of first-year residency positions.

Budget challenges not only make new funding unlikely but also threaten to cut current monetary support for this crucial step in medical education.

Currently Loma Linda University Medical Center budgets the salary and benefits of more than 100 residents beyond the capped number of positions paid by Medicare. With the commitment of the Medical Center and our affiliated teaching hospitals, Loma Linda University has more than 700 residents in 46 specialties. We have 186 PGY-1 slots and a medical school enrollment of 168. We are doing more than our share in making sure that our local, national and worldwide community is supplied with competent, caring practicing physicians.

Research

Any study or investigation in which the goal is to generate generalized knowledge made available to the public, such as underlying biological mechanisms of health and disease; natural processes or principles affecting health or illness; evaluation of safety and efficacy of interventions for disease such as clinical trials and studies of therapeutic protocols; laboratory-based studies; epidemiology, health outcomes and effectiveness; behavioral or sociological studies related to health, delivery of care, or prevention; studies related to changes in the health care delivery system; and communication of findings and observations (including publication in a medical journal).

Subsidized Health Services

Subsidized health services are clinical programs that are provided despite a financial lost so significant that negative margins remain after removing the effects of financial assistance, bad debt, and Medicaid shortfalls. The service is provided because it meets an identified community need and if not longer offered, it would either be unavailable in the area or fall to the responsibility of government or another not-for-profit organization to provide.

Community Health Development Team

Gerald Winslow, PhD
VP Mission and Culture

Dora Barilla, DrPH
Assistant VP Strategy and Innovation

Marti Baum, MD
Medical Director, Community Health Development

Angela Coaston, RN, MSN, FNP, PHN
Manager, Community Health Development

Timothy Gillespie, D.Div
Faith and Health Liaison
Mission and Culture

Laura Acosta, MPH (c)
Community Health Development

whole.

LOMA LINDA
UNIVERSITY
HEALTH

11175 N. Mountain View Avenue, Suite M
Loma Linda, CA 92354
909-558-3842