Loma Linda University Health

Community Health Implementation Strategy (CHIS)

Fiscal Years 2020-2022

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Community Health Implementation Strategy

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

Loma Linda University Health
Licensed Hospitals

Loma Linda University Medical Center
11234 Anderson St,
Loma Linda, CA 92354
Phone # (909) 558-4000

Loma Linda University Medical Center - East Campus
25333 Barton Rd,
Loma Linda, CA 92354
Phone # (909) 558-4000

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

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

Loma Linda University
Children's Hospital
11234 Anderson St,
Loma Linda, CA 92354
Phone # (909) 558-4000

Children's Hospital License # 46-3214504

Loma Linda University
Behavioral Medicine Center
1710 Barton Rd,
Redlands, CA 92373
Phone # (909) 558-9275

Behavioral Medicine Center License # 33-0245579

Loma Linda University
Medical Center – Murrieta
28062 Baxter Rd,
Murrieta, CA 92563
Phone # (909) 290-4000

Medical Center – Murrieta License # 37-1705906

To continue the teaching and healing ministry of Jesus Christ

To our community,

The implementation strategy presented here represents the four licensed hospitals of Loma Linda University Health's commitment to be relevant and responsive to needs of the community as identified in the 2019 Community Health Needs Assessment. At LLUH, we have been working with the people of the Inland Empire for over 100 years in fulfillment of our institutional mission to continue Christ's work on earth through both our educational and health care mission.

LLUH is committed to improving the health and well-being of the people in our community through our community benefit investments and strategies.

The implementation strategy presented here is based on the collective voice of the community members we surveyed, will be implemented on behalf of the community, and will be evaluated by the community through our ongoing community conversations.

Adopted by our board on August 27th, 2019, the needs, priorities, and strategies represented here are our commitment to implementation through the work of the LLUH Institute for Community Partnerships (ICP) as ICP translates LLUH's plan into action. We will go where those in our community ask LLUH to work with community members, non-profit partners, and public partners to provide resources, access to services, linkages, social supports, and most importantly, increased connection and community.

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

Richard Hart, MD, DrPH
President
Loma Linda University Health

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

Thomas Lemon
Chairman of the Board
Loma Linda University Health

Board Adoption of the LLUH CHIS

Fiscal Years2020-2022

Documented Board Approval of the CHNA needs & CHIS Priorities & Implementation Strategy obtained August 27th, 2019 *Except from Board Minutes*

For the following item, the LLUH Board acted on behalf of itself and as the Boards of LLUMC, LLUBMC, LLUCH and LLUMC-M

2020-2022: COMMUNITY BENEFIT PRIORITIES & IMPLEMENTATION STRATEGIES
LLUH-BT-19-046

Dr. Juan Carlos Belliard presented the 2020-2022: Community Benefit Priorities and Implementation Strategies (Exhibit A) which included:

- Community Benefit requirements
  - Understand community – every three years a Community Health Needs Assessment (CHNA) is done
  - Invest in un-met health needs – Board approval of three-year Community Health Implementation Strategy (CHIS)
  - Measure impact – annual report on outcomes
- Community Health Needs Assessment (CHNA) done with the community in 2019
- CHNA 2019 findings
  - Poverty and access to essentials
  - Access to care
  - Behavioral health
  - Green spaces
- LLUH proposed priorities 2020-2022
  - Workforce development
    - Addressing poverty and access to essentials
  - Health and wellness
    - Addressing access to care, behavioral health, and green spaces

- Next steps
    - Engagement
        - Continuous community engagement and conversations
        - Engagement with partner hospitals to address regional problems (homelessness & recuperative care)
        - Leverage strong community partners for collective impact
    - Logistics
        - Board adoption of CHIS priorities (August 27, 2019)
        - Draft & review plans for each hospital
            - 3-year timeframe in which to address needs
        - Hospital-specific focus & objectives:
            - BMC & Murrieta have allocations now for specific projects

Time was allowed for questions.

It was noted it would be good to develop a common focus for healthcare in the community for the Adventist health systems. The Adventist Health Policy Association (AHPA) President will be asked to develop something that could come back to the various system boards.

The 2020-2022 Community Benefit Priorities and Implementation Strategies were presented to the LLUH Board of Trustees for information. The priorities and implementation strategies were also reviewed by the
LLUMC, LLUBMC, LLUCH, and LLUMC-Murrieta Boards of Trustees. It was

VOTED to approve the 2020-2022 Community Benefit Priorities and Implementation Strategies as presented.

August 27, 2019

LOMA LINDA UNIVERSITY HEALTH

Institute for Community Partnerships

Mission

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

Vision

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

Values

Collaboration, Respect, Equity, Compassion, and Excellence

The LLUH Institute for Community Partnerships wishes to thank the following community-based organizational partners in conducting the 2019 CHNA to support the creation of our implementation strategy:

CEO San Bernardino

Consulado de Mexico en San Bernardino

Community Health Systems, Inc.

Faith Advisory Council for Community Transformation

Huerta del Valle

Institute for Community Partnerships – Community Benefit Administrative Council

Loma Linda Spanish Church of Seventh-day Adventists

Loma Linda University Medical Center – Murrieta, Community Advisory Council

Loma Linda University Medical Center – Murrieta, Pediatric Advisory Council

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

Loma Linda University Health – San Manuel Gateway College

La Escuelita

San Bernardino County Youth Advisory Board

San Bernardino County Superintendent of Schools

San Bernardino City Unified School District

Sanctuary of Our Lady of Guadalupe (Mecca)

Torres Martinez Desert Cahuilla Indians

Youth Hope Foundation

LLUH wishes to thank SAC Health System, our Federally Qualified Health Center care partner in the care of the most vulnerable populations in our region:

Summary of Findings

Summary of Findings

In 2019, Loma Linda University Health conducted a Community Health Needs Assessment (CHNA)[1] in partnership with non-profit, community-based partners and their community health workers in order to implement a social determinants of health survey with 1060 community members; to conduct community conversations in both English and Spanish (focus groups) with over 200 community members; and to survey 74 families on children's health. Seventy-nine percent of the people who participated in the extensive survey effort were from households living on $50,000 a year or less, with 44% of participants living on $25,000 or less. The CHNA achieved a statistically significant sampling of community members living on lower incomes and achieved representation for the 4.85 million people in our region, in keeping with community benefit guidelines for identifying the un-met health needs of the *most vulnerable* members of the community. Most importantly, the needs identified through the methodology of this study were those the *community members* identified as the most pressing needs in their communities.

The following is a summary of the highest priority needs identified by the 2019 CHNA:

Over and over again, the difficulties people face day-to-day in affording the essentials and by the experience of poverty were echoed as people shared the challenges with cost of living in our region. The triple impact of the need for jobs, affordability of housing, and the ability to afford healthy foods experienced by community members moved **poverty and access to essentials** to the top of the areas of greatest need representing a cluster of the following: income insecurity (or the need for jobs), food insecurity, and affordable housing or housing insecurity.

Although the intent of a CHNA is to identify needs, the methodology of this assessment was a needs and asset-based approach to community assessment. The resiliency of the people who live and work in the Inland Empire is at the core of the assets identified. **Resiliency** is also the backbone to the needs the community expressed. In the many encouraging community conversations, people told us again and again that they want more community and that they were aware they needed to increase the health of our community. There was a strong sense of hope for the future. The resounding message of the 2019 assessment is that we truly are healthier when we are together in community. Places of community were also noted as our region's top strengths: **places of worship, education, community centers, and neighborhoods, voiced as "my neighbors," were the most frequently cited strengths**. Despite the challenges many of the people who participated in the

[1] For a complete copy of the 2019 CHNA and to read the details of the study, please visit: https://lluh.org/about-us/community-benefit/reports-and-resources

CHNA cited, they equally shared a strength in community and **a desire for increased experience of community**.

> … Youth mentioned they felt isolated due to technology and a desire to be in community with adults who could just listen to them.
>
> … Older adults shared a desire to help young people navigate the complexities of modern living and a need to they felt for connections.
>
> … Middle-age adults and parents talked about the stress of the cost of living and affordability of the essentials coupled with the challenges of parenting in the age of smart phones and 24-hour internet and social media. Parents caring for children, especially children or family members with special needs, spoke of care for the caregivers in our region.

All of the community members shared a belief in the power of community through their desire to experience more of it through relationship, interconnection, and increased social support. The need for community was a key finding that aligned with the growing sense of isolation affecting people in our region and beyond.

The 2019 LLUH CHNA: A representative sample of low-income peoples living with resiliency and community, despite the challenges of poverty in San Bernardino & Riverside Counties

Total Community Members Surveyed (All Methods): 1339	
Population Health Data	**LLUH & SACHS**
Community-based Survey for SDOH:	**N = 1060 People**
99% Confidence Interval	English: 542 (51%)
4% Margin of Error	Spanish: 518 (49%)
Community Conversation/Focus Groups 18 Groups: 11 English, 7 Spanish	**N = 205 People**
Children's Health Survey	**N = 74 People**

Needs that were Identified

The population data from LLUH & SAC Health System, an FQHC partner in LLUH's community health investment strategy, provided summary data on the top health needs of some of the most vulnerable populations in our region. From the two systems data, the trends indicate that the chronic disease burden in lower income populations in our community form a set of health conditions collectively referred to as "lifestyle disease." Given the correlation between poverty, access to care, and the prevalence of reduced or poor health due to chronic stress at the lower end of the socioeconomic spectrum, the top health conditions people are struggling in our region are collectively referred to **lifestyle diseases** where the social determinants of health contribute to higher prevalence rates: Asthma, behavioral health, cardiovascular disease, hypertension, and obesity.

To identify the top un-met health needs of the community, the results from the surveys and community conversation were surveyed and conversations were aggregated and weighted by frequency, or the number of times community members mentioned the issue in focus groups, with the most-cited issues receiving the most "weight" in priority.

In addition to **access to care**, a core focus area of community benefit investment strategies on behalf of the most vulnerable, concerns in the community over **behavioral health** (including substance use) was by far the top rated health concerns of the community across all age groups. Additionally, the prevalence of **isolation** experienced by community members was an unexpected need identified: 1 in 3 adults who participated in surveys reported feeling isolated.

Finally, the remaining area of greatest need identified due to the aggregation of the findings was the need for safe places to play for children in **green spaces**. Over and over again, community members shared a lack of access to safe green spaces where families and especially children could exercise and be in community with one another. Crime, lack of infrastructure, and/or lack of access due to geography were the top reasons why many communities lack basic access.

2019 CHNA Results: Aggregated and Prioritized Needs by Study Method

Loma Linda University Health - Community Health Needs Assessment 2019

Shortlisted eas of Needs

Community-Based Survey
(Languages: English and Spanish)
≤ 25%
26% to 45%
46% ≥

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

Community-Based Focus Group
(Languages: English and Spanish)
≤ 10%
11% to 15%
16% ≥

Need	%
Cost of Housing & Homelessness	21%
Work/Jobs	14%
Access to Care	11%
Mental/Behavioral Health	11%
Alcohol and Substance Abuse	9%
Food, Transportation and Other Resources	7%
Parks/Built Environment/Green Spaces	7%
Immigration, Discrimination and Isolation	6%
School/Education	5%
Disability	4%

Children's Health Survey
≤ 15%
16% to 20%
21% ≥

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

LLUH Hospital Patient Data & SACH Health System Population Health Data: Chronic Health Condition or Conditions due to Lifestyle Only
Based on ICD-10 and DRGs
(Listed in Alphabetical Order)

Condition
Asthma
Behavioral Health
Cardiovascular Disease (CVD)
Diabetes
Hypertension
Obesity

The complete data set and findings are available in the 2019 CHNA:

https://lluh.org/about-us/community-benefit/reports-and-resources

To learn how needs are directly and indirectly addressed, see tables in the Appendix.

Community Summary Sheet Report of the 2019 CHNA

… provided to community members in conversations

Community Health Needs Assessment (CHNA) 2019: Findings

Poverty & Access to Essentials

Access to Care

Behavioral Health

Green Spaces

Highest Priority Needs Identified by the 2019 CHNA Assessment

Top Chronic Disease Findings: Hospital & FQHC Data*

Alphabetical Order (Based on ICD – 10 and DRGs)*

Asthma
Behavioral Health
Cardiovascular Disease
Diabetes
Hypertension
Obesity

*LLUH Patient Data & SAC Health System Population Health Data: Chronic Health Condition or Conditions due to lifestyle only

Social Determinant Findings: Community-Based Surveys

n = 1,060 (English = 542; Spanish = 518)
Confidence Interval = 99%; Margin of Error = 4%

Poverty
Food Insecurity
Stress Related to Immigration
Crime and Safety
Housing
Social Isolation
Employment Support

Community-Based Focus Groups

n = 205 (18 Groups; English = 11; Spanish = 7)

Housing / Homelessness
Jobs
Access to Care
Behavioral Health
Alcohol and Substance Abuse
Built Environment / Green Spaces

Children's Health Survey Findings:

n = 74 Families

Green Spaces & Playground
Poverty
Access to Care
Parent/Guardian Need Emotional Support
Behavioral Health Counseling

LISTEN | RESPECT | ENGAGE

Institute for Community Partnerships – Community Benefit Office

Plan to Address the Needs

A Centralized Community Benefit Plan

Implemented by the Institute for Community Partnerships

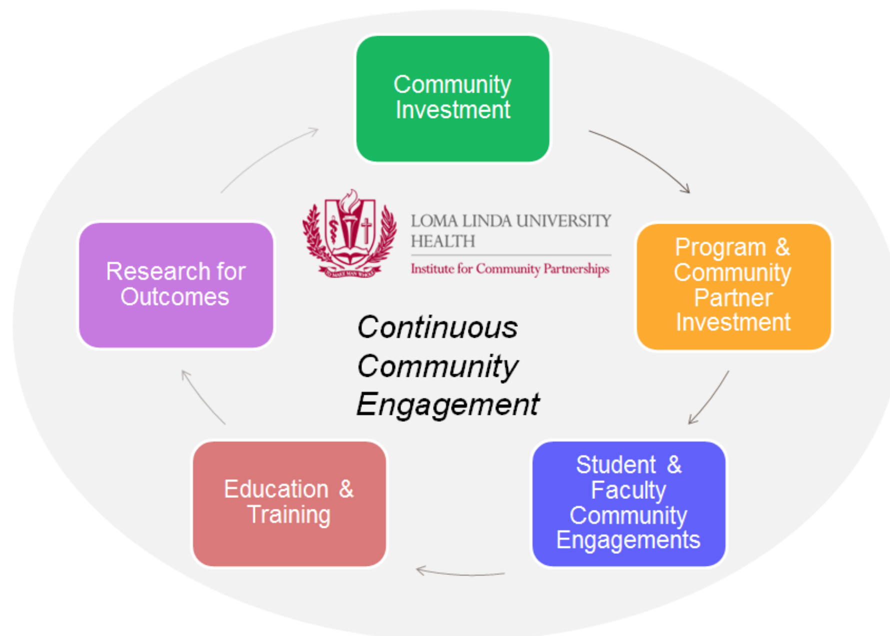
LOMA LINDA UNIVERSITY HEALTH

Institute for Community Partnerships

LLUH is unique among many health systems as the hospitals have made a consistent and historic investment in the operations necessary to effectively coordinate and partner with our community. The Institute for Community Partnerships (ICP) and the office of Community Health Development are the strategic arm of the four hospitals community benefit programming.

The four licensed hospitals within the LLUH system coordinate their community benefit investments through the Institute for Community Partnerships in order maximize the strategic use of funds to have a greater impact on behalf of the communities they serve.

While ICP centralizes and coordinates implementation efforts, all community benefit allocations are tracked and reported, per licensed hospital's 990 Schedule H.



The Institute for Community Partnerships serves as the primary portal for connecting hospital resources to the needs and people as the LLUH liaison to our community. The mission of ICP is to ensure LLUH remains responsive and relevant to the community. The institute is committed to strategically working with our community partners to better understand and address the needs of the community through activities such as research, teaching, and service-based learning. Community participation is at the core of our efforts, with structured learning opportunities for underrepresented minority students, training programs for community health workers and community research projects. ICP implements the LLUH-operated community benefit programs and assessment and provides the research necessary to better target health system interventions to the underrepresented people and in under-estimated communities to promote resiliency and hope. The Institute implements research and programs operated by LLUH and oversees the office of Community Health Development to ensure the strategic investment with partner organizations, and the coordination and reporting of community benefit outcomes on behalf of LLUH. This unique model allows LLUH to focus our impact on the community towards the social determinants (workforce development and education) and in the health priorities where we are working to increase access to care for vulnerable populations.

ICP manages the following community engagements on behalf of LLUH to ensure that LLUH is both relevant and responsive to the communities we serve:

1. **Community-based partnerships** with non-profits on assessment and interventions for target populations. This includes funding community partner's work or collaborating with partners to extend access to vulnerable populations, like through the Coachella Connect health access events where screenings, ophthalmology, and dental services are provided to lower income communities.

2. ICP leads LLUH's efforts in ***listening*** **to the community** and documenting the needs in order to maximize our responsiveness through various methods: Maintaining a community based advisory council, a community member advisory council, and regular town hall meetings to bring external and internal members of LLUH together on important topics and interventions in the community. Additionally, ICP conducts ongoing community conversations in order to maintain an open dialogue with our community.

3. Developing the **community health worker workforce** in non-profits (both health systems, community-based organizations, and in school districts). LLUH is developing a community health worker program in our system with the goal of maintaining 60% of the CHWs time in the community working with patients and their families to overcome undue burdens due to the social determinants of health. These CHWS conduct home visits and provide linkages and accompaniments with patients to social services, the patient's outpatient primary and specialty care providers (regardless of the health system), and peer support and informal coaching to increase self-efficacy of those who face undue burdens.

4. **Service learning** coordination for all of LLUH's graduate schools and implementation of the CAPS program, or Community-Academic Partners in Service, so the LLUH graduate student populations are serving or volunteering in our local communities as part of their education here at LLUH.

5. Through the Community-Academic Partners in Service (CAPS) program, ICP implements all pipeline programs designed to introduce underserved youth to the health professions in order to encourage youth to pursue higher education and consider the health professions as part of the workforce development goals of LLUH. Approximately 240 middle and high school students attend the LLUH pipeline programs per year producing impactful success stories that improve the lives of the students, their families, and their communities.

The FY 20 – FY 22 CHIS Priorities: July 1, 2020 – June 30, 2022

LOMA LINDA UNIVERSITY
HEALTH

Community Health Implementation Strategy (CHIS) 2020 - 2022

Poverty & Access to Essentials

Access to Care

Behavioral Health

Green Spaces

Highest Priority Needs Identified by the 2019 CHNA Assessment

Primary Focus Area:

Workforce Development

Scholarships: workforce entry for adults, youth, and people from marginalized or special populations.

Pipeline Programs to higher education for underserved middle school & high school students.

CHW Workforce Integration & Development: community-based, school-based, clinic-based CHWs.

Secondary Focus Area:

Health & Wellness

Increase access to healthy and affordable food options through community health workers and ***community gardens.***

Decrease ***social isolation*** through multi-generational community engagement; increase access to ***mental health resources***, screenings, and support for parents and school age children.

Health System interventions to ***address lifestyle disease*** (obesity, asthma, diabetes, and hypertension): extend access to care for the most vulnerable.

Relevant & Responsive to Our Community

Institute for Community Partnerships – Community Benefit Office

Primary Social Determinant Focus Area: Workforce Development

The three-year plan for the FY 20- FY 22 fiscal years centers on LLUH's attempt to address the root cause of poverty in our region through workforce development and education and to increase access to care for vulnerable populations who live with un-met health needs that cluster into "lifestyle diseases." The two are inextricably linked as poverty decreases health status is a well-documented contributor to chronic stress and higher rates of hypertension, diabetes, decreased cardiac health, and even environmentally triggered conditions like asthma.[2] Populations living at the lower levels of income, or having a low socioeconomic status, is also a well-documented correlation to a decrease in mental and behavioral health and higher prevalence rates of substance use.[3] **When poverty is pervasive, those living in poverty cannot maximize their health status as survival concerns decrease overall health and wellness.**

To maximize our work and investments in communities of highest need, LLUH is building on our strengths as an economic anchor in our region in order to strategically respond to the needs expressed by our community. LLUH employs over 16,000 people between our university and healthcare system and we are a job engine for people in our community and provide access to higher, livable wages through our health system. As LLUH is also a graduate institution for health education, we can increase local resident's access to education through our expertise in this industry. The mission of LLUH is to continue both the teaching and healing ministry of Jesus Christ to make man whole with equal emphasis as on both aspects of the mission, including how this mission informs our responsiveness to the communities we serve. For the FY 20 – FY 22 three year cycle, LLUH is committed to addressing un-met health needs that are exacerbated by poverty through a focus of community benefit investment in workforce development & education and health and wellness issues where LLUH can make targeted investments in interventions in our work with non-profit partners and community members.

Resources Allocated to the Needs

The following implementation strategy outlines the activities and investments made by the four licensed hospitals as executed through the Institute for Community Partnerships. **Major initiatives are covered in the following implementation strategy, routine system activities related to health access or outreach are reported annually only as they fit and address the needs identified for focus by the FY 20 –FY 22 CHIS.**

The legend below signifies throughout the plan which hospitals are investing to correlate the dollars invested and reported on the 990 Schedule H to the activities undertaken by the LLUH system for community benefit over the CHIS cycle:

Loma Linda University Medical Center

Loma Linda University Children's Hospital

Loma Linda University Medical Center - Murrieta

Loma Linda University Behavioral Medicine Center

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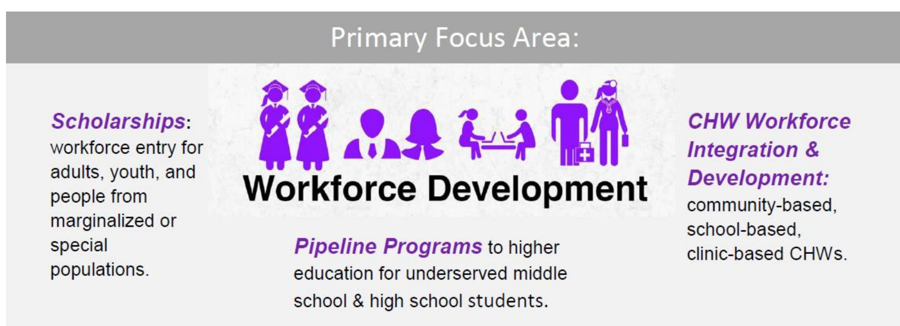
[2] Health Affairs. "Health, Income, & Poverty: Where we Are & What Could Help." October 4,2018 and the foundational study by Singh, Ajai R & Shakuntala A. Singh. Diseases of Poverty and Lifestyle, Well-Being and Human Development." NCBI. 2008.

[3] Substance Abuse and Mental Health Services Administration, 2016. https://www.samhsa.gov/data/sites/default/files/report_2720/Spotlight-2720.html



Workforce Development Objective	Assessment for Impact Measurement	Timeline
Scholarships: Workforce Entry for adults, youth, and people from marginalized or special populations. **Investing Hospitals:** **LLUMC** **LLUCH**	# of scholarships invested in youth going to college to transition vulnerable or at/risk youth to higher education. # of scholarships to LLUH graduate programs for youth who meet criteria as disadvantaged/vulnerable youth. Investments or technical assistance with workforce development with partners to increase outreach to marginalized & specialty populations (# of people).	FY 20 FY 21, FY 22 – *In Development* FY 20 – FY 22
Pipeline Programs to introduce underserved middle & high school students to healthcare careers and health lifestyle choices. **Investing Hospitals:** **LLUMC** **LLUCH**	CAPS program: # of youth served in My Campus and Summer Gateway pipeline programs that bring underserved youth to LLUH campus for health career seminars. # of youth served through Goal 4 Health soccer league & # of parents served through outreach at Goal 4 Health Games % of children and youth served who attend college and graduate programs (longitudinal tracking for social & economic impact).	FY 20 – FY 22 FY 20 – FY 22 FY 20 – FY 22
CHW Workforce Integration (See Implementation Plan) **Investing Hospitals:** **LLUMC** **LLUCH** **LLUMC –Murrieta** **LLUBMC**	$ Invested dollars and technical assistance provided to organizations in the development of the community health workforce in three primary areas: Health Systems Non-profit Partners School-based (K-12) $ Dollars Invested (direct and in-kind) # of CHW jobs created in region	FY 20 – FY 22

Community Health Worker – Workforce Development Implementation Plan

Through ICP, the hospitals are investing in the development of the community health worker workforce in our region in school districts, with non-profit partners, and in health systems.

The implementation plan for this effort includes the following major initiatives:

1. **ICP contracts and provides technical assistance to School Districts to create CHEW jobs:** LLUH through ICP is building community health education worker teams (CHEWs) in local school districts in order to extend outreach to at-risk populations of students, or youth who are at-promise, based on what districts most need addressed. The CHEWs are trained to work in the education system and through relationship building and home visits, extend outreach, social supports, linkages and accompaniments to families, resource support, and informal peer counseling to help students who are chronically absent, face undue health challenges, or are experiencing mental or behavioral health crisis have additional, intensive supportive resources.

    a. ICP currently contracts with 2 school districts and employs 6-8 CHEWS working in the community, a manager of integration to oversee the project, and is conducting interventions with families who have children who are chronically absent (one district) and the other district is a focused intervention to prevent against suicidal ideation or action (behavioral health prevention).

    b. **Resources Allocated: All four licensed hospitals invest in ICP operations in order to carry out this level of partnership, responsiveness, and intervention in our communities. Only expenses above and beyond contractual revenue are reported as community benefit.**

2. ICP is investing in **non-profit, community-based organizational partners** who want to expand outreach to their populations through the addition of community health workers through either seed funding for community health worker positions or, through technical assistance with grant activities to help increase partner potential to acquire dollars to hire community health workers.

    a. ICP invested in a community health worker integration program with a non-profit partner in the Coachella Valley where FIND Food Bank added a CHW to their outreach team. The position will be sustained by Cal Fresh enrollment dollars as a sustainability plan while the CHW working there is focused on intensive outreach visits to at-risk families.

    b. **Resources allocated: All four licensed hospitals invest in ICP operations in order to carry out this level of partnership, responsiveness, and intervention in our communities. LLUMC and LLUCH dollars are currently invested in the non-profit partner CHW position.**

3. **Creation and integration of the CHW workforce in the LLUH system.** In FY 2019 LLUH conducted a pilot with 2 CHWs who integrated into high-risk areas where vulnerable populations access our health system but face undue health burdens in trying to address their health and wellness post-encounter in either inpatient our outpatient settings. This includes linkages to LLUH's priority on disease related to poverty through a focus on at-risk infants and mothers in the NICU and at-risk adults with diabetes in the outpatient Diabetes Treatment Center. Due to the initial success of the pilot program in 2019, LLUH

is formally creating a CHW Integration and Intervention Program through the Institute for Community Partnerships based on the following parameters:

1. LLUH hospitals will invest in hiring **6 CHW positions** and **two operations positions** (Manager & coordinator/supervisor) to run the program. The ICP management/operations positions oversee the CHEW contracts in school districts in addition to the establishment of the CHW program at LLUH.

2. The LLUH CHWs will be **entirely** focused on the target population, those from underserved communities who lack access to services and face poverty, based on the community benefit investment in this community intervention. It is the goal of this program to use the hospital's investment to intervene and lighten the burden of the social determinants of health through community peers who are expertly trained in recognizing and navigating the social determinants of health. While the CHWs are employed by LLUH and meet people who represent vulnerable populations in our region, they are assigned to work in the community with patients and their families who represent the target population, as defined by community benefit parameters. To ensure this is upheld, CHWS working within the LLUH program will abide by the following metrics:

    a. A **51% minimum of time in the community** with a **stretch goal of 60% time spent in the community** will serve as the macro indicator for the program.

    b. **Secondary outcomes** related to special populations, as well as demographic information, will be captured to study the impact of CHWs working with underserved or marginalized populations. Outcomes will be presented in community benefit reporting and in research published and presented on in professional circles by ICP to help increase the access and technical assistance available to health systems on how to integrate and create this resource in other health systems.

    c. LLUH CHWs will focus on home visits and community outreach classes/peer support groups for vulnerable populations with the following programmatic goals:

        i. **Time is the Medicine** – Unlike many of the health care providers and workforce, CHWs are able to do time-intensive interventions. This is accomplished through a trusted relationship as CHWs are able to quickly establish as community peers and engage with community members once they are home. CHWs work with community members and their family members to navigate complex social and health systems to address, manage, and maintain their help once these community members are no longer "patients" in our facility, but integrating back to the home to get the care they need.

        ii. **Interventions without borders –** CHWs are able to provide supportive coaching and mentoring to help those they work navigate complex social services and benefits like (DMV, Social Security, Veterans Affairs, etc.). CHWs are also able to provide accompaniment by meeting with community members at appointments and in outpatient and inpatient systems of care (both LLUH and non-LLUH), and CHWs are able to support individuals in accessing resources for survival needs like food banks,

housing and rental assistance, and other supportive sources in the community offered by non-profits and community organizations.

iii. **Special Populations Focus** – The LLUH CHWs will be stationed in critical access areas of the health system in order to become connected to community members who are experiencing the highest levels of need. The following are special populations the CHW program will address:

1. At-risk infants and mothers
2. Adults with diabetes
3. Children and youth with diabetes
4. Homeless individuals in our Emergency Department
5. Individuals experiencing escalation of symptoms related to Sickle Cell Diseases
6. Individuals experience a lack of access to mental health or behavioral health services and resources.
7. High utilizers of the LLUH system who experience undue social determinant burden and require extensive, supportive accompaniment and linkage to health and social services upon discharge from the LLUH inpatient system.

iv. **Finally, special to this program is the two-for-one investment that creating the CHW workforce does to create jobs and develop the workforce. To give CHWs jobs is an act of economic development as people doing the work of a CHW often need *the same access* to employment as those they are tirelessly serving. CHWs are traditionally, not part of the systems they support, nor do they have access to the workplace benefits. Employment reduces the reliance on grant-based or project—based employment for CHWs, a source of income insecurity**. In addition to the programmatic outreach and intervention provided by the CHWs, the creation of the jobs for community members who are trained in this work is also a fulfillment of the community benefit workforce development strategy as priority hiring is reserved for people with lived experience in navigating the social determinants of health, having lived experience with poverty, and those who have received training to become community health workers in the communities from which they are from or with special populations of which they have special knowledge or lived experience.

d. **Resources Allocated: All four licensed hospitals invest in ICP operations in order to carry out this level of partnership, responsiveness, and intervention in our communities. All four licensed hospitals are investing dollars in workforce development and job creation for the community health worker workforce program at LLUH.**

Secondary Focus Area:

Increase access to healthy and affordable food options through community health workers and ***community gardens.***

Health & Wellness

Decrease ***social isolation*** through multi-generational community engagement; increase access to ***mental health resources***, screenings, and support for parents and school age children.

Health System interventions to ***address lifestyle disease*** (obesity, asthma, diabetes, and hypertension): extend access to care for the most vulnerable.

Health & Wellness Objectives	Assessment for Impact Measurement	Timeline
Increase access to healthy and affordable food options through community health workers, community gardens, and access to safe green spaces. **Investing Hospital:** **LLUMC**	Establishment & creation of a community garden next to a federally qualified health center in San Bernardino with a community organizational partner. ICP can provide technical assistance to local school districts on partnerships for land use agreements after school to open playgrounds and school yards for exercise and play in communities to increase access to green spaces.	FY 20 – Project Design phase FY 21, 22 – Full Implementation *FY 20 – In concept development*
Decrease social isolation through multi-generational community engagement and increase access to mental health resources, screenings, and support for parents and school age children. **Investing Hospital:** **LLUBMC** **LLUMC – Murrieta**	Mental Health (LLUBMC): Assign 1 of the 6 community health workers to support existing efforts of behavioral health with outreach goals of the CHW to conduct: • Small group/community events where screenings and resources are available as part of increasing social participation. • Facilitate support "Community Groups" with education on mental and physical health, screenings, and options for seniors and youth experiencing isolation to come together for social connection. Murrieta: Assign 1 of the 6 a community health worker to address at-risk populations through home visits and linkages to services and to create outreach classes for parents of school age children, including behavioral health resources for parents.	*FY 20 – Concept Development* *FY 20 – Concept Development* *FY 20 – Concept Development* *FY 20 – Concept Development*

Health System interventions to address lifestyle disease (health priorities: obesity, hypertension, diabetes, and asthma): Investing Hospitals: All 4 through support of ICP's implementation of programs **Investing Hospitals:** **LLUMC** **LLUCH** **LLUBMC**	The following are population-specific programs run by the hospitals that contribute to planned interventions that are either recurring (ongoing or new). These system activities are evaluated every year to ensure the people served and outcomes from the programs are in alignment with guidelines for what counts as community benefit activities: # of people served $ invested in community **Highlight examples:** **LLUMC:** PossAbilities program serving people living with disabilities to increase access to resources and community (decrease isolation). **LLUCH:** Camp Good Greif for children who experience the death of a sibling to improve mental health, reduce trauma for improved resiliency, and decrease social isolation. **LLUBMC:** Stand up to stigma 5K to bring the community together and provide education as to the prevalence of behavioral health	On-going, recurring FY 20 – FY 22

How the Needs are Directly or Indirectly Addressed

Due to the reality that more needs are often identified in community health assessments than what can be acted upon in order to show an impact, LLUH prioritized the needs and implementation strategy according to the highest priority needs, reflected in this implementation strategy.

To learn about how all needs identified by LLUH were either addressed directly, indirectly, or not addressed, summary tables are included in the Appendix of this report to detail how these are:

a) **Directly addressed** by the CHIS and the annual system activities that are in alignment with community benefit principles and connected to the 2019 CHNA needs identified.

b) **Indirectly addressed** by LLUH's partnerships with other organizations already working in these areas in the community.

c) **Not addressed** due to it not being an area of either direct investment or indirect work with partner organizations.

Planned Collaborations

Planned Collaborations

Central to ICP's work on behalf of the four licensed hospitals is coordinating our engagement with community partners on regional initiatives.

For the FY 2020-2022 CHIS, two regional collaborations are in development with potential partners. Projects mentioned here will have status updates reported in the annual community benefit reports:

Regional Effort to Address Homelessness

In September 2019, ICP brought together hospital partners from across our more immediate region, within 30 miles of the hospital, to discuss potential shared approaches on dealing with homelessness. Hospitals in close proximity to one another have a degree of overlap between the homeless patients, ICP facilitated a preliminary discussion to determine the feasibility and likelihood of a regional approach and use of community benefit dollars to add resources that do not currently exist into the continuum. LLUH, through ICP, is currently in discussions with major health systems and hospitals in our region to discuss a potential collaboration over this three-year cycle. While a potential project concept is in the development phase, the following was discussed:

1. Hospitals are having to navigate the long-term policy discussion and potential investment in housing discussions (long-term impact projects) at the same time they are navigating the demand for resources and the increased pressure to show responsiveness (short-term impact projects). All hospitals are facing a resource shortage and this is intensified based on geography (like for mountains or desert communities). Additionally, given the complexity of long-term housing development investments city-to-city, hospitals may need to focus on more immediate responsiveness and projects in a regional collaboration or collective impact model.

2. The homeless population can be divided into chronically homeless and the situationally or short-term homeless. Hospitals may be better positioned to focus new resources or interventions on populations that are situationally homeless given the County efforts on the chronic population. There is interest to partner on projects for the situationally homeless locally for collective impact regionally.

Early Intervention & Prevention and Increasing Access to Care for School-age Children

Early Intervention & Prevention

Loma Linda University Children's Hospital (LLUCH) currently holds a First 5 Grant[4] for the Help Me Grow initiative. Help Me Grow (HMG) is a system that builds multi-sector collaborations and assists families, child health care providers, early education providers, and human service providers to recognize early signs of developmental or behavioral concerns. HMG motivates providers to conduct systematic, standardized developmental screenings of young children and providing them the electronic linkages to improve care across the region for children with developmental delays. HMG assists, when needs are identified, in finding programs designed to address those needs. It is an

[4] Only costs incurred by LLUH above and beyond grant funding are counted as community benefit in the reporting of dollar amounts.

efficient and effective system that builds on existing resources by improving access to services for families, infants and children through age eight. First 5 San Bernardino and First 5 Riverside, in partnership with Loma Linda Children's Health, convened key stakeholders and experts across diverse sectors, including health departments, early intervention and preschool education, and medical providers to engage in the planning of a dual county HMG system model for the Inland Empire. LLUCH is investing significant workforce time in the leadership of this regional collaboration to ensure it improves the health and well-being of the children not only served by the hospital, but in our entire region.

Between our two counties, over 400,000 children ages 0-5 have the potential to benefit from the Ages and Stages (ASQ-3) screening tools and benefit from referrals and increased provider connectivity in addressing their needs.

LLUH and regional pediatric care providers will now have the ability on the LLUH Epic platform, the electronic health record system, to access the screening and resource needs of children in the program. Making the LLUH Epic platform available to LLUH physicians, non-LLUH physicians, and other providers of care for children in early start programs is one way LLUH is operating above and beyond the standard of care for people in our region. The linkages provider on behalf of children enrolled in the program will help all providers in responding to critical interventions, preventions early in children's lives.

Increasing Access to Care for School-Age Children

LLUH and the FQHC Partner SAC Health System, is providing consultative support on the establishment of school-based districts in order to extend care to families where they are more easily able to access community-based services: local schools.

In October 2019, San Bernardino City Unified School District and SAC Health System launched a school-based clinic in the district's Enrollment Center where families can access health care resources for their children and family members. The clinic is focused on providing access to children who currently lack access to care and for children who need vaccines and annual check-ups in order to enroll in school.

In addition to the school-based clinic, the ability to ensure linkages between families and this new school-based clinic can be facilitated by the community health education workers currently overseen by ICP to help increase linkages to resources for families and their school-age children.

With school-based clinics and CHEWs working in school districts, the collaboration potential between LLUH and the multi-sector partners is opening a new chapter of increasing access to care for at-risk populations: this is a new phase of development and possibility in the region.

Micro Financing – Increasing Access for Historically Under-invested Communities

LLUH through ICP is in the preliminary phase of learning about regional microfinancing efforts that have a willingness to provide financing to either a) loans to people who have lower socioeconomic status or come from communities that are historically under-invested b) local non-profits that may benefit by micro-financing to support capacity building in order to create "proof of concept" and identify sustainability for interventions or resources they seek to establish. As low-income communities often face the economic burden of under-investment and decreased access to small business development, revitalizing neighborhoods through increasing access to non-predatory lending and affordable microloans may be a way LLUH can influence and support the economic empowerment of people with the desire to start small businesses to overcome cycles of poverty. This is a potential in the research and development stage only.

Technical Assistance to Non-profit Organizations for Workforce Capacity Building

ICP is currently planning the following capacity-building activities to leverage the LLUH investment in ICP & community benefit staff to further serve our community through skill-building of emerging workforces.

Workforce Integration – Professional Skills Training

Free professional skills training, conducted by community benefit staff and community partners, will be offered to workforce entry professionals who require access to continuing education and support in order to maintain employment and to ensure the transition into the workforce is successful and maintained to help alleviate poverty due to unstable employment.

The target audience for this population is:

1. Entry-level health professionals who require support to maintain and maximize work opportunities;
2. Individuals from low-income communities;
3. People of color and/or people with low socio-economic status;
4. People who are part of emerging workforces or first-generation workforce;
5. People who have traditionally lacked access to professional development resources such as training and/or coaching and mentorship due to an inability to pay.

ICP and partners will recruit professionals who meet the above criteria in order to fill cohorts for training. The FY 20 will be a pilot test year of 2-3 cohorts to test if this will become a longer-standing community benefit activity implemented by ICP and community benefit staff.

Technical Assistance – Organizational Capacity Building for Non-profit Partners

ICP and community benefit staff are also working on an initiative to increase support of non-profit partner's ability to test expanded interventions and the addition of community health workers to their operations. As many non-profits struggle with tight operating margins, ICP will assist selected non-profit partners in the following activities:

1. Support in grant development and management
2. Financial and/or project financing consultation

3. Program design and evaluation
4. Pilot testing of integrating community health workers into operations with a plan for sustainability to ensure job creation.

This project is currently in-design and will be tested with one-two partners in the coming months.

The workforce development and technical assistance projects piloted by ICP are one of the implementation strategies so LLUH can leverage the investment in the institute's operations and staff on behalf of the community so our professional team working in community partnerships also professionally contributes to workforce development.

Community Input Process

Community Input Process for CHNA & CHIS

LLUH has established, through ICP, an ongoing community conversation cycle to continue to engage in our communities and be relevant and responsive. The following is the draft implementation plan for the FY 20 cycle and updated information will be reported on in the Community Benefit Annual Report:

FY 20 Ongoing Community Conversations & Feedback Plan Facilitated by ICP	
High Desert – Region Community	*COMPLETED in July 2019*
Community Health Assessment Presentation on 2019 Findings & Community Based Advisory (Joint Meeting)	*Audience: Organizational Partners (all partners) Completed June 2019. Attendees: 65 People*
Community Health Findings & Community Based Advisory (Joint Meeting)	November 2019
Community Members CHIS Presentation – CHWs with El Sol Neighborhood Outreach	November 2019
Community Members CHIS Presentation – La Escuelita	November 2019
Community Members CHIS Presentation – Cope	November 2019
Loma Linda Partners: PossAbilities & Just for Seniors & Youth Hope & Loma Linda Spanish Church	December 2019
Riverside/Murrieta Partners	December 2019
Coachella Partners: Torres Martinez Band of Indians & Families from FIND Food Bank	December 2019
High Desert Partners	January 2020
Community Member Advisory Winter - Local Community Members)	Launch in January 2020
CBAC Winter Meeting	February 2020
Coachella Partners – Regional	March 2020
Murrieta Partners – Regional	March 2020
Community Member Advisory Spring (Local Community Members)	April 2020
Riverside Partners – Regional	April 2020
CBAC Spring Meeting	May 2020

Community Members in Conversation

ICP hosts two councils in order to stay close to the needs, perspectives, and feedback from our community. ICP also facilitates ongoing community conversations in collaboration with our non-profit partners across the region to capture the geographic and regional perspectives of the people we serve.

Community Benefit Administrative Council (CBAC)

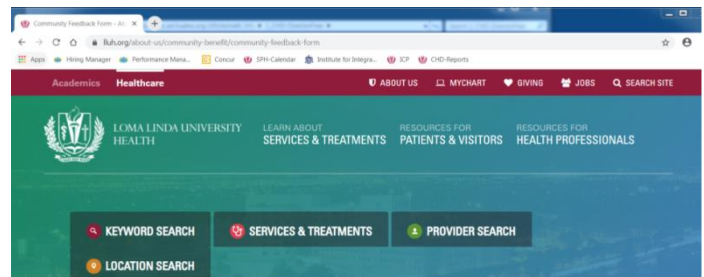
CBAC is a long-standing council of non-profit and public sector organizations who act as advisors and partners. CBAC members provide perspective, assist ICP with alignment strategies to regional efforts, share their initiatives and priorities with council members, and assist ICP in the mission of staying relevant and responsive to the diverse needs of special populations in our region. Members also provide feedback on our planning and implementation strategies to ensure community benefit investments account for the needs of their community member populations.

Community Engagement Council

ICP's engagement council, comprised of community members, ensures that a diverse group of people help evaluate ICP's planning and activities. The community member council is a grassroots effort. Community members are recruited from programs and from the regional community conversations. The goal of the council is to obtain direct feedback from community members to ensure LLUH's community-based strategies and efforts are relevant and responsive to the communities we serve. The council provides perspective, suggestions, and direction from people who understand the lived experience and populations our community benefit investments serve.

Open Invitation Online

In addition to on-going communications with our community members on our implementation strategy, the Community Health Implementation Strategy will include two additional strategies to obtain feedback from the community; ICP maintains the LLUH website where all reports are published is a comment form welcoming feedback from anyone who visits the site on our community benefit programs. Comments are reviewed and evaluated by the community benefit team.



HOME › ABOUT US › COMMUNITY BENEFIT › COMMUNITY FEEDBACK FORM

Community Feedback Form

NAME *

First Name

Last Name

CONTACT NUMBER

CONTACT EMAIL ADDRESS *

FEEDBACK/COMMENTS RELATED TO *

Select one

FEEDBACK / COMMENT *

SUBMIT

Connecting the LLUH Workforce to Our Community

The mission of ICP extends to the 16,000+ employees of LLUH to ensure that the LLUH campus is connected to our community partners in order to increase linkages, knowledge, and information with both our academic and clinical audiences.

ICP Town Hall Meetings

The institute hosts quarterly meetings where external partners present and provide education to both academic and clinical staff in order to connect ICP's internal and external partners on shared priorities. In addition to the Town Hall meetings, ICP hosts the following events on-campus:

- Educational events on special topics pertinent to community
- On-going education with managers & leaders on Community Benefit Priorities and "What Counts"
- Institution-wide conversations on high-need and special populations

LLUH as an Anchor Institution in the Inland Empire

The Loma Linda University Health Anchor Dashboard is part of LLUH's efforts to quantify our total economic and social impact on the region as part of the resources we contribute above and beyond community benefits. The Democracy Collaborative developed the concept of Anchor Institutions from a foundational study that "introduces a framework that can assist anchor institutions in understanding their impact on the community and, in particular, their impact on the welfare of low-income children and families in those communities."[5] The dashboard is a data collection effort that will provide a snapshot of the economic contribution LLUH makes in the region and the employment investment in the people who live and work in the Inland Empire. As the dashboard data is analyzed over time it will benchmark and trend indicators such as:

- the economic investment in employees via salaries;
- the students and employees at the institution from high-need zip codes;
- the number of students from the local community accessing graduate programs at LLU;
- the number of local pipeline students retained by LLUH in our health care workforce;
- local vender contracting;
- the tuition benefits used by LLUH employees, especially those at lower income levels.

[5] Democracy Collaborative. "The Anchor Dashboard: Aligning Institutional Practice to Meet Low-Income Community Needs." 2013

Total Community Benefit & Investment by LLUH Health

Over the last 4.5 years, LLUH reported over $1 billion in benefit to the community, based on the reporting categories.

The Community Health Investments accounted for over $16 million in dollars invested in community health improvement through programs and services.

LLUH has impacted the lives of over 600,000+ community members in our two-county service region with community benefit programs and services.

4.5 Year Community Benefit Summary**

LOMA LINDA UNIVERSITY
HEALTH

Community Benefit Report
January 2014 - June 2018

$1.09 Billion Total
Inland Empire Service Region

$791.51 Million
Shortfalls in Medicaid

$56.15 Million
Free, Low-Cost care & Subsidized Health Services

$16.04 Million
Community Health Services

$221.44 Million
Education & Research

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

****A note on dates:**
In 2014-2016, LLUH financial information was reported on calendar year cycles. Fiscal year 2017 was a "short year," January 2017 – June 2017, in order to change reporting to fiscal year. As of July 1, 2017, LLUH reports all financial information on a fiscal year cycle (July 1- June 30th of every year).

2.5 Year Community Benefit Summary – Last CHIS Cycle

LOMA LINDA UNIVERSITY
HEALTH

Community Benefit Report
January 2016 - June 2018

$516.80 Million Total
Inland Empire Service Region

$367.06 Million
Shortfalls in Medicaid

$20.78 Million
Free, Low-Cost care & Subsidized Health Services

$7.16 Million
Community Health Services

$121.80 Million
Education & Research

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

Most Recent Fiscal Year Summary – FY 18

LOMA LINDA UNIVERSITY
HEALTH

Community Benefit Report
July 1, 2017 - June 30, 2018

$128.10 Million Total
Inland Empire Service Region

$69.29 Million
Shortfalls in Medicaid

$8.99 Million
Free, Low-Cost care & Subsidized Health Services

$3.56 Million
Community Health Services

$46.26 Million
Education & Research

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

Appendix

How the Needs are Directly or Indirectly Addressed

The following tables translate the findings from the 2019 CHNA and all the needs identified and define how needs are either:

a) **Directly addressed** by the CHIS and the annual system activities that are in alignment with community benefit principles and connected to the 2019 CHNA needs identified.

b) **Indirectly addressed** by LLUH's partnerships with other organizations already working in these areas in the community.

c) **Not addressed** due to it not being an area of either direct investment or indirect work with partner organizations.

Addressed Directly: LLUH Licensed Hospitals Community Benefit Program					
Community Health Needs Assessment 2019 Source	Priority	Type (Clinical or Social Determinates of Health (SDOH))	Hospital Leading Program and Investment	Primary Non-LLUH Partner	LLUH Partners (University, Centers and/or Institutes) (besides the licensed hospitals and hospital departments)
LLUH Patient Data	Asthma	Clinical	LLUMC & LLUCH	SAC Health System	LLU - Faculty Medicine
LLUH Patient Data	Behavioral Health	Clinical	LLUMC & LLUCH	SAC Health System	LLU - School of Behavioral Health
LLUH Patient Data	Cardiovascular Disease (CVD)	Clinical	LLUMC & LLUCH	SAC Health System	LLUH - Faculty Medicine
LLUH Patient Data	Diabetes	Clinical	LLUMC & LLUCH	SAC Health System	LLU - Diabetes Treatment Center
LLUH Patient Data	Hypertension	Clinical	LLUMC & LLUCH	SAC Health System	LLUH - Faculty Medicine
LLUH Patient Data	Obesity	Clinical	LLUMC & LLUCH	SAC Health System	LLUH - Faculty Medicine
Community-based Survey	Challenge Paying for Essentials (Food, Medical, Housing, Utilities)	SDOH	LLUMC & LLUCH	Community Based Organizations	LLU - Office for Philanthropy

Community-based Survey	Food Insecurity	SDOH	LLUMC & LLUCH	FIND Food Bank & Feeding America	LLU - Faith & Health
Community-based Survey	Isolation and Lonely	SDOH	LLUMC, LLUCH, LLUBMC & LLUMC-M	Health Plans, Other Hospitals and Community Based Organizations	LLU - CAPS and LLU PossAbilities
Community-based Survey	Assistance with Employment	SDOH	LLUMC & LLUCH	Community Health Workers, El Sol and Community Based Organizations	LLU - San Manuel Gateway College
Community-based Survey	Basic Financial Literacy: Leading Risk of Predatory Lending	SDOH	LLUMC & LLUCH	Community Based Organizations	LLU - San Manuel Gateway College
Community-based Survey	Need Help with School or Training	SDOH	LLUMC & LLUCH	San Bernardino & Riverside County - City Unified School District	LLU - San Manuel Gateway College
Children's Health Survey	Built Environment, Green Spaces and Need Playground/Parks	SDOH	LLUMC & LLUCH	SAC Health System and Huerta del Valle	LLU - CAPS and LLU PossAbilities
Children's Health Survey	Difficulties Affording Essentials (Food, Medical, Housing, Utilities)	SDOH	LLUMC & LLUCH	Health Plans, Other Hospitals and Community Based Organizations	LLU - Faith & Health
Children's Health Survey	Access to Health Care	SDOH	LLUMC & LLUCH	SAC Health System, Health Plans, Other Hospitals and Community Based Organizations	LLUH - Faculty Medicine, LLU School of Medicine & LLU School of Dentistry
Children's Health Survey	Mental Health Counseling (Received or Needed)	SDOH	LLUMC, LLUCH, LLUBMC & LLUMC-M	Health Plans, Other Hospitals and Community Based Organizations	LLUH - Faculty Medicine and LLU School of Behavioral Health
Children's Health Survey	Asthma	SDOH	LLUMC & LLUCH	SAC Health System, Health Plans, Other Hospitals	LLUH - Faculty Medicine and LLU School of Medicine
Community-based Focus Group	Work/Jobs	SDOH	LLUMC & LLUCH	San Bernardino & Riverside County - Department for Workforce Development	LLU - San Manuel Gateway College
Community-based Focus Group	Access to Care	SDOH	LLUMC & LLUCH	SAC Health System, Health Plans, Other Hospitals	LLUH - Faculty Medicine, LLU School of Medicine & LLU School of Dentistry
Community-based Focus Group	Mental/Behavioral Health	SDOH	LLUMC, LLUCH, LLUBMC & LLUMC-M	San Bernardino & Riverside County - Department of Behavioral Health	LLUH - Faculty Medicine and LLU School of Behavioral Health

Community-based Focus Group	Alcohol and Substance Abuse	SDOH	LLUMC, LLUCH, LLUBMC & LLUMC-M	San Bernardino & Riverside County - Department of Behavioral Health	LLUH - Faculty Medicine and LLU School of Behavioral Health
Community-based Focus Group	Parks/Built Environment/Green Spaces	SDOH	LLUMC & LLUCH	SAC Health System and Huerta del Valle	LLU - CAPS and LLU PossAbilities
Community-based Focus Group	School/Education	SDOH	LLUMC & LLUCH	San Bernardino & Riverside County - City Unified School District	LLU - San Manuel Gateway College
Community-based Focus Group	Disability	SDOH	LLUMC & LLUCH	Health Plans, Other Hospitals and Community Based Organizations	LLU - CAPS and LLU PossAbilities

Addressed Indirectly: Other LLUH Partnerships and Collaboration

Community Health Needs Assessment 2019 Source	Priority	Type (Clinical or Social Determinates of Health (SDOH))	Hospital Supporting Program	Primary Non-LLUH Partner	LLUH Partners (University, Centers and/or Institutes) (besides the licensed hospitals and hospital departments)
Community-based Survey	Stress Related to Immigration	SDOH	LLUMC & LLUCH	Mexican Consulate	LLU School of Public Health
Community-based Survey	Community Crime Perception: Neighborhood Safety	SDOH	LLUMC & LLUCH	San Bernardino & Riverside County - Department of Public Health	
Community-based Survey	Community Crime Perception: Level of Crime and Issue	SDOH	LLUMC & LLUCH	San Bernardino & Riverside County - Department of Public Health	
Community-based Survey	Problems-related to Current Housing	SDOH	LLUMC & LLUCH	United 211 and Health Plans	
Community-based Survey	Reliable Transportation	SDOH	LLUMC & LLUCH	United 211 and Health Plans	

Community-based Survey	Housing Insecurity	SDOH	LLUMC & LLUCH	Health Plans, Other Hospitals and Community Based Organizations	LLU - Faith & Health
Children's Health Survey	Parent/Guardian Needed Emotional Support	SDOH	LLUMC, LLUCH, LLUBMC & LLUMC-M	San Bernardino & Riverside County - City Unified School District	
Children's Health Survey	Child Experienced Racism/Discrimination	SDOH	LLUMC, LLUCH, LLUBMC & LLUMC-M	San Bernardino & Riverside County - City Unified School District	
Children's Health Survey	Need Extra Support of Help Coordinating Child's Care	SDOH	LLUMC & LLUCH	SAC Health System, Health Plans and School-based Clinics	
Children's Health Survey	Neighborhood Safety	SDOH	LLUMC & LLUCH	San Bernardino & Riverside County - Department of Public Health	
Community-based Focus Group	Cost of Housing & Homelessness	SDOH	LLUMC & LLUCH	Health Plans, Other Hospitals and Community Based Organizations	
Community-based Focus Group	Food, Transportation and Other Resources	SDOH	LLUMC & LLUCH	FIND Food Bank, Feeding America and United 211	
Community-based Focus Group	Immigration, Discrimination and Isolation	SDOH	LLUMC & LLUCH	Mexican Consulate and San Bernardino & Riverside County - Department of Public Health	LLU School of Public Health

INSTITUTE FOR COMMUNITY PARTNERS (ICP) - 2019

LOMA LINDA
UNIVERSITY
HEALTH

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Ted Wilson	General Conference of SDA	2010
Roger Woodruff	LLU School of Medicine	2015

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To Make Man Whole