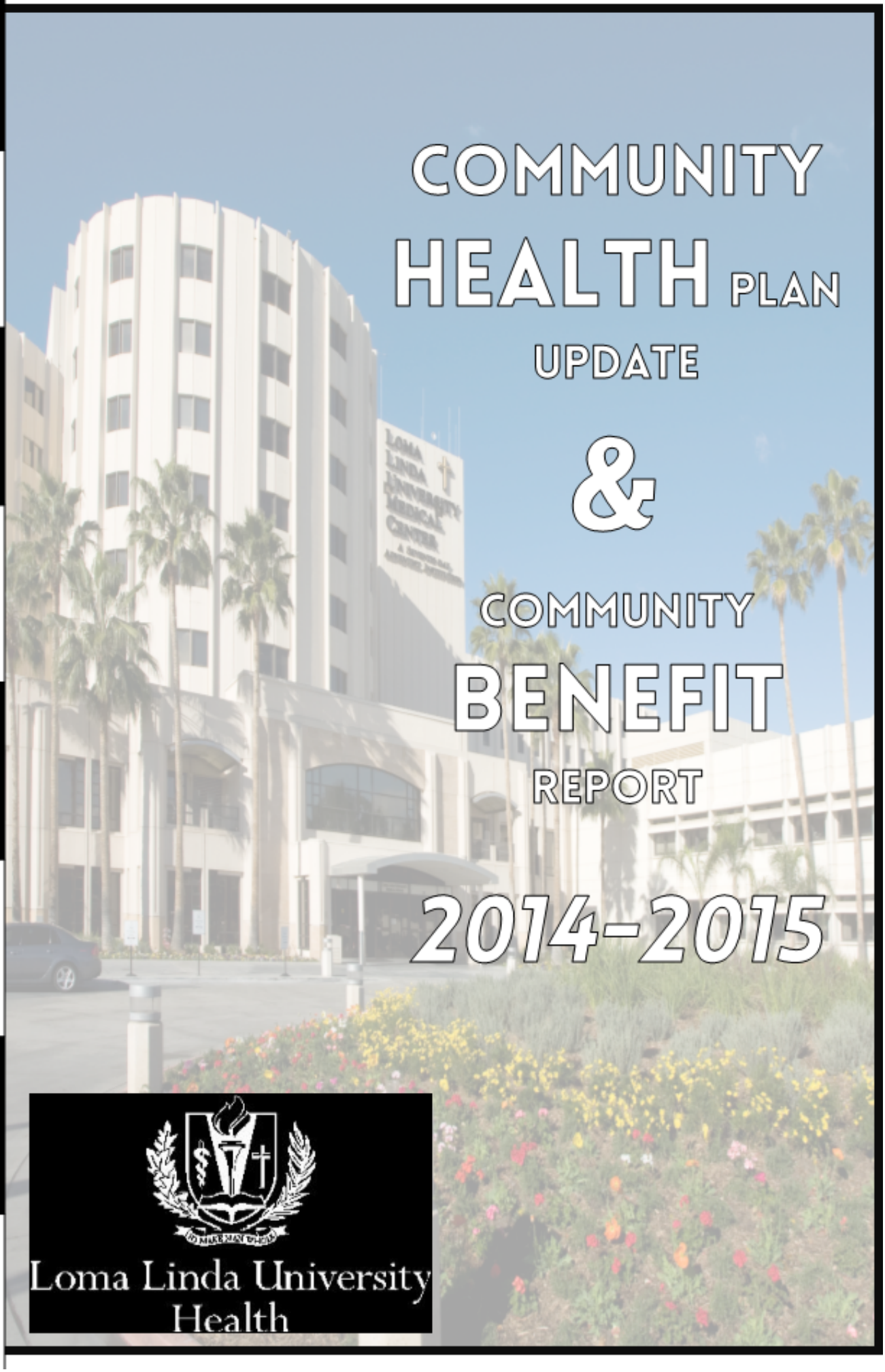
COMMUNITY HEALTH PLAN UPDATE

&

COMMUNITY BENEFIT REPORT

2014-2015



Loma Linda University Health

LOMA LINDA UNIVERSITY
HEALTH

Loma Linda University Health System

Community Benefit Report for:

Loma Linda University Medical Center
Loma Linda University Children's Hospital
Loma Linda University Behavioral Medicine Center
Loma Linda University Medical Center – Murrieta

Prepared by:

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Community Health Development

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Submitted May 2015 to:

California Office of Statewide Health Planning and Development
Accounting and Reporting Systems Section
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Prepared in Compliance with
California's Community Benefit Law

Letter from the CEO

Dear Community,

As Chief Executive Officer for the hospitals consisting of Loma Linda University Health, 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 Benefit Report with you.

This report highlights our accomplishments for 2014. In 2014, we invested over **$274,080,029** in community benefits. Loma Linda University Health believes, however, that providing charity care alone is not sufficient in meeting the health needs of our region. 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 concerted 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 passage of 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 proactively meeting the diverse health needs of our region through this historic transition.

Improving community health requires expertise and engagement beyond the hospital campus and beyond 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 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.

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

Sincerely,

Kerry Heinrich, JD,
Chief Executive Officer
Loma Linda University Health

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Loma Linda University Health Identifying Information

Loma Linda University Health
Kerry Heinrich, JC, Chief Executive Officer
Lowell Cooper, Chair, Board of Trustees

Licensed Hospital 1 (Includes Loma Linda University Medical Center, Loma Linda University Medical Center East Campus, Loma Linda University Surgical Hospital)

Loma Linda University Medical Center
Number of hospital beds: 371
Trevor Wright, Administrator
Lowell Cooper, Chair, Board of Trustees

Loma Linda University Medical Center East Campus
Number of hospital beds: 134
Lyndon Edwards, Administrator
25333 Barton Road
Loma Linda, CA 92354
(909) 558-6000

Loma Linda University Surgical Hospital
Number of hospital beds: 28
Lyndon Edwards, Administrator
26780 Barton Road
Redlands, CA 92373
(909) 558-4000

Licensed Hospital 2

Loma Linda University Children's Hospital
Number of hospital beds: 348
Kerry Heinrich, JD, Chief Executive Officer
11234 Anderson Street
Loma Linda, CA 92354
(909) 558-4000

On November 16, 2014 obtained separate license

Licensed Hospital 3

Loma Linda University Behavioral Medicine Center
Number of hospital beds: 89
Lyndon Edwards Administrator
1710 Barton Road
Redlands, CA 92373
(909) 558-9204

Licensed Hospital 4

Loma Linda University Medical Center - Murrieta
Number of hospital beds: 106
Rick Rawson, CEO
28062 Baxter Road
Murrieta, CA 92563
(951) 290-4000

Terry Hansen, Chief Operating Officer, Loma Linda University Health, (909) 558-5199 provides executive oversight to Community Health Development.

Loma Linda University Health System primary service area includes both San Bernardino and Riverside counties. Loma Linda University Health System is comprised of 1,076 beds for patient care including: Loma Linda University Medical Center, Loma Linda University Children's Hospital, Loma Linda University Medical Center East Campus, Loma Linda University Behavioral Medicine Center, and Loma Linda University Surgical Hospital, and Loma Linda University – Murrieta. The health system consists of four licensed hospitals. This report will outline the activities for LLUH in 2014 as a consolidated document while separating out the community health needs assessment and community health plan for 2014 in four distinct plans for each licensed hospital.

Mission, Vision, and Values

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, respects 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.

LLUH Service Area

Loma Linda University Health's primary service area can be defined, broadly, as California's Inland Empire – Riverside and San Bernardino Counties. The Inland Empire is a region of Southern California situated directly east of the Los Angeles metropolitan area. Riverside and San Bernardino Counties range from Lake Arrowhead in the north, Yucaipa in the east, Perris in the south, and Ontario in the west, serving a little over 4 million people with more than 90% from the two counties.

For the purposes of community health development a "service area" for LLUH includes the geographic area where the hospitals deploy their free and under-reimbursed services in the effort to improve population health and quality of life.

Community Health Development Team

Terry Hansen
Chief Operating Officer

Angela Coaston, RN, MSN, FNP, PHN
Transitional Care Director

Marti Baum, MD
Medical Director

James A. Martinez, EdD, MPH
Population Health Analyst/GIS Specialist

LOMA LINDA UNIVERSITY
HEALTH

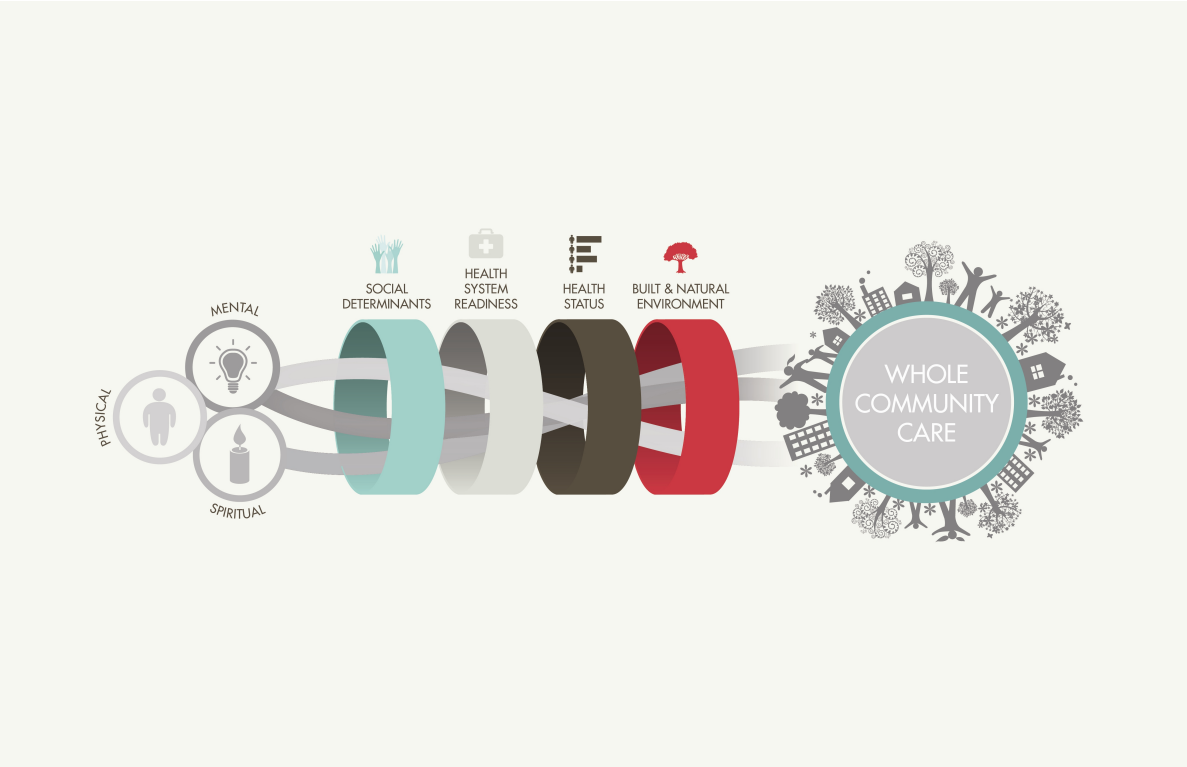
Community Health Needs Assessment Overview

Loma Linda University Health

A Community Health Needs Assessment (CHNA) was conducted in 2013 and detailed plans for each licensed hospital were created to meet the identified community needs and address community plans to address needs the hospitals are unable to address. 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 the Loma Linda University Health: to further the teaching and healing ministry of Jesus Christ. The development and methodology for the 2016 CHNA is currently underway and will begin in January of 2016.

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.

Whole Community Care Model



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 encompassed 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.

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

Purpose

Community Vital Signs is a community health improvement framework jointly developed 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 41 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 community health needs assessment, set regional priorities for health, and provide a framework to evaluate the interventions. This will be the basis of our triennial community health needs assessment with additional elements added to help identify specific healthcare 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 towards 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 collected from the U.S. Census Bureau, American Community Survey
- Health Indicator Data Collected from a variety of publicly available data

To validate the data, and to ensure a broad representation of the community, qualitative data was collected from:

Qualitative

- 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.
- Key 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 with broad and diverse perspectives.
- Focus groups with our chaplains, fire departments, and nurses.

In addition**,** LLUH was highlighted in the release of the 2012 County Health 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 2014 rankings. We are actively working with the County of Riverside to achieve similar results

Community Health Management System (CHMS)

As LLUH matures in their 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 data is continually being monitored and interventions are evaluated for success.

Objectives for CHMS

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

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. LLUH is working with multiple stakeholders to identify collective evaluation measures to work towards key health indicators as a region and not in isolation. Loma Linda University Health continues to challenge itself and the region to be proactive in understanding the community and become early adopter of interventions that will improve the health status of our region. LLUH has been instrumental in promoting ***The Community Guide***, (www.the communityguide.org), a free resource to help communities choose programs and policies to improve health and prevent disease. This resource guides communities towards interventions that have proven to be effective, that 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 providing relevant feedback at the local level?

A Community Health Needs Assessment (CHNA) was conducted in 2013 and detailed plans for each licensed hospital were created to meet the identified community needs and address community plans to address needs the hospitals are unable to address. In response to the identified needs in our assessment, Loma Linda University Health System have adopted the following initiatives and strategies for our community health investments for 2013-2015 in response to our community health needs assessment.

Loma Linda University Health Priority Areas

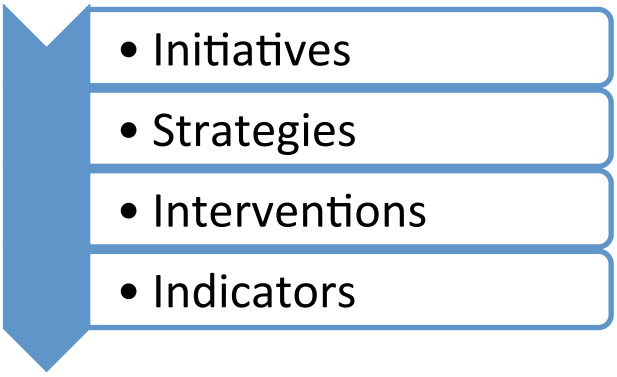
Elevate the health status of residents living in the Inland Empire.

Four Coordinated Plans

1. Working together effectively as a team.
2. Best practice interventions in a coordinated manner.
3. Metrics addressing identified community need.

One Team

LLUH working together as a coordinated and effective leader in prevention and community outreach.



Along with each licensed hospitals own detailed community health plan LLUH has brought together the strength of an academic health center to serve the community with system wide initiatives to better serve the region. Regional resources such as an advisory board, a community health development team, and academic resources are deployed at a system level to provide more integrated services to our region. This is complemented by community health development teams at each hospital while benefiting from a larger pool of resources. Some strategies serve the region better in at the local level, but some serve and improve health better at a regional level. System wide initiatives are outlined in a combined plan for the system and individual strategies are outlined in each hospital's community health plan. Outlined below you will find the balance of integration and the realization of our mission at the local level.

LOMA LINDA UNIVERSITY
HEALTH

Loma Linda University Health – System Wide Initiative
Healthy Communities
Faith and Health
Whole Health System

Loma Linda University Medical Center
Whole Child Care
Whole Cancer Care
Whole Chronic Disease Management Care
Whole Rehabilitation Care
Whole Behavioral Health Care
Whole Aging Care
Whole Sickle Cell Anemia Care
Healthcare Pipelines

Loma Linda University Medical Center - Murrieta
Whole Child Care
Whole Behavioral Health Care
Whole Chronic Disease Management

Loma Linda University Behavioral Medicine Center
Whole Behavioral Health Care

Loma Linda University Children's Hospital
Whole Child Care

Were we Successful in 2014?

LLUH achieved many great successes in 2014 in redefining our random acts of kindness and unmanaged charity to more strategic community investments while we continue to strive for excellence and better accountability for elevating the health status of our community. We have developed metrics and dashboards to be aligned with national and statewide metrics to leverage our efforts with our trusted community partners.

In addition to LLUH's system wide initiatives and strategies for each licensed hospital, the health system offers many community health development interventions throughout the community. We all looking at strategic venues to improve population health throughout our region and have aligned all of our interventions with an identified community need and best and promising practices for community health. We continue to improve our efforts in evaluating our interventions beyond just the numbers served and will be working to improve health behaviors and systems with the goal of improving health outcomes. LLUH is investing in a Community Health Management System and will use this as the basis for evaluating future community health interventions.

We believe healthy individuals depend on healthy communities, socially, economically, and environmentally. And it follows that healthy communities depend on healthy individuals — healthy in all the dimensions of body, mind, and spirit. Our interventions have a focus on those who lack access to vital services due to barriers, community empowerment and knowledge, as well as building partnership and relationships with our community members and leaders.

We hope you enjoy reading the activities that took place in 2014 as much as we had doing them.

2014 Community Benefit Inventory

2014 COMMUNITY BENEFIT INVENTORY								
Whole System Strategies: Faith and Health Initiative/Health Communities/Health System Care Initiative								
Clergy Appreciation Luncheon San Bernardino Diocese Day of Learning Renegade Pastor Conference								
Activities	**Child Care**	**Cancer Care**	**Chronic Disease Care**	**Sickle Cell Care**	**Aging Care**	**Rehabilitation Care**	**Health Care Pipeline**	**Behavioral Health Care**
Community Health Improvement								
San Bernardino County Healthy Communities	●	●	●	●	●	●	●	●
Healthy Valley Coalition	●	●	●	●	●	●	●	●
Community Health Education and Awareness								
211 San Bernardino County	●	●	●	●	●	●	●	●
Adopt – a – School : Victoria Elementary	●						●	
Boy Scouts of America	●							
Breast Cancer Education		●						
Cancer:		●						
▪ Outreach Events		●						
▪ Prevention/Education Interventions		●						
▪ Support Groups		●						
▪ Walks		●						
▪ Support Services		●						
Behavioral Health Education &	●							●

Awareness								
Breastfeeding Consultation/Education	●	●	●	●	●	●	●	●
Camp Good Grief	●						●	
Camp Good Grief – Special Victims Program	●						●	
Camp Good Grief – Teen Retreat	●						●	
Chemical Dependency Children's Program								●
Children's Day Health Fair	●							
CPR and Chest Pain Community Awareness								
Diabetes Treatment and Prevention			●					
▪ Screenings								
▪ Support Groups								
Family Health Fair (Prevention & Screening)	●	●	●	●	●	●	●	●
Family Program	●							●
Gateway Program	●						●	
Health Library (Web-based Education and Awareness)	●	●	●	●	●	●	●	●
Heart Health								
Joint Replacement Education								
Junior Public Health Internship								
Newborn Necessities Education								
Prevention Plus								
Senior Services – Behavioral Health								●
Substance Abuse Support Groups								
Smoking Cessation								
▪ Alcoholics Anonymous	●							●
▪ Pain Pills	●							●
Speaking of Woman's Health								

Stress Management								
Street Medicine								
Weight Loss Support Group								
Weight Loss Surgery Education								
Health Care Support Services								
Charity Medications	●	●	●	●	●	●	●	●
Community Clinic Support	●	●	●	●	●	●	●	●
Just for Senior – Empowering Seniors								
Non-Emergency Medical Transportation	●	●	●	●	●	●	●	●
Poss**A**bilities – Empowering Disabled Individuals						●		●
In Kind Donations								
In Kind Donations/Meeting Room								
Health Professionals Education and Research								
Health Professionals Education	●	●	●	●	●	●	●	●
Research	●	●	●	●	●	●	●	●

Community Members served: 235,824

2014 Community Health Investments

Loma Linda University Health - Detail

Clergy Appreciation Breakfast

Identified Need: Poor communication and awareness of health services available in the Inland Empire.

On August 27, 2014 the Annual Clergy Appreciation luncheon took place in the Centennial Complex on the campus of LLUH. Approximately **160** people were in attendance with the majority being clergy, chaplains, and regional representatives from denominational entities. Pastor Sam Casey, who has worked closely with many Faith Communities in the Inland Empire, was the presenter. Clergy were given access to a resource list that was compiled through the Community Health Development office. This was also the continuation of relationship building within the Faith Community Network. The goal of the annual Clergy Appreciation is to provide a space for clergy, chaplains, and regional representatives from various denominational entities to gather and hear the resources LLUH has that would be of service to their community.

Objectives

1. Increase the number of faith communities aware of services available to their members.
2. Decrease barriers for clergy to assist their members while their members are accessing health services.
3. Increase awareness of clergy to behavioral health services for their own need.
4. Show appreciation for the vital role clergy play in supporting our community.

Community Clinic Support

Identified Community Need: Lack of access to health insurance and poor availability to primary care.

Loma Linda University Health provides support to local community clinics that serve the community's underserved population. The clinics provide a continuum of care and provide a medical home to the medically underserved.

The continuum of care provided to the community through these clinics include:

- Care for acute and chronic illness
- Mental health services
- Dental care
- Physical, occupation, and speech therapy
- Prenatal care and other women's services
- Immunization
- Health promotion and preventative care

- Specialized care for HIV/AIDS

The demographic make-up of the **13,059** unduplicated patients served by the clinics supported by LLUH:

- 2/3 are uninsured and do not qualify under Medi-Cal
- 90 percent are minorities, 57 percent are Hispanic
- 64 percent are women, 35 percent are children

Objectives

1. Increase the proportion of persons who have a specific source of ongoing care.
2. Increase the proportion of persons with health insurance.

Diocese Day of Learning

Identified Community Need: High rates of behavioral health and chronic disease issues in the Inland Empire. Poor communication and awareness of health services available in the Inland Empire.

On March 11, 2014 the Diocese Day of Learning took place at the Diocese of San Bernardino. Approximately 100 clergy from the Diocese were in attendance. Topics covered included healthy aging, behavioral health, diabetes, cardiovascular health, and prevention and wellness. The goal is to establish an ongoing relationship with the Diocese because of their extensive influence in faith communities within our region. The Diocese of San Bernardino, which encompasses Riverside and San Bernardino Counties, is the 5th largest Diocese in the United States.

Objectives

1. Increase appropriate utilization of behavioral health services.
2. Create a discussion for clergy to increase their capacity to care for their congregants, and to understand their role in behavioral health interventions.
3. Increase awareness of clergy to behavioral health services for their own need
4. Increase awareness of clergy to chronic disease and the importance of nutrition and exercise.

Faith and Health Initiative –Healthy Ontario Faith Collaboration Health

Identified Community Need: High rates of poverty, chronic disease, and food insecurity within a specific geographic region of the city of Ontario. Poor access to physical activity and nutritious foods.

Healthy Ontario is a partnership between the city of Ontario, Kaiser Permanente, El Sol, Partners for Better Health, Pitzer College, and Loma Linda University Health (LLUH). Healthy Eating Active Living (HEAL) is an initiative that supports healthy behaviors to reduce obesity and improve community health. HEAL is a designated geographical area located within the city of Ontario. Within the grant is a faith-based initiative that focuses on partnering with churches and faith-based organizations to improve health in the community. Loma Linda University Health, and more specifically Community Health Development's expertise, was requested to help fulfill the faith-based portion of the grant.

In 2014 Community Health Development facilitated relationships with three faith-based organizations within the HEAL Zone: Christian Life Center, Friendship Missionary Baptist Church, and the Salvation Army. Faith-based partners have hosted over 20 exercise classes with a cumulative attendance of more than **210** participants. We have also helped to facilitate educational, environmental, and policy changes that positively impact the health of each faith community. Some of the interventions delivered through the faith communities are outlined below:

- Weekly Zumba classes are hosted at Christian Life Center, Friendship Missionary Baptist Church, and Salvation Army
- Weekly Karate classes are hosted at Christian Life Center and Salvation Army
- CHD purchased a refrigerator for Christian Life Center's food pantry so that fresh fruits and vegetables could be included in monthly giveaway.
- Through a partnership with Huerta del Valle, a nearby community garden, produce is donated to the food pantry on a monthly basis.
- Monthly faith-based roundtable
- Monthly healthy eating active living newsletters delivered to churches
- Healthy eating policies have been implemented at Christian Life Center and Salvation Army

Objectives

1. Improved access to quality, affordable healthy foods and beverages and activity in community settings.
2. Improved community and organization policies related to healthy eating and active living.
3. Increases awareness, knowledge, skills, motivation and utilization among community members around healthy eating and active living.
4. Increase awareness, knowledge, and skills motivation and utilization among community members around healthy eating and active living.

Faith Based Monthly Case Discussions

Identified Community Need: High rates of behavioral health issues in the Inland Empire.

Monthly roundtable luncheons facilitated by a mental health professional. This is an opportunity for pastors and chaplains to spend time with a mental health professional to discuss any scenarios or behavioral health cases clergy are experiencing within their communities of faith. Clergy can safely discuss challenges they are presented with and brainstorm solutions or appropriate referrals. The monthly discussions occur on the 3rd Wednesday of every month. In 2014, a total of **40** faith based leaders attended the monthly sessions.

Objectives

1. Increase appropriate utilization of behavioral health services.
2. Create a resource-oriented discussion for clergy to increase their capacity to care for their congregants, and to understand their role in behavioral health interventions.

Gateway Program

Identified need: Low educational attainment in the Inland Empire. Lack of health professionals that reflect the community in the Inland Region.

Fifty-nine high school students participated in the 2014 Gateway program. These students represented 29 high schools from the Inland Empire. During the two-week core program students learned about the health careers by engaging in interactive presentations with Loma Linda University students and professors, valuable college prep workshops such as study skills, leadership skills, health disparities, and communication etiquette. Students also get exposed to Loma Linda University values through daily devotional speakers and a day of community outreach. On the final day of the core program students participated in hands-on simulations thanks to the Sim Lab staff. Twenty-two students were selected to stay and shadow health care providers within the LLUMC health system. Each student experienced 8 shadowing rotations during the week. 2015 program will mark the 10th year LLU has offered a summer pipeline program (originally called Si Se Puede).

Objectives

1. Expose high school students to all health related fields.
2. Increased community relationships with schools, universities, and community organizations.

Health Library

Identified Community Need: Lack of access to local online health services for the community.

In our 2010 Community Health Needs Assessment the community clearly told LLUH that they wanted more health information available online. In response to that request we continue to offer the Health Library. This is an online health information service with the goal of promoting and educating around health and wellness areas that include a library on diseases and conditions,

healthy living, health centers, daily health news, and daily health tips. Additional features include: Healthy Living modules, information on blood pressure, smoking, stress, and weight loss. Interactive health promoting tools are available and include adult and child BMI calculators, a wide range of health and mental health quizzes, and a health symptom checker. A healthy recipes database can be accessed to provide information to promote healthy eating. In **2014, 47,110** visitors accessed the Health Library.

Objectives

1. Increase the proportion of online health information seekers who report easily accessing health information.
2. Improve the health literacy of the population.
3. Increase the proportion of persons who use electronic personal health management tools.
4. Increase the proportion of persons who report that their health care providers involved them in decisions about their health care.

Junior Public Health Internship Program

Identified Need: Low high school graduation rates and inadequate public health workforce in the Inland Empire.

The Junior Public Health Internship Program was developed through local collaboration of municipal, university, and non-profit organizations within San Bernardino County. We invited school administrators to nominate students with academic competence and leadership abilities. Students engaged in learning opportunities through local healthy community initiatives, participated in leadership trainings to become change agents in their respective high schools and communities. The goal is to motivate and facilitate college enrollment to increase the number of City of San Bernardino students represented in college Public Health programs.

Objectives

1. Increase the proportion of the population that completes high school education.
2. Increase the proportion students that have health education goals or objectives which address the comprehension of concepts related to health promotion and disease prevention.
3. Create a high school pipeline program in cities within the Inland Empire to engage, train and expose students to the public health field.

Randall Lewis Health Policy Fellowship

Identified Need: Low high school graduation rates and inadequate public health workforce in the Inland Empire.

The Randall Lewis Health Policy Fellowship (RLHPF) is collaborative enterprise of corporate, LLUH, university, and community leadership. The fellowship had its beginnings in San Bernardino County, California, in 2010 to assist municipal efforts in the County's Healthy Communities initiative. The Fellowship is now an eight month field experience where graduate students in public health and urban planning work with policy and policy implementation within a local municipal government context.

Now in its fifth year, the 2014/15 fellowship program comprises **23** graduate students from eight universities: Cal Polytechnic University Pomona, California State University San Bernardino, Claremont Graduate University, Loma Linda University, University of California Irvine, University of California Los Angeles, University of Southern California and Western University of Health Sciences. Also participating are Los Angeles, Riverside and San Bernardino County Health Departments along with city-based Healthy Communities Initiatives in all three counties. In unincorporated areas of San Bernardino County, local school districts and hospitals also help drive healthy communities efforts. This year, the Fellowship also initiated collaborations with Southern California Association of Governments, and San Bernardino and Western Riverside County government associations.

The purpose of the Health Policy Fellowship is to:

- Ensure the development of public health professionals who possess the necessary skills to influence positive change in public policy, systems, and the built environment in our local municipalities.
- Create educational and professional opportunities for local students in health policy, planning and policy implementation.
- Provide for the expansion of the regional health policy infrastructure, and retain essential intellectual capital in the Inland Empire.
- Provide expertise to our local healthy communities efforts.

The fellows were involved in the following activities:

- Developing policy briefs and action plans;
- Assisting city leaders with reviewing General Plans;
- Revitalizing existing community health programs;
- Establishing farmers' markets;
- Providing support during outreach and collaborative events;
- Conducting comprehensive reviews of key issues that make a city a family-friendly and nurturing community;
- Assisting in the development of municipal active transportation plans;
- Conducting community health needs assessments and recommendations.

Regional Coordination of Community Resources -211 San Bernardino County

Identified Community Need: Lack of access and knowledge to existing resources such as food, housing, and transportation available to our community.

2-1-1 is a toll-free phone number that provides information and referrals for health and social services in San Bernardino County such as, shelter and housing, clothing, food and water, childcare, health care, government resources, and transportation. Dialing 2-1-1 is the quickest way to access non-emergency resources for our community. In 2014, LLUMC partnered with 211 San Bernardino and developed a direct link to 211 resources throughout LLUH's intranet. This enabled all providers affiliated with LLUH to directly access community resources and make referrals while patients are being discharged from the hospital or for community members who are in need of basic resources. This direct link has increased the awareness of providers who in turn will share this resource with the community. As a result of our new system we are able to run reports for the highest priority needs for our community and work with our community partners to ensure that adequate resources are available. This data will directly influence the partnerships developed by the Community Health Development Department to identify gaps in services for our community.

Objectives

1. To increase access to social services in the community for our patients.
2. To identify unmet social service needs in our patients receiving care in the Emergency Department.
3. To strategically develop partnerships wit the community to address unmet needs.

Renegade Pastor Conference

Identified Need: Increasing rates of obesity, diabetes and heart disease among those engaged in the pastoral profession.

The Nelson Searcy Renegade Pastors Conference held a meeting in Anaheim, CA on August 6th, a total of **60** clergy attendees were present. Pastors had the opportunity to network and plan. Biometric screenings were provided to the participants. The screenings were provided in collaboration by Loma Linda University School of Public Health.

Objectives

1. Increase the proportion of clergy aware of their health risks.

San Bernardino Diocese Education

Identified Need: Increasing rates of obesity, diabetes, and heart disease within the Hispanic community that is majority Catholic in faith orientation.

On August 28, 2013 LLUH brought in multiple experts to speak to **100** diocesan employees regarding the benefits of healthy aging, health statistics in the region, and the possibilities of

connecting faith communities to LLUH formalized faith community health network. The day included breaks for aerobics, a healthy eating experience, and education. As a result of the conference, the diocese has instituted a healthy vending machine policy, walking groups, and weight loss support groups.

Objectives

1. Increase local clergies awareness of health risks for chronic disease.
2. Increase local clergies awareness of best practice interventions for their communities of faith.

Transitional Care Management

Identified need: High prevalence of chronic diseases.

Transitional Care Management (TCM) is a free service for qualified patients that focuses on helping them transition from the hospital back to their home. When a patient enrolls in TCM, we become partners in their care to achieve the best quality of life as possible. A care manager assists a patient with their transition and engages in coordinating a patient's self care needs for up to 90 days after hospital discharge. Our goal with TCM is to help our patients follow their home instructions for medications, self-care and recognize symptoms that signify potential complications that may require immediate attention.

Objectives

1. Increase the proportion of persons of all ages who have a specific source of ongoing care.
2. Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines.

2014 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 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, 10-year national objectives for improving the health of all Americans.

For 3 decades, Healthy People 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 County Health 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. The *Rankings* look at a variety of measures that affect health such as the rate of people dying before age 75, high school graduation rates, unemployment, limited access to healthy foods, air and water quality, income, and rates of smoking, obesity and teen births.

Based on data available for each county, the Rankings are unique in their ability to measure the overall health of each county in all 50 states on the many factors that influence health, and they have been used to garner support among government agencies, healthcare providers, community organizations, business leaders, policymakers, and the public for local health improvement initiatives. 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-informed 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 County Health 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 2014 rankings. We are actively working with the County of Riverside to achieve similar results. Knowing that overall health of a community cannot be achieved along, LLUH is working actively with the counties to identify collective impact measurements that can be used to align interventions with other sectors such as education, transportation, the business community, and pubic safety.

LOMA LINDA UNIVERSITY
HEALTH

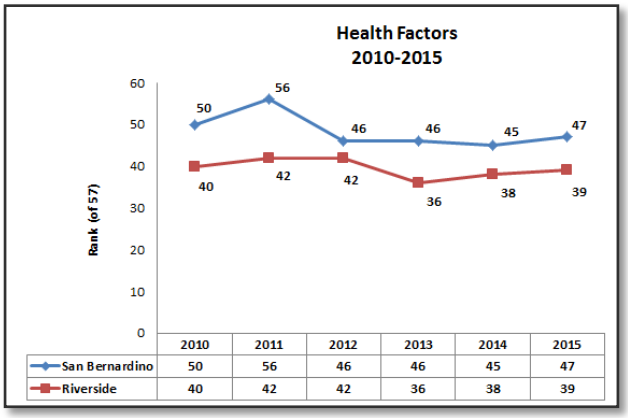
We are slowly making system changes and the health of our region is improving. Take a look at the most recent data!

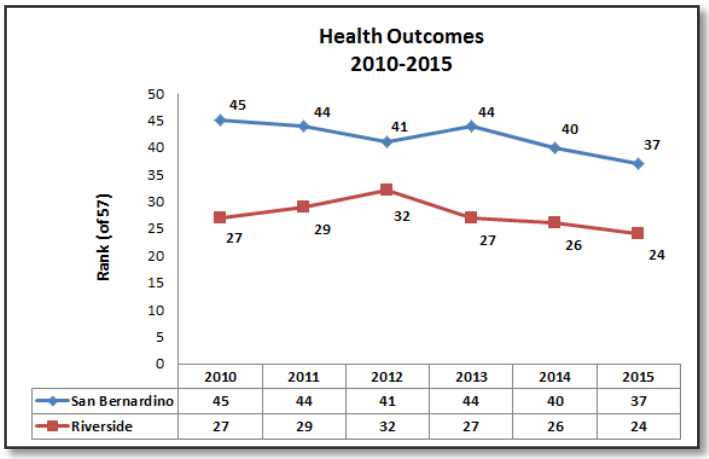
The table below reflects the changes per year for health outcomes and health factors for San Bernardino and Riverside County.

2010 2015 County Health Rankings

	San Bernardino						Riverside					
	2010	2011	2012	2013	2014	2015	2010	2011	2012	2013	2014	2015
Health Outcomes	45	44	41	44	40	37	27	29	32	27	26	24
Mortality	37	35	36	32	32	30	30	27	28	25	25	23
Morbidity	48	49	46	51	48	50	32	34	36	41	38	38
Health Factors	50	56	46	46	45	47	40	42	42	36	38	39
Health Behaviors	48	48	45	46	44	44	36	33	39	33	34	32
Clinical Care	54	56	50	52	50	52	50	54	43	46	48	48
Social & Economic Factors	37	40	39	39	39	36	31	29	29	31	31	29
Physical Environment	54	55	55	46	53	53	62	54	54	41	48	49

Source: CountyHealthRankings.org





In addition to the collective impact indicators LLUH, community health development has created a dashboard to review high-level indicators for all of our interventions. We are still measuring our process but challenging our system to ensure our investments are yielding the outcomes we desire and improving the health of our region. If they are not, we want to do better and course correct to ensure that we are serving our community with the highest expertise and professionalism possible.

Community Health Development Dashboard

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 Community Benefit Administrative Council, also known as CBAC, purpose 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 and 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

LOMA LINDA UNIVERSITY
HEALTH

Community Benefit Administrative Council		
Last	**First**	**Title**
Baltazar	Angelica	Health and Human Services Industry Support Specialist, ESRI
Baum	Marti	Medical Director, Community Health Development, LLUMC
Belliard	Juan Carlos	Associate Professor in Global Health, School of Public Health Director, Institute for Community Partnerships
Berto	Jessica	
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	Executive Director, Partners for Better Health
Elwell	Larry	Principal, Victoria Elementary School
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, Loma Linda University Behavioral LLUMBC
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 a description of the relationships of connectivity that is necessary to collectively improve the health of our region. One of the objectives is to partner with other nonprofit 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 underway 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 LLU 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. The Health System'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 and developed strategic collaborations with the following organizations.

Local Organization	Purpose	Objectives
Community Clinic Association of San Bernardino County	The support the Community Clinic Association of San Bernardino in building an effective, county-wide association of community clinics that efficiently deliver culturally appropriate quality healthcare to the medically indigent, underserved, uninsured and/or underinsured.	1. To 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.	1. To 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.
Social Action Community (SAC) Health System	To support the development of a community based clinic and create an infrastructure for the clinic to become financially sustainable.	1. Increase the proportion of persons who have a specific source of ongoing care. 2. Increase the proportion of persons with health insurance
Waterman Garden	Waterman Garden is a low income housing complex located in the City of San Bernardino. LLUH has identified diabetes as a need. As a result, providing diabetes education using the Promotora model and connecting them to the healthcare system has been designed.	1. Connect community health (CHWs) workers to health care systems 2. Integrate CHWs to care team 3. Connect patients to community resources 4. Develop a continuum of care delivery model for diabetic patients. 5. Pilot a community-based chronic care management model utilizing community health workers for diabetic patients in Waterman Gardens

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 towards health improvement.

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 Barstow
    - Healthy Big Bear Lake and Greater Big Bear Valley
    - City of Bloomington
    - Healthy Chino
    - Healthy Chino Hills
    - Healthy Colton
    - Healthy Fontana
    - Healthy Grand Terrace
    - 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 Snowline Communities
- 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

Community Benefit and Economic Value

For over a century, Loma Linda University Health System 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 2014, Loma Linda University Children's Hospital obtained a separate license making them the newest addition to our system.

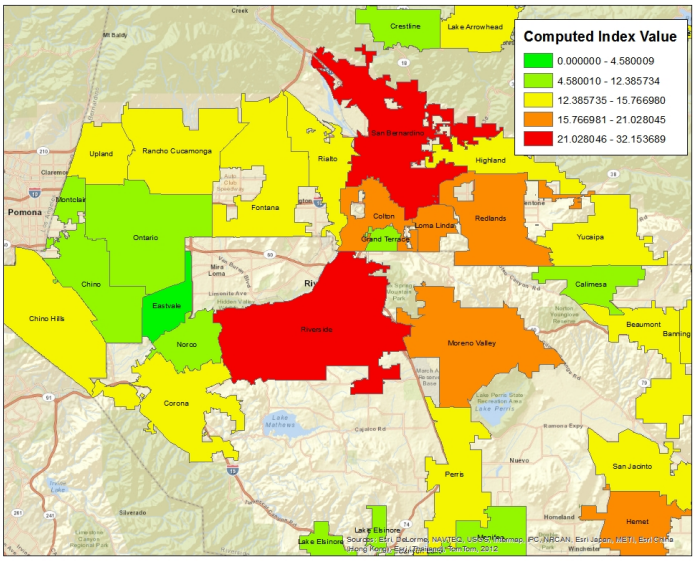
Valuation of Community Benefit

Year 2014 –SB697 Valuation – Cost-Based

Loma Linda University Health System Totals	
Charity Care	$16,200,511
Medi-Cal and Other Means Tested Government Programs	$195,447,851
Community Health Development	$5,339,084
Health Professional Education	$52,383,078
Subsidize Health Services	$1,192,402
Research	$3,517,103
Total Community Benefit Economic Value	**$ 274,717,749**

Creating a Healthier Community in 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? and, 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 of Highest Need

- San Bernardino City
- Highland
- Riverside
- Colton

Identified Community Needs

- Lack of affordable 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;
- Growing Hispanic population and increase in the elderly population; and
- Disproportionate share of children living in poverty and homelessness

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 ULCA 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.

Loma Linda University Health 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 for 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 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 forward in 2013 and beyond.

In response to the 2013 CHNA LLUH has outlined the following strategies to comprehensively meet the needs of our community:

Loma Linda University Health – System Wide Initiative
Healthy Communities
Faith and Health
Whole Health System

Loma Linda University Medical Center
Whole Child Care
Whole Cancer Care
Whole Chronic Disease Management Care
Whole Rehabilitation Care
Whole Behavioral Health Care
Whole Aging Care
Whole Sickle Cell Anemia Care
Healthcare Pipelines

Loma Linda University Medical Center - Murrieta
Whole Child Care
Whole Behavioral Health Care
Whole Chronic Disease Management

Loma Linda University Children's Hospital
Whole Child Care

Loma Linda University Behavioral Medicine Center
Whole Behavioral Health Care

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HEALTH

Loma Linda University Health – System Wide Initiatives

One Goal

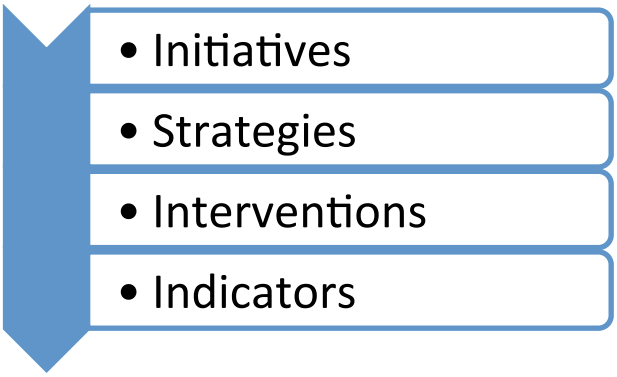
Elevate the health status of residents living in the Inland Empire

Four Coordinated Plans

1. Working together effectively as a team
2. Best practice interventions in a coordinated manner
3. Metrics addressing identified community need

One Team

LLUH working together as a coordinated and effective leader in prevention and community outreach.



Along with each licensed hospitals own detailed community health plan Loma Linda University Health has brought together the strength of an academic health center to serve the community with system wide initiatives to better serve the region. Regional resources such as an advisory board, a community health development team, and academic resources are deployed at a system level to provide more integrated services to our region. This is complemented by community health development teams at each hospital while benefiting from a larger pool of resources. Some strategies serve the region better in at the local level, but some serve and improve health better at a regional level. System wide initiatives are outlined in a combined plan for the system and individual strategies are outlined in each hospital's community health plan. Outlined below you will find the balance of integration and the realization of our mission at the local level.

Paradigm Shift in Public Health and Prevention

Public health is in a paradigm shift. The paradigm shift is from traditional health promotions and programs that focus on individual behavior changes, including education and awareness programs, to a focus on creating a supportive infrastructure for health that includes public policies, built environments, and systems that promote health. The Institute of Medicine (IOM, 2003) report: THE FUTURE OF THE PUBLIC'S HEALTH IN THE 21ST CENTURY (IOM, 2003) states, " It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and physical environment conspire against such change." This view is echoed by researchers studying the effect of the social environment on physical activity: "Advising individuals to be more physically active without considering social norms for activity, resources, and opportunities for engaging in physical activity, and environmental constraints such as crime, traffic, and unpleasant surroundings, is unlikely to produce behavior change" (McNeill et al., 2006). Conversely, changing people's environment to provide equal access to factors that determine health will enable them to better control their health and its determinants, make healthier choices, and thereby improve their health.

Spectrum of Prevention

The socio-ecological model recognizes the interwoven relationship that exists between the individual and their environment. 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, worksites and healthcare 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 walk-able 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. LLUMC 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

Whole Health System Care Initiative

Overview of the Initiative

With the passage of the Affordable Care Act (ACA), 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 ACA 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 is 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 SAC Health System.

Loma Linda University Health will work closely with Covered California to help with the 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 ACA. 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.

Strategies

1. Whole Child Care
2. Healthcare Pipelines
3. Whole Mental Health Care
4. Chronic Disease Management Care
5. Whole Cancer Care
6. Whole Rehabilitation Care
7. Whole Sickle Cell Anemia Care
8. Whole Aging Care

Center for Strategy and Innovation

In 2013 LLUH established a Center for Strategy and Innovation (CSI) to support the LLUH 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 healthcare, 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.

Health Library

The health library is an online health information service with the goal of promoting and educating around health and wellness areas that include a library on diseases and conditions, healthy living, health centers, daily health news, and daily health tips. Additional features include: Healthy Living modules, information on blood pressure, smoking, stress, and weight loss. Interactive health promoting tools are available and include adult and child BMI calculators, a wide range of health and mental health quizzes, and a health symptom checker. The health library is a resource to help promote a virtual health system.

Evaluation Indicators

1. Improve the percent of patients receiving care in a timely manner.
2. Increase culturally and linguistically appropriate health services provided in the Inland Empire.
3. Reduce 30-day all cause unplanned readmission.

Faith and Health Initiative

Overview of Initiative

Faith Communities and Healthcare Systems are often pillars in the community, places we turn in our greatest hours of need. In the Inland Empire we are surrounded by significant and stark health disparities. Healthcare is often used, and perceived, as only a safety net for the forgotten and underserved. Community members travel through our system without a continuum of care that empowers them to rise above the barriers of broken systems and neighborhoods. Many of our community members struggle to meet their basic needs on a daily basis, and when their basic needs go unmet they often look to Faith Communities for support.

The Faith and Health Initiative is an effort to be a better companion to Faith Communities in ministering to and caring for community. It seeks to bridge the gap that exists between the well-intentioned services of Healthcare Systems, and achieving a lifelong journey of health. It makes sense that these two healing institutions should work together in order *create new forms of faith-based collaborations for health in our communities*.

The Faith and Health Initiative is embedded into the mission of Loma Linda University Health, and therefore becomes a true delivery model for Christ's ministry of teaching and healing. Faith Communities have a significant footprint, and become the ideal companion in being faithful to, and delivering, our value of Wholeness.

Due to 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 include the following: Whole Behavioral Health Care, Whole Chronic Disease Care, and Whole Sickle Cell Anemia Care.

Goal: Creating new forms of Faith-based collaborations for health in our communities.

Priority Areas

1. Whole Behavioral Health Care
2. Whole Chronic Disease Care
3. Whole Sickle Cell Anemia Care

Interventions

1. Case Discussion Lunches, Counseling for Clergy
    a. Providing pastors with a forum to discuss mental health issues in their congregations as well as the opportunity to receive counseling services from a licensed psychiatrist.

2. San Bernardino Diocese Behavioral Health Conference.
    a. Increasing awareness and providing behavioral health education to clergy from parishes in the 5th largest Diocese in the United States

3. Micro-grants
    a. Strategically investing in Faith Communities who are proactively attempting to prevent disease and promote health in the Inland Empire.

4. Transitional Care Management (TCM)
    a. Partner with TCM and Faith Communities to further reinforce support for patients post-discharge.

5. Crosswalk Church Intervention
    a. Develop a place-based model for delivering preventive services to community.

6. Healthy Ontario/Healthy Eating Active Living (HEAL)
    a. Improve access to quality, affordable healthy foods and beverages and activity in community settings.

7. Sickle Cell Anemia - Faith Community Pilot Study
    a. Partner with our Sickle Cell Team and Faith Communities to improve the continuum of care for Sickle Cell patients.

8. 211
    a. Participation as a 211 advisory committee member with the intention of providing feedback from the community and input on the strategic direction of community resource delivery in the Inland Empire.

Evaluation Indicators

1. Target five churches in San Bernardino to award micro-grants in 2015.
2. Provide 40 hours of counseling services to Community Clergy in 2015.
3. 10 congregations as members of the Ontario Faith-based Roundtable
4. Increase food security by facilitating the development of a community gardens in Faith Communities.
5. In collaboration with Transitional Care Management, identify 3 Faith Communities willing to work with TCM in supporting transitions of care.

Healthy Communities Initiative

Overview of 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.

Loma Linda University Health 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 address in isolation, and a key focus of the community health development interventions will be anchored through a "Healthy Community Model" implemented throughout the 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 health 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 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.

2015 Update

San Bernardino County is the largest county in the contiguous United States with a population of two million living in diverse geographic and civic environments. The health problems facing this region make it imperative that we give priority to the health needs of our residents.

Many modern health problems including obesity, heart disease and stroke, cancer, asthma, stress, and traffic related injuries are impacted by how & where we build our communities. It is for this reason that the planning and health disciplines must work together for healthier future outcomes.

As a result, in 2006, the Healthy Communities program was created as a central point of contact for health related issues throughout the county. Technical assistance by the county is provided to

communities throughout the county giving specific recommendations for policy and environmental strategies to improve residents' health.

Currently, there are 24 (incorporated) cities and 23 of the 24 have Healthy City agreements and an additional 6 in unincorporated areas. While each community focuses on improving nutrition and increasing physical activity, each Healthy City addresses its unique priorities as determined by the community itself. The widely varying approaches and expertise among the Healthy Cities has created a wealth of opportunities for sharing and learning from one another. In 2014, the County of San Bernardino partnered with the Riverside County Healthy Communities and have begun partnering with them on some initiatives to collaboratively decrease the negative health outcomes that are affecting the health of the residents across County boundaries. This partnership is an important step for our region for a greater strategic impact to elevate the health status of the region.

LOMA LINDA UNIVERSITY
HEALTH

Loma Linda University Medical Center

2014 Community Health Inventory

2015 Community Health Plan

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 Medical Center East Campus
Number of hospital beds: 134
Lyndon Edwards, Vice President
25333 Barton Road
Loma Linda, CA 92354
(909) 558-6000

Loma Linda University Surgical Hospital
Number of hospital beds: 28
Lyndon Edwards, Vice President
26780 Barton Road
Redlands, CA 92373
(909) 558-4000

LLUMC Service Area

LLUMC'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, and Southwest Riverside County. In the year 2012, 92.8% of LLUMC's inpatient cases originated from the Inland Empire.

2014 Community Health Investments

Loma Linda University Medical Center - Detail

Adopt-a-School – Victoria Elementary

Identified Community Need: Mental health needs, access to primary care, and high obesity rates in children.

The core concept of the Adopt-a-School model allows for the building of sustainable relationships between health systems, schools and the community, and brings about a substantive long-term improvement in the environment of the learners.

The task of elevating the health status of our region cannot be accomplished by one sector alone. In order for the health system and school districts to reach their goals of health improvement and advanced educational levels they must work together focusing on their area of specialty. Partnering with a school in a targeted area allows for a focused intervention with measurable outcomes. The model consists of three phases. In 2014 LLUH worked with Victoria Elementary School with an enrollment of **599** students and teachers.

The actions below outline the steps taken in the adopt-a-school model.

Phase one:

- Schools apply or are identified by the health system
- Schools are appraised in consultation with stakeholders
- A high level due diligence is conducted on the school

Phase two:

- Potential schools are brought to the health system for approval
- The profiles of schools and an assessment are conducted for the school
- An adoption agreement is entered into between the schools and the health system
- Potential programs are offered to the school based upon the assessment
- An action plan is developed with all the stakeholders
- An oversight committee is formed with all the stakeholders

Phase three:

- During phase 3 implementation work begins.

All of these phases were completed with Victoria Elementary School (VES) in 2014. Victoria Elementary School (VES) has been serving the Inland Empire since 1949. It is part of the Redlands Unified School District and serves students in Grades K-5 who live in San Bernardino, Redlands, and Loma Linda. VES is centered in a low socioeconomic community. VES is has train tracks that run through it and found to lack sidewalks on streets that border the school.

A strategic plan was developed for the school year with the following objectives and strategies:

Objectives

1. Increase access to health care.
2. Increase knowledge around nutrition and physical activity.
3. Increase access to mental health s services.

Strategies Accomplished in 2014

1. Garden launch at school. Successful crops. Vegetables have been incorporated into the students lunch.
2. BodyWorks nutrition class led by 4 master of occupation physical therapy students to 25 5th grade students.
3. Green Apple Day of Service Health and Wellness
4. Nutrition Education for Staff
5. Massage therapy for teachers and staff on a monthly basis.
6. Healthy lunches and health promoting gear for teachers on teacher appreciation day.
7. Behavioral health education for teachers and counselors. (In Progress)
8. Referral sources for behavioral health issues for students and parents. (In Progress)
9. After school nutrition program with a garden component. (In progress)

Breastfeeding Friendly Communities

Identified Community Need: Poor 6-month breastfeeding rates and high rates of childhood obesity.

San Bernardino County ranks low on exclusive breastfeeding and breastfeeding duration at 1, 3 and 6 months, according to the 2012 Maternal and Infant Health Assessment (MIHA) survey, when compared to the other California counties.

LLUMC partnered with First 5 San Bernardino to develop a countywide strategy to support mothers who choose to breastfeed. First 5 San Bernardino will be funding the breastfeeding grant BONUS, Babies Optimal Nutrition w/Ultimate Support. This is a three and ½ year grant.

The fundamentals of the grant are:

- Development of close associations with current Baby-Friendly hospitals and Baby-Friendly hospitals that are working on their re-certification.
- International Board Certified Lactation Consultants who will be available via 211 (24/7) to triage, answer questions and refer to existing breastfeeding clinics.
- Follow-up with mothers who have called 211 for assistance.
- Development of a Pregnancy/Breastfeeding booklet has been developed and a pilot study has already taken place.

- Grant employees will develop relationships with Obstetricians and Pediatricians offices. They will work with the Obstetricians and Pediatricians and their staff to explain the booklet, which travels through all the phases of gestation, delivery, breastfeeding and post-partum concerns (including post-partum depression).

The grant is expected to be funded to the County of San Bernardino in July of 2015 for an initial 3-year cycle, each year funding will be $500,000.00. 2015 will bring the pilot study of the BONUS grant, it is slated to begin July 2015.

In addition, San Bernardino County Department of Public Health has developed a Workplace Lactation Accommodation Policy, that is soon to be instituted within the Department of Public Health, based on the City of Rancho Cucamonga's Lactation Accommodation policy and city resolution. LLUMC provided the expertise to develop this countywide strategy and will work in collaboration with the San Bernardino County Department of Public Health.

Objectives

1. Increase the number of cities that have adopted lactation accommodation policies.
2. Improve exclusive breastfeeding rates for infants at 6 months.

Cancer

Identified Community Need: High rates of breast and prostate cancer in the Inland Region.

The Loma Linda University Cancer Center (LLUCC) was established in 1991 with the purpose of leading and coordinating cancer-related activities and services. LLUCC is responsible for the

development and coordination of institution-wide, multi-specialty approaches for cancer patients, including early detection, optimal treatment and total care, clinical research, and basic science research. Navigators are available to guide patients through the healthcare system while providing education, support, and advocacy, but the ultimate goal is to provide the necessary support to enable our patients to find strength, which can lead to healing. In **2014, 19,149** cancer patients were served. This number also represents the patients Loma Linda University Medical Center – Murrieta provided services to.

Objectives

1. Increase the proportion of persons who were counseled about cancer screening consistent with current guidelines.
2. Increase the proportion of women who receive a breast cancer screening based on the most recent guidelines.
3. Increase the proportion of men who have discussed with their health care provider whether or not to have prostate-specific antigen (PSA) test to screen for prostate cancer.

Charity Medications

Identified Community Need: Lack of access to necessary medications for patients who are un and underinsured.

Charity Medications assists patients who are: Medi-Cal pending, Medically Indigent Adults (MIA), Medi-Care without prescription coverage, and uninsured patients. This intervention benefits patients and helps reduce re-admissions due to lack of continuity of care or possible admissions. In 2014**, 496** community members in need were helped.

Objective

1. Increase the proportion of our community who have access to social support services.

Community Health Workers

Identified Community Need: High rates of diabetes in the Inland Region

Loma Linda University Health is an institution centered on wholeness. Our heritage is wholeness. Our belief is wholeness. Our motto is wholeness. In our over century-long journey of wholeness, we have already discovered many important things. We have discovered that wholeness is not found in lifestyles, in labels, or in limits. It does not reside in reduction, retraction, or retrenchment. It does not exist is silos or cynicism. It is not a goal to be achieved or a finish line to be crossed. Wholeness is not perfection. It is not a thing at all. It is a Way. And that Way is made through The Science of Connection and the 7 Principles of that science:

1. The Principle Of Willing Acceptance
2. The Principle Of Life Aspiration
3. The Principle Of Personal Contribution
4. The Principle Of Beginner's Curiosity
5. The Principle Of Immersive Experience
6. The Principle Of Divine Cooperation
7. The Principle Of Peaceful Community

To improve the health outcomes of our community, it is imperative to understand its current health status and associated behaviors to create targeted interventions and integration and continuity of care if we wish to improve the health status of our diabetes population. There is evidence that utilizing community health workers to educate communities is one the most cost-effective means of producing behavior modification, partly due to their knowledge of cultural nuances and potential connectedness with the participants.

According to the CDC, diabetes is currently the seventh leading cause of death in the U.S. and affects 8.3% or 25.8 million Americans. In 2010, 26.9% of the U.S. population aged 65 years or

older was reported to have diabetes. In Riverside nearly 8.5% of the population has diabetes, the majority of which are Hispanic/Latinos. Diabetes rates are typically higher among ethnic minority populations in the U.S. For example, compared to non-Hispanic Whites, risk of diabetes diagnosis has been reported to be 77% higher for non-Hispanic Blacks, 66% higher for Hispanics, and 18% higher for Asian Americans. Cumulatively, such rates have burdened the U.S. healthcare system with $116 in direct medical costs and another $58 billion in indirect costs. Thus, prevention and self-management efforts are needed.

Diabetes complications include increased risk of heart disease, stroke, diabetic retinopathy, kidney failure, and heightened risk of premature death. Current empirical evidence suggests that type 2 diabetes is predominantly associated with excessive body weight and lack of physical activity. As a result, primary preventive strategies include behavioral and lifestyle changes including maintaining a healthy weight, being physically active for at least 30 minutes, adhering to a healthy diet, and lack of tobacco use. Social support has been shown to increase behavior that helps maintain weight loss. Online social support has been correlated with less consumption of sugary drinks, more fiber consumption and more physical activity and social connectedness in general was associated with health behavior that helps to delay or prevent type II diabetics. The Community Guide has recognized diabetes disease management as a best practice. Disease Management is an organized, proactive, multicomponent approach to healthcare delivery for people with a specific disease, such as diabetes. Care is focused on and integrated across the spectrum of the disease and its complications, the prevention of comorbid conditions, and the relevant aspects of the delivery system.

As a result, Loma Linda University Health has developed a “wholeness way” to care for our diabetes population through intentional deployment development teams using The Science of Connection Experience. This is a process by which we will fully engage our diabetic community with wholeness as a way. Improving Experience in the pursuit of Wholeness is vital to the fulfillment of our mission and continuation of our legacy. This intervention was developed in 2014 and will be fully implemented in 2015.

Objectives

1. Connect community health (CHWs) workers to health care systems
2. Integrate CHWs to care team
3. Connect patients to community resources
4. Develop a continuum of care delivery model for diabetic patients.
5. Pilot a community-based chronic care management model utilizing community health workers for diabetic patients in Waterman Gardens

Diabetes Education

Identified Community Need: High rates of diabetes and a lack of access to chronic care management for diabetic patients.

The Diabetes Treatment Center (DTC) is recognized by the American Diabetes Association for providing up-to-date and accurate patient self-management education to persons with diabetes. The community benefit provided by the DTC is accomplished through blood glucose screenings, diabetes education and awareness at venues such as health conferences, universities, seminars, and wellness fairs. Last year, **246** community members were served. These interventions were not a part of the traditional services for our patients but as a community outreach in response to the high prevalence of diabetes in the Inland Empire.

Objectives

1. Reduce the annual number of new cases of diagnosed diabetes in the Inland Empire.
2. Increase prevention behaviors in persons at high risk for diabetes with pre-diabetes.
3. Increase the proportion of persons with diagnosed diabetes who receive formal diabetes education.
4. Pilot a community-based chronic care management model utilizing an RN trained in Diabetes care through the Diabetes Treatment Center at Murrieta Medical Center

Family Health Fair

Identified Community Need: Increase awareness health awareness in families and provide onsite screenings.

Going on its 37th year, the Family Health Fair is an annual event that invites the community to come learn more about their health and to "Live it" through health screenings, flu shots, blood screenings, and informational booths. For the second year the event includes a 5K run/walk designed for everyone from casual walkers to elite runners. Each participant receives an event T-shirt and is eligible to win a race medal. After the 5K, the excitement continues with exhibits, opportunity drawings, delicious food, live entertainment, and all-around family fun. Last year **3,606** community members attended the event.

Objectives

1. Increase awareness around health and wellbeing to families.
2. Increase access to health services.

Heart Health Education

Identified Community Need: High rates of cardiac morbidity and mortality. Cardiac disease is the leading cause of death in the Inland Empire.

Loma Linda International Heart Institute opened in 1987, and serves as the cardiac service line for LLUMC. Cardiologists, cardiothoracic surgeons, nurses, and other clinicians are committed to work as an integrated specialty team to provide compassionate patient-centered care. The Heart Institute offers full cardiac services from diagnostic procedures such as echocardiograms

and cardiac stress tests to cardiac surgery and transplantation. The community outreach component of the Heart Institute includes heart health prevention, education, awareness, and screening at multiple venues in the community. Support groups are also available for cardiac patients and their families. The interventions offered for our heart health education range from the involvement of our local communities to improve access to nutritious foods and safe open space for physical activity to helping to manage cardiac patients after they leave the hospital. Our specific focus is on the uninsured patients that do not have access to support services. The goal of the community outreach is to educate the community to reduce the risk of heart disease mortality in the region. In **2014, 23,722** hearts were touched without individual programs but entire regions were served with improvement to the built environment. This number also includes Loma Linda University Medical Center – Murrieta community.

Objectives

1. Increase the proportion of adults aged 20 years and older who are aware of the symptoms of and how to respond to a stroke.
2. Increase the proportion of adults aged 20 years and older who are aware of the early warning symptoms and signs of a heart attack.

Just for Seniors

Identified Community Need: Growing senior population without access to health services.

Older adults are one of the fastest growing age groups with the baby boomers entering Medicare at a rapid rate. The focus of Just for Seniors is to improve the health, function, and quality of life for older adults. Just for Seniors is a free community service program available to anyone over 55 years of age. The program began in 1990 and has a membership of over **45,000** seniors, and

continues to grow. 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. 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. LLUMCEC recognizes that seniors need a safe and positive environment to engage in and connecting them to a group is beneficial for the mind, body, and spirit.

Objectives

1. Increase the proportion of older adults who are up to date on a core set of clinical preventive services.
2. Increase the proportion of older adults with reduced physical or cognitive function who engage in light, moderate, or vigorous leisure-time physical activities

Non-Emergency Medical Transportation

Identified Community Need: Lack of non-emergency medical transportation for uninsured residents.

In 2007, the Case Management department started a charity non-emergency medical transportation service. This service provides gurney or wheelchair transport to patients who need to be transferred home or to a skilled nursing facility. Most of the patents do not qualify for ambulance transport, have no income to pay for transport, or have family members that can assist them. This service is provided on a case-by case basis, need is determined by case managers. In **2014, 740** patients were provided medical transportation services.

Objectives

1. Increase the proportion of persons who have access to non-emergency medical transportation services.
2. Increase the proportion of persons who have a specific source of ongoing care.

PossAbilities

Identified Community 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. 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. LLUMCEC 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, socials, educational and spiritual interaction with peers and their community. This free membership program is tailored to persons with physical disabilities such as limb amputations, stoke, 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.

Objectives

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

Speaking of Women's Health

Identified Community Need: High rates of heart disease, diabetes, and cancer in women in the Inland Empire.

Speaking of Women's Health is an interactive health education experience, hosted by LLUMC that provides attendees awareness and education around health, well-being and personal safety. Although obesity is still an issue, the overall results look a little better than the 2012 results. In 2014, 1, 200 woman attended the event. And participated in complete health risk assessment with biometric screenings to include a Personal Health Report (a 10 page customized summary with recommendations) were in attendance and enjoyed the following screenings:

- Ask a Doctor booth
- Blood Pressure screening
- Body Fat assessment screening
  Bone Density screening
- Dry Mouth Treatment options and Dental Hygiene advice
- Glucose screening
- Macular Degeneration screening
- Mental Health screening
- Vision screening
- Stress Management assessment
- Waist to Hip Screening

Objectives

1. Increase the percentage of women who know their BMI, blood pressure, and cholesterol levels.
2. Identify women at risk of heart disease and connect them to health education and medical services.
3. Increase the percentage of women taking action to improve their BMI, blood pressure and cholesterol levels.

Evaluation Indicators for 2104

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 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, 10-year national objectives for improving the health of all Americans.

For 3 decades, Healthy People 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 County Health 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. The *Rankings* look at a variety of measures that affect health such as the rate of people dying before age 75, high school graduation rates, unemployment, limited access to healthy foods, air and water quality, income, and rates of smoking, obesity and teen births.

Based on data available for each county, the Rankings are unique in their ability to measure the overall health of each county in all 50 states on the many factors that influence health, and they have been used to garner support among government agencies, healthcare providers, community organizations, business leaders, policymakers, and the public for local health improvement initiatives. 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-informed 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 County Health 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 2014 rankings. We are actively working with the County of Riverside to achieve similar results. Knowing that overall health of a community cannot be achieved along, LLUH is working actively with the counties to identify collective impact measurements that can be used to align interventions with other sectors such as education, transportation, the business community, and pubic safety.

The table below reflects the changes per year for health outcomes and health factors for San Bernardino and Riverside County.

2010 2015 County Health Rankings

	San Bernardino						Riverside					
	2010	2011	2012	2013	2014	2015	2010	2011	2012	2013	2014	2015
Health Outcomes	45	44	41	44	40	37	27	29	32	27	26	24
Mortality	37	35	36	32	32	30	30	27	28	25	25	23
Morbidity	48	49	46	51	48	50	32	34	36	41	38	38
Health Factors	50	56	46	46	45	47	40	42	42	36	38	39
Health Behaviors	48	48	45	46	44	44	36	33	39	33	34	32
Clinical Care	54	56	50	52	50	52	50	54	43	46	48	48
Social & Economic Factors	37	40	39	39	39	36	31	29	29	31	31	29
Physical Environment	54	55	55	46	53	53	62	54	54	41	48	49

Source: CountyHealthRankings.org

Loma Linda University Medical Center has identified specific indicators and metrics to use to evaluate whether the interventions have been successful. Indicators align with the system's goals along with Healthy People 2020.

Community Benefit and Economic Value

For over a century, Loma Linda University Health System 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 2014, Loma Linda University Children's Hospital obtained a separate license making them the newest addition to our system.

Valuation of Community Benefit

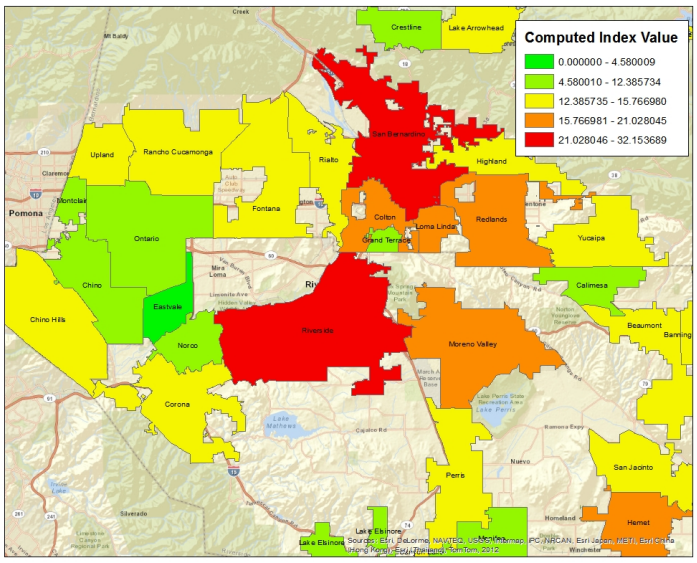
Year 2014–SB697 Valuation – Cost-Based

Loma Linda University Medical Center	
Charity Care	$13,966,035
Medi-Cal and Other Means Tested Government Programs	$183,986,128
Community Health Development	$4,904,963
Health Professional Education	$50,609,902
Subsidize Health Services	$1,192,402
Research	$3,517,103
Total Community Benefit Economic Value	**$258,176,533**

LLUMC – 2015 Priority Update

Creating a Healthier Community in 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? and, 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 of Highest Need

- San Bernardino City
- Highland
- Riverside
- Colton

Identified Community Needs

- Lack of affordable 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;
- Growing Hispanic population and increase in the elderly population; and
- Disproportionate share of children living in poverty and homelessness

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 ULCA 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.

Loma Linda University Health 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 for 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 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

Whole Cancer Care

Identified Need

Lower than average breast cancer risk although 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.

Goal

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

Whole Cancer Care

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:

- Income
- Education level
- Occupation
- Social status in the community
- 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

1. Increase the proportion of women who receive cervical cancer screening.
2. Increase the proportion of men who receive colorectal cancer screening.
3. 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. Community education and awareness campaign targeting prostate cancer and African American males.
3. Nutrition classes for cancer patients.
4. Wig bank for cancer patients.
5. Look Good Feel Good – Makeovers for patients experiencing chemotherapy
6. 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 & mortality related to cancer.

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.

Chronic Disease Management

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 management is a broad term that encompasses many different models for improving care for people with chronic disease. Elements of a structured chronic disease management 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 to displace 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 Leads 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 3 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. Flu vaccinations at health fairs and in the community.

Evaluation Indicators

Short Term – Decreased 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. Healthy People 2020 Objectives

Health Care Pipelines

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 healthcare occupations and ultimately to care for the residents of the Inland Empire.

Health Care Pipelines

Loma Linda University Health is working in collaboration with the community to prepare a health care workforce for the 21st century. Investing in our future healthcare 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 - Healthcare exposure and unique connected summer experiences to foster interest and understand pathway to careers in health delivery systems.
2. Inland Coalition for HealthCare Pathways - Regional coalition development and networking, in 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 pediatricians visit and creating a partnership is preschool and school districts for collaboration and support.

6. Participation in Policy Development for Healthcare Workforce at the state and local level.

7. Strategic Planning for Healthcare 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. Jr. 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 - Improved high school graduation rates. Third grade literacy scores to increase. Tracking of the health care career numbers.

Whole Sickle Cell Anemia Care

Identified Need

High readmission rates for Sickle Cell Anemia patients.

Increased 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.

Increased 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.

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 efforts to improve the health outcomes of this group require a focused multidisciplinary effort and healthcare partnerships connecting community resources, providers, and patients.

Thru this focused multidisciplinary effort we will educate Medical 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. We desire 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. 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 Patient and those

surrounding them that are affected by this illness will be the passion of our work**.**

SCD management aligns with a long history of "mission" at Loma Linda Health 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. This is the passion of our work!

Objectives

1. Decrease ED and urgent care utilization rates for adult sickle cell anemia patients.
2. Improve patient satisfaction scores for sickle cell anemia patients.
3. Increased number of healthcare providers educated on sickle cell anemia patients.

Interventions

1. Annual Sickle Cell Symposium.
2. Implementation of a mobile plan of care for sickle cell anemia patients.
3. Recommendations to the IE HIE on data sharing for sickle cell anemia patients throughout the region.
4. Sickle Cell Anemia provider education program.
5. Community education and awareness campaign for sickle cell anemia to include the faith community.
6. Disease management transition program between LLUH pediatrics hematology/oncology and adult sickle cell program.
7. Advocacy and feedback to Covered California on adequate insurance coverage for sickle cell anemia patients.
8. Representation from LLUH on the California Community Engagement Advisory Committee's for Sickle Cell Anemia care representing the Inland Empire.
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 –Increased attendance to adult sickle cell support group.
Improve patient satisfaction scores for sickle cell anemia served at LLUH.

Long Term – Reduced ED utilization for sickle cell anemia patients.

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

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 towards a collaborative healthy aging model for the region.

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. healthcare 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 elderly.

Interventions

1. 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.
2. 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.

3. Care Coordination for an Accountable Care Organization (ACO) with community partners.
4. Implement the American Heart Association "Get with the Guidelines" protocol at LLUH.
5. 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.
6. Whole Aging Conference – An innovative aging conference.
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.

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.

Goal

Improve the quality of life for individuals with disabilities.

Whole Rehabilitation Care

PossAbilities
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, socials, educational and spiritual interaction with peers and their community.

Objectives

1. Increase the proportion of people with disabilities who participate in social, spiritual, recreational, community and civic activities.

2. Increase the proportion of adults with disabilities who report sufficient social and emotional support.

Interventions

1. **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, stoke, 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.

Evaluation Indicators

Short Term – Increased number of sports related activities for the disabled population in the Inland Empire.

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

LOMA LINDA UNIVERSITY
HEALTH

Loma Linda University Medical Center Children's Hospital

2014 Community Health Inventory

2015 Community Health Plan

This Community Health Plan includes Loma Linda University Children's Hospital (LLUCH). It is licensed hospital under Loma Linda University Health System.

Loma Linda University Children's Hospital
Number of hospital beds: 348
Kerry Heinrich, JD, Chief Executive Officer/Administrator
11234 Anderson Street
Loma Linda, CA 92354
(909) 558-4000
** Obtained seprate license in 2014**

LLUCH Service Area

LLUCH'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, and Southwest Riverside County.

2014 Community Health Investments

Loma Linda University Children's Hospital - Detail

Breastfeeding Friendly Communities

Identified Community Need: Poor 6-month breastfeeding rates and high rates of childhood obesity.

San Bernardino County ranks low on exclusive breastfeeding and breastfeeding duration at 1, 3 and 6 months, according to the 2012 Maternal and Infant Health Assessment (MIHA) survey, when compared to the other California counties.

LLUMC partnered with First 5 San Bernardino to develop a countywide strategy to support mothers who choose to breastfeed. First 5 San Bernardino will be funding the breastfeeding grant BONUS, Babies Optimal Nutrition w/Ultimate Support. This is a three and ½ year grant.

The fundamentals of the grant are:

- Development of close associations with current Baby-Friendly hospitals and Baby-Friendly hospitals that are working on their re-certification.
- International Board Certified Lactation Consultants who will be available via 211 (24/7) to triage, answer questions and refer to existing breastfeeding clinics.
- Follow-up with mothers who have called 211 for assistance.
- Development of a Pregnancy/Breastfeeding booklet has been developed and a pilot study has already taken place.
- Grant employees will develop relationships with Obstetricians and Pediatricians offices. They will work with the Obstetricians and Pediatricians and their staff to explain the booklet, which travels through all the phases of gestation, delivery, breastfeeding and post-partum concerns (including post-partum depression).

The grant is expected to be funded to the County of San Bernardino in July of 2015 for an initial 3-year cycle, each year funding will be $500,000.00. 2015 will bring the pilot study of the BONUS grant, it is slated to begin July 2015.

In addition, San Bernardino County Department of Public Health has developed a Workplace Lactation Accommodation Policy, that is soon to be instituted within the Department of Public Health, based on the City of Rancho Cucamonga's Lactation Accommodation policy and city resolution. LLUMC provided the expertise to develop this countywide strategy and will work in collaboration with the San Bernardino County Department of Public Health.

Objectives

1. Increase the number of cities that have adopted lactation accommodation policies.
2. Improve exclusive breastfeeding rates for infants at 6 months.

Breastfeeding Consultation

Identified Community Need: Childhood obesity and low breastfeeding rates for infants.

The Maternal-Fetal department at LLUMC believes that to provide optimal nutrition for children breastfeeding is the superior choice for nutrition. Many new mothers lack support for breastfeeding once they leave the hospital after delivery. The breastfeeding support program provides one-on-one breastfeeding consultation to all breastfeeding mothers in the community. This is a free service to our community and provides critical lactation support for mothers who are having difficulty breastfeeding. This is an important intervention to our community and the first step in our health system's efforts to reduce childhood obesity. In **2014,** mothers were provided breastfeeding support.

Objectives

1. Increase the proportion of infants who are breastfed. Until 6 months of age.

Camp Good Grief (CGG)

Identified Community Need: Poor emotional and grief support for children who have experienced a loss due to a tragic illness or accident

Camp Good Grief began in 1996. It is a two-day camp experience for children and teens (ages 10-16) who have had a family member die due to illness or accident. Camp Good Grief has been designed to help children: 1) build a network of peers, 2) develop new coping skills, and, 3) decrease negative symptoms of grief. Through the use of therapeutic groups and activities, CGG staff is able to create a supportive environment where children share their pain and learn positive coping skills. Sessions and staff are trained to be sensitive to the cultural, religious differences of the campers. In **2014, 24** campers participated in the sessions. The camp took place November 7-9, 2014.

Objectives

1. Increase the proportion of adolescents who have an adult in their lives with whom they can talk about serious problems.
2. Decrease school absenteeism among adolescents due to illness or injury.
3. Reduce the proportion of persons who experience major depressive episodes.

Camp Good Grief-Special Victims Program (CGG SVP)

The purpose of Camp Good Grief-SVP was for boys and girls who have experienced a violent death in their family such as a murder or vehicular manslaughter to meet children their own ages that are also learning about and understanding their grief. By meeting other children who have

had similar ordeals they discover that they can share the same feelings and that those feelings are normal and acceptable. Their pain is understood and accepted. In addition to grief counseling the children were also given the opportunity to run, play, laugh and challenge themselves-to really have a great camp adventure. A total of **26** boys and girls attended the camp in 2014.

Objectives

1. Increase the proportion of adolescents who have an adult in their lives with whom they can talk about serious problems.
2. Decrease school absenteeism among adolescents due to illness or injury.
3. Reduce the proportion of persons who experience major depressive episodes.

Camp Good Grief – Teen Retreat

Camp Good Grief- Teen Retreat has been created for teens ages 14-18 who have attended Camp Good Grief or Camp Good Grief-SVP. It is for the purpose of coming together to strengthen

friendship with camp good grief peers; experience the adventure of a high ropes course and kayaking; and to reinforce constructive coping skills. A total of **14** teen campers returned in 2014. The camp was held September 19-21, 2014.

Objectives

1. Increase the proportion of adolescents who have an adult in their lives with whom they can talk about serious problems.
2. Decrease school absenteeism among adolescents due to illness or injury.
3. Reduce the proportion of persons who experience major depressive episodes.

Children's Day

Identified Community Need: Poor health outcomes for children in the Inland Empire.

Children's Day is an annual health education fair for young children and parents coordinated by the Child Life Department at Loma Linda University Children's Hospital. Each year, LLUMC, LLUCH, LLUEC, LLUBC, Loma Linda University, and community partners come and participate at the event. The purpose of Children's Day is to provide a non-threatening exposure to a medical setting for children ages 2-8 in our community. In **2014, 956** adults and children attended the health education event.

Objectives

1. Increase awareness around health and wellbeing to families.
2. Increase access to health services.

Inland Empire Childhood Obesity Task Force

Identified Community Need: High rates of childhood obesity and a lack of best practice interventions for reducing childhood obesity in the Inland Empire.

Loma Linda University Health System is taking a proactive approach to be part of the solution and decrease obesity rates in the Inland Empire. In 2010, an obesity task force had its beginnings while working on a grant proposal. The task force is comprised of school representatives, community organizations, and San Bernardino and Riverside county representatives. The task force is committed to improving the health of all children living in the Inland Empire through education, collaboration, and policy that promotes overall health. In 2013, the task force developed criteria for breastfeeding-friendly cities and incorporate into the Healthy Cities initiative and launch a partnership with school districts to promote physical activity.

Objectives

1. Reduce the proportion of children and adolescents who are considered obese.
2. Develop breastfeeding promotion as an obesity prevention intervention.
3. Increase partnerships in the Inland Empire to strategically decrease childhood obesity.
4. Train healthcare providers on best practices for reducing childhood obesity.
5. Increase physical activity in families and schools through awareness and best practices.

OK KIDS (Outreach to "Kommunity Kids")

Identified Community Need: High rates of childhood obesity and poor physical fitness in children.

OK Kids is a pediatric outreach to the identified needs of the children in our community, with the goal of increasing awareness and healthy living. This program integrates health topics for 2,467 children and families of preschools, elementary schools, middle and high schools. In addition, a summer program provides a "bridge summer program" for education and peer interaction that teaches healthy choices of nutrition and active living.

Throughout the year, weekly safety seminars with hands on activities are taught to 167 second graders addressing drowning prevention and pool safety, poisoning and prescription drug use, gun safety, slip and fall issues, burn prevention and fire safety, and airway safety. Parent information sheets accompanied the classroom learning lessons for additional home environmental modifications for family safety.

Health4Life is a comprehensive health education program is given over eight weeks to 360 middle school students emphasizing personal health and nutrition, exercise, sleep, and bullying.

Parent information sheets carry the message and information to the families. In addition, five weeks of day camp, Operation Fit, are provided for 150 children of unhealthy weight during the summer. Children and their parents are exposed to healthy nutrition choices for snacks and meals. Family time is reinforced, meal planning and shopping is taught. Children visit a garden, harvest food, and prepare and healthy meal for their parents. The parent education component is the evidenced based program, BodyWorks, from the Office of Women's Health.

These activities occur for the youth in our Title I schools of San Bernardino County Unified School District. In **2014, 4,720** children participated in the various OK KIDS activities.

Objectives

1. Increase the proportion of elementary, middle, and senior high schools children around health education to prevent health problems in the following areas: unhealthy dietary patterns and inadequate physical activity.
2. Increase the proportion of children who meet current physical activity guidelines for aerobic physical activity and for muscle-strengthening activity.
3. Reduce the proportion of children who are have unhealthy weight being above >85%ile BMI.

Safe Kids Inland Empire Coalition

Identified Community Need: High rates of unintentional injuries and violence.

The Safe Kids Inland Empire Coalition was established in 1991 by the Trauma department as a result of the epidemic of accidental injury to children in Riverside and San Bernardino Counties.

The Safe Kids Coalition of the Inland Empire is based out of Loma Linda University Medical Center and Children's Hospital. The coalition brings together safety experts, educators, foundations, government officials, and volunteers to advocate for better laws to help keep children safe, healthy, and out of emergency room, encourage conduct research on leading injury risks, and evaluate solutions for injury risks. Areas of focus include:

- Water Safety/Drowning Prevention
- Child Passenger Safety/Hyperthermia/Keeping Kids Safe In and Around Cars
- Poisoning Prevention
- Fall Prevention
- Wheeled Sports Safety/Helmet Protection
- Fire Prevention/Safety
- Pedestrian Safety

In **2014, 6,155** children and parents were educated and brought awareness around safety issues.

Objectives

1. Reduce unintentional injury deaths.
2. Reduce nonfatal unintentional injuries.

Youth Alternative Services (YASP)

Identified Community Need: High substance abuse rates in San Bernardino and Riverside County.

The Youth Alternative Services program services approximately 20 teens, predominately Hispanic and Caucasian males between the ages of 14-18 years old from Riverside and San Bernardino counties. YASP is a month long program consisting of:

- Orientation: Orientation geared for parents/guardians and teens;
- Entrance Interview/Psychosocial Assessment: Staff members meet with meets with the students on individual bases. A systematic assessment tool is used to assess the appropriateness of a participant in the program and any referrals needed to help the client stay healthy.
- Workshops #1 and #2: Workshops are geared towards education of health issues related to drugs and alcohol, stress, problem solving, peer pressure and family issues. Games, art activities, guest speakers and films are used as teaching tools.
- Coroner's Visit: Each session is held at the San Bernardino County Coroner's Office;
- A slide presentation related to alcohol, drug and violence is given as well as a tour of the morgue. Career opportunities are shared with the students.
- Trauma Center Visit: Time is spent observing traumas in the emergency department and intensive care areas. Activities include impairment goggles and wheelchair exercises. The purpose of this session is to directly expose students to the effects of drugs and/or alcohol related injuries. Medical staff is involved with educating clients of the trauma situation and will share career opportunities in the field.
- 12-step meeting: Students attend one Narcotics/Alcoholics Anonymous meeting. This session exposes them to the addiction process and the impact of families.
- Exit Interview: Certificates of completion are given and the student writes a 500-word essay evaluating and sharing their experience while enrolled in YASP.

Additional interventions that YASP participates include the following:

Activity	Description
Alcohol Presentation	Presentations are geared toward youth and the effects alcohol has on their developing brain. It is an interactive presentation with ample opportunities to ask questions. The presentation covers the reaction a youth's body has from one beer all up to six beers within the course of several hours.

Committee Meeting	Drug Free Rancho Cucamonga is a collaborative effort working with schools, parents and youth organizations, elected officials, law enforcement agencies, businesses, chamber of commerce, civic groups and faith based organizations who are dedicated to creating a healthy community. The goal is prevent and reduce the use of alcohol, tobacco, and other drugs by the youth in Rancho Cucamonga.
Faith and Justice Summit	Utilizing a holistic approach to crime prevention, the Redlands Police Department has partnered with religious leaders to create the Cops & Clergy Conference. The organization is working to create a safe environment for the youth through character development programs and an emphasis on marriage, family, healthy choices and living a healthy lifestyle.
Governor's Youth Conference	The Governor's Drug-Free Youth Conference (GDFY) was established in 1989 by an Act of the General Assembly in an effort to accelerate Arkansas' fight against substance abuse. The Commission works in a collaborative capacity representing a majority of Arkansas' counties. Each year, GDFY conference is charged with implementing comprehensive community plans, which address substance abuse challenges through treatment, prevention and enforcement. The Commission lends leadership and expertise in the development of these comprehensive strategies to ensure that resources needed to treat substance abuse are effectively targeted. The YASP coordinator coordinates the youth portion of the event. Students are trained to train other students. Gang and Drugs Task Force The San Bernardino Countywide
Gang and Drugs Task Force	The San Bernardino Countywide Gangs and Drugs Task Force is committed to a leadership role in advocating the prevention and suppression of gang membership and drug use throughout San Bernardino County through coordination, collaboration, and communication between education, law enforcement, the criminal justice system, elected officials, private enterprise, and community at-large.
Marijuana Presentation	Youth participants are presented with information regarding marijuana with the following learning objectives: 1) Participants gain understanding of how marijuana affects the brain. 2) Participants learn basic skills on how to present marijuana to various audiences. 3) Participants learn the four parts of the body affected by THC. 4) Participants receive information on how to appropriately communicate the dangers of smoking marijuana. 5) Participants will be able to identify the signs of a user. 6) Participants will be able to adequately answer the common pro-use questions individuals have concerning marijuana.
Probation training	Probation training includes is a combination of Alcohol and Marijuana training for youth.
Red Ribbon ATOD Presentation	Red Ribbon ATOD presentation is a combination of Alcohol and Marijuana training for all of high school students. Schools that received the training: Valley College, Norco High School El Cerrito Norco High School Ramirez, Auburndale , Santiago, Centennial High School , Lee Pollard, River Heights, Roosevelt High School, Corona High School,

	Orange Grove, and Citrus Hills.
SAP Summer Youth Conference	Student Assist Program (SAP) summer camp is a summer training to teachers, educators and administration in Palm Springs. Coordination for the ATOD portion of the event is the responsibility of the Youth Alternative Services director. Student Assistance Program is a school-based approach to providing focused services to students seeking support or needing interventions for academics, behavior, and attendance often due to deeper concerns relating to substance abuse, mental health, or social issues. SAP is a process - not a curriculum or treatment center - that connects programs and services within and across school and community systems to create a network of supports to help students. As a process, SAPs identify students in need of intervention, assess these students' specific needs, and provide them with support and referral to appropriate resources. The overarching goal of SAP is to remove barriers to education so that students may strive academically.

In total, the YASP program served **373** children.

Objectives

1. Decrease the incidence of substance abuse.
2. Provide adolescents with positive behavior choices.
3. Expose adolescents to realistic consequences of high-risk behavior.
4. Educate adolescents on the effects of drugs and alcohol.
5. Encourage them to think about future career choices and introduce them to the medical field.

2014 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 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, 10-year national objectives for improving the health of all Americans.

For 3 decades, Healthy People 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 County Health 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. The *Rankings* look at a variety of measures that affect health such as the rate of people dying before age 75, high school graduation rates, unemployment, limited access to healthy foods, air and water quality, income, and rates of smoking, obesity and teen births.

Based on data available for each county, the Rankings are unique in their ability to measure the overall health of each county in all 50 states on the many factors that influence health, and they have been used to garner support among government agencies, healthcare providers, community organizations, business leaders, policymakers, and the public for local health improvement initiatives. 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-informed 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 County Health 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 2014 rankings. We are actively working with the County of Riverside to achieve similar results. Knowing that overall health of a community cannot be achieved along, LLUH is working actively with the counties to identify collective impact measurements that can be used to align interventions with other sectors such as education, transportation, the business community, and pubic safety.

We are slowly making system changes and the health of our region is improving. Take a look at the most recent data!

The table below reflects the changes per year for health outcomes and health factors for San Bernardino and Riverside County.

2010 2015 County Health Rankings

	San Bernardino						Riverside					
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Health Outcomes	45	44	41	44	40	37	27	29	32	27	26	24
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Morbidity	48	49	46	51	48	50	32	34	36	41	38	38
Health Factors	50	56	46	46	45	47	40	42	42	36	38	39
Health Behaviors	48	48	45	46	44	44	36	33	39	33	34	32
Clinical Care	54	56	50	52	50	52	50	54	43	46	48	48
Social & Economic Factors	37	40	39	39	39	36	31	29	29	31	31	29
Physical Environment	54	55	55	46	53	53	62	54	54	41	48	49

Source: CountyHealthRankings.org

Loma Linda University Children's Hospital has identified specific indicators and metrics to use to evaluate whether the interventions have been successful. Indicators align with the system's goals along with Healthy People 2020.

Community Benefit and Economic Value

For over a century, Loma Linda University Health System 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 2014, Loma Linda University Children's Hospital obtained a separate license making them the newest addition to our system.

Valuation of Community Benefit

Year 2014 –SB697 Valuation – Cost-Based

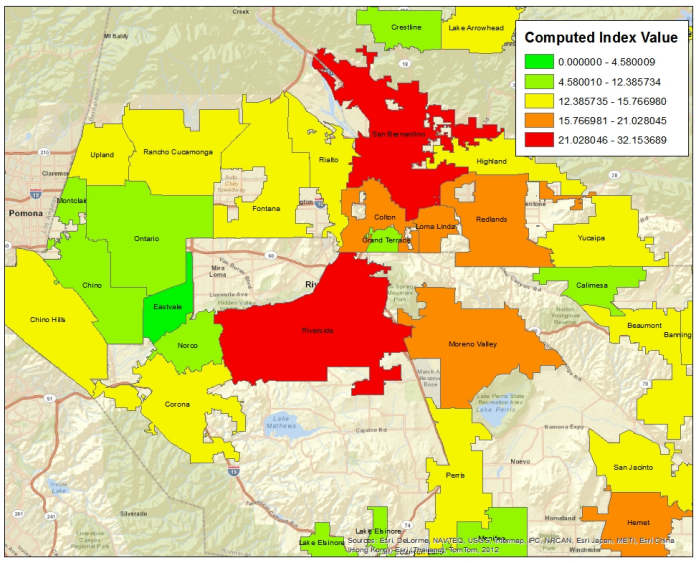
Loma Linda University Children's Hospital	
Charity Care	$183
Medi-Cal and Other Means Tested Government Programs	$4,467,732
Community Health Development	$88,045
Health Professional Education	$1,773,176
Subsidize Health Services	$0
Research	$0
Total Community Benefit Economic Value	**$6,329,136**

**** Loma Linda University Children's Hospital became independently licensed on November 16, 2014.****

LLUCH – 2015 Priority Update

Creating a Healthier Community in 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? and, 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 of Highest Need

- San Bernardino City
- Highland
- Riverside
- Colton

Identified Community Needs

- Lack of affordable 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;
- Growing Hispanic population and increase in the elderly population; and
- Disproportionate share of children living in poverty and homelessness

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 ULCA 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.

Loma Linda University Health 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 for 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 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

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

Improved health status for children living in Inland Empire.

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 compromise more than 39 percent of our population, 33 percent of our families live at poverty level, and 44 percent 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 percent.

Our mission at Loma Linda University Health 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.

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. In one clinic, 22% of two year olds are overweight or obese. With each year of life there is a 2% increase in children with unhealthy weight with nearly 50% of 15 year olds over. 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 disease 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 percent likelihood of being overweight as an adult.

Meeting the health needs of our children will require a symphony of care and coordinated

response from healthcare 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.

Loma Linda University Health recognizes that our children are our future. LLUH 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

1. 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.
2. OK Kids or Outreach to "K"ommunity Kids focuses the integration of young pediatricians in training into communities supportive services focusing on whole child, specifically addressing the issues of lifestyle living, childhood safety and teen pregnancy and parenting.
3. Safe Kids Program is the Loma Linda chapter of the national organization with focuses on safety education of children and parent to reduce the avoidable death statistics. In childhood, Accidents and unintentional injuries are ranked as the #1 cause of death in childhood.
4. Camp Good Grief – An intensive camp that provides emotional support and grief counseling for children who have suffered family losses
5. Operation Fit is a week long summer day camp at the university recreational center that gives children a hands on exposure to wellness through healthy choices of nutrition and physical activity.
6. BodyWorks, is a national program that provides health education with regards to physical activity, nutritional choices, and goal setting for well-being in teenagers and parents.
7. Lactation Consultations provide the one to one coaching for the new mothers seeking breast feeding skills to increase the health of their infants with regards to and an early obesity prevention
8. 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 the each city.

9. Adopt- A-School Model provides a saturation of efforts for success in domains of academics, nutrition, physical activity, and even a school garden.
10. 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.
11. Walk with the Doc Program is a national physical education connecting physicians with their community promoted through the multiple community efforts including the California Medical Association that address the sedentary lifestyle of communities.
12. Community Based Prevention Plus Clinics will provide the opportunity for community's and healthcare providers to create a rich educational forum for lifestyle transformation.
13. Inland Empire Children's Health Initiative is a regional coalition promoting health insurance coverage for children.
14. 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.
15. 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.

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 - Improved breastfeeding rates at 6 months. Reduce obesity in the community by creating awareness of healthy lifestyle choices. Improve family's ability to achieve wellness in their own neighborhoods and schools.

LOMA LINDA UNIVERSITY
HEALTH

Loma Linda University Behavioral Medicine Center

2014 Community Health Inventory

2015 Community Health Plan

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

Loma Linda University Behavioral Medicine Center
Number of hospital beds: 89
Lyndon Edwards, Administrator
1710 Barton Road
Redlands, CA 92373
(909) 558-9204

For questions regarding the Community Health Plan, please contact:

Jessica Berto, BMC Manager of Marketing & Community Relations
909-558-3463
jberto@llu.edu

LLUBMC Service Area

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, and Southwest Riverside County.

2014 Community Health Investments

Loma Linda University Behavioral Medicine Center - Detail

Behavioral Health Education and Awareness

Identified Community Need: Poor access to behavioral health services in the Inland Empire.

Behavioral Health Education and Awareness are aimed at professionals and non-professionals in the community such as clinicians, teachers, case managers, students, law enforcement 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. Topics include awareness around mental health and substance abuse for children, adolescents, and adults. In **2014, 3,936** community members were provided education regarding mental health issues and provided resources in venues such as educational forums, health fairs, or lectures.

Objectives

1. Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral.
2. Increase the proportion of professionals and non-professionals who are informed around behavioral health areas: addiction; alcohol or other drug use and inform of available resources.

Family Program

Identified Community need: Adolescents experiencing psychological/emotional challenges due to substance abuse.

The 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 their presence of their peers, and other patient families is a way to engage children in the healing process. The goal is achieved in two ways: 1. Children receiving treatment spend the first hour in a children's group and 2. In the second hour, children are joined by their families to share what they have learned. Children discover that someone is there to not only help their parents but also help them learn invaluable communication tools and coping skills. In **2014, 13** children and families were touched.

Objectives

1. Increase awareness on substance abuse to children of addicted parents and provide proper counseling.
2. Increase the proportion of adolescents who disapprove of substance and illicit drug abuse.

Senior Services – Behavioral Health

Identified community need: Increase in older adult's psychiatry anxiety and depression prevalence.

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 due to 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. Last year, **850** seniors were provided education, prevention, or awareness around mental health.

Objectives

1. Increase the proportion of older adults who are up to date on a core set of clinical preventive services.
2. Increase the proportion of older adults with mental health disorders who receive treatment.

***Staying with Sobriety* Newsletter**

Identified Community Need: High rates of behavioral health and chemical dependency.

In **2014, 5,120** people viewed the *Staying with Sobriety* quarterly newsletter. The newsletter 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.

Objectives

1. Increase the proportion of online health information seekers who report easily accessing health information.
2. Improve the health literacy of the population.
3. Increase the proportion of persons who can use electronic health management tools.
4. Increase the proportion of persons who report that their health care providers involved them in decisions about their health.

Substance Abuse Support Groups

Identified Community Need: Increased use of substance abuse.

In **2014, 27,150** community members participated in our substance abuse support groups.

Support groups include:

Support Group	Description
Alcoholics Anonymous	Alcoholics Anonymous is a support group for men and women recovering from alcoholism. Members share their experience, strength, and hope with each other. The goal is to stay sober and help others achieve and maintain sobriety. Family members are encouraged to participate in the healing process.
Pain Pills Anonymous	Pain Pills Anonymous is a support group open to men and women to discuss and deal with conflicting emotions experienced during recovery. Meetings provide an opportunity for group members to share experiences with others.

Objectives

1. Increase the proportion of health care providers that provide support to live a substance-free life.
2. Increase the proportion of health care providers that provide ongoing substance abuse support groups.
3. Increase the proportion of individuals who disapprove of substance abuse

2014 Evaluation Indicators

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Valuation of Community Benefit

Year 2014 –SB697 Valuation – Cost-Based

Loma Linda University Behavioral Medicine Center	
Charity Care	$455,453
Medi-Cal and Other Means Tested Government Programs	$2,655,780
Community Health Development	$63,035
Health Professional Education	$0
Subsidize Health Services	$0
Research	$0
Total Community Benefit Economic Value	**$ 3,174,268**

LLUBMC – 2015 Priority Update

Creating a Healthier Community in 2015

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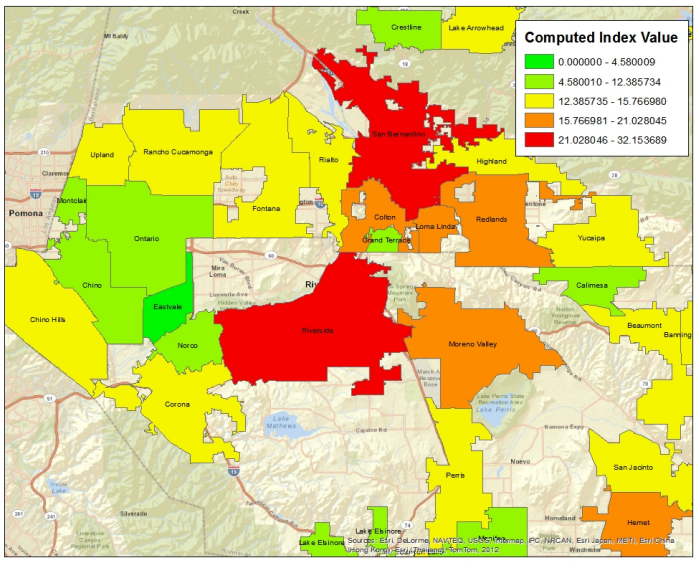

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- Lack of qualified health care workers to meet emerging community needs;
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- Detailed forecasts of the hospitals catchment area through the year 2030, including rates and prevalence of chronic conditions, behaviors, mortality, and population projections.
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This tool will be used to support a forward thinking decision support tool to assess 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

Whole Behavioral Health Care

Identified Need:

Inappropriate utilization of Emergency Departments for 5150's 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.

Behavioral Health Care:

Behavioral health includes both mental health and substance use disorders and is a state of successful performance of mental function, resulting in productive activities, 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 disorders 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 people's ability to maintain good physical health. Behavioral illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors**.**

Loma Linda University Health (LLUH), as a faith-based healthcare leader, is building partnerships with interfaith communities to change the health status in our region. Participation in a community of faith significantly improves the likelihood for congregation members of becoming healthy, and staying healthy. LLUH is helping faith communities to redefine themselves as 'health centers,' where the whole person is treated: emotionally, spiritually, relationally, and physically.

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.

Loma Linda University Health 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 our faith-based organizations (FBOs). At the intersection of faith and health are communities who value healing the whole person. Loma Linda University Medical

Center and the Behavioral Medicine Center are teaming up with the, 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 are 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 resource clergy and faith leaders in a more effective outreach to their own members.

Objectives

1. Increase the proportion of primary care facilities that provide behavioral health treatment onsite 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

1. Create a behavioral health task force.

2. The development of specialized resources and identification of best practices for the promotion, prevention, and critical interventions as those can be delivered by those in direct ministry.

3. The development of 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.

4. The development of 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.

5. The Implementation of the "Moses Principle Intervention". Even Moses needed that someone 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.

6. The implementation of 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.

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

8. Provide information and referral services for Veterans experiencing PTSD through faith communities.

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

10. 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.

11. Chemical Dependency's 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 their presence of their peers, and other patient families is a way to engage children in the healing process.

12. Behavioral Health Screenings geared towards 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.

13. 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 due to 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.

14. SHIELD Behavioral Health Trainings- Trainings are often geared towards community members, law enforcement, medical providers, teachers, or faith based leaders, who work with adolescents in some scope. The clinical therapist equip 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.

15. *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.

16. Substance Abuse Support Groups

    a. Alcoholics Anonymous
    b. Narcotics Anonymous
    c. Pain Pills Anonymous

17. Master Each New Direction (MEND) is an outpatient program developed for children with severe chronic illness to live into adulthood. MEND helps them learn tools to deal with or avoid stress. In MEND kids understand and accept the unique challenges of living with 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.

LOMA LINDA UNIVERSITY
HEALTH

Loma Linda University Medical Center – Murrieta

2014 Community Health Inventory

2015 Community Health Plan

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

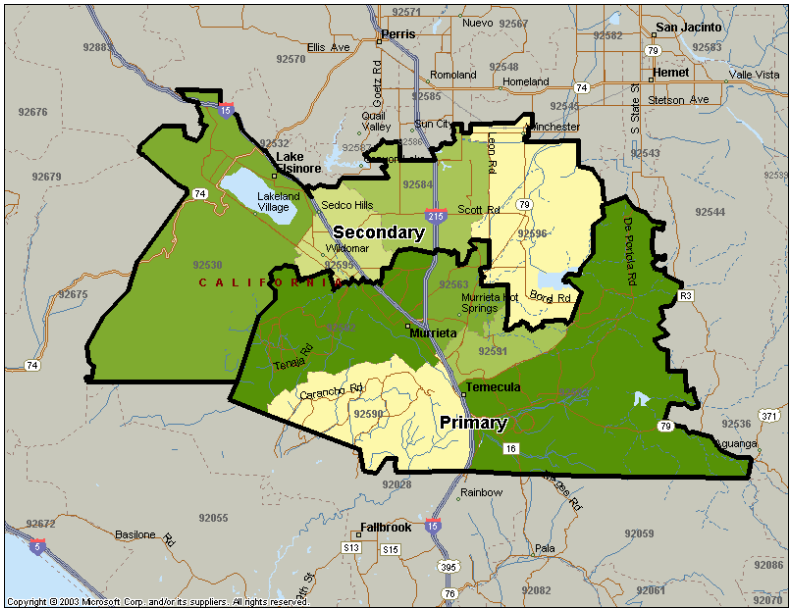
Loma Linda University Medical Center - Murrieta
Number of hospital beds: 106
Rick Rawson, CEO
28062 Baxter Road
Murrieta, CA 92563
(951) 290-4000

For questions regarding the Community Health Plan, please contact:

Kathryn Stiles
kstiles@llu.edu

LLUMC-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.



2014 Community Health Investments

Loma Linda University Medical Center – Murrieta - Detail

Boy Scouts of America

Identified Community Need: Poor physical fitness levels for the youth in LLUMC- Murrieta's service area.

The Boy Scouts of America is one of the nation's largest and most prominent values-based youth development organizations. The BSA provides a program for young people that builds character, trains them in the responsibilities of participating citizenship, and develops personal fitness. A total of **124** people walked through our doors.

Objectives

1. Increased physical fitness levels of children participating in the BSA program.

Breastfeeding Education

Identified Community Need: Childhood obesity and low breastfeeding rates for infants.

The breastfeeding 101 course covers the basic learning topics which include: benefits of breastfeeding, breastfeeding positioning techniques, proper latch techniques, feeding cues, the breastfeeding crawl, and proper nutrition while nursing, pumping and storing breast milk. In 2014, **46** mothers participated in the education.

Objectives

1. Increase the proportion of infants who are breastfed.

Childbirth Education

Identified Community Need: Mother support during pregnancy.

This interactive series will use games, videos & more to both prepare you for the birth of your baby and to help you feel more confident as you approach your upcoming birth. Topics include: Pain coping practices, Pregnancy & nutrition, Confidence & birth satisfaction, Role of pain, Informed decision making, Stages of labor & what to expect, Lamaze's Healthy Birth Practices, Comfort measures & positions, Common interventions & meds, Basic newborn & postpartum care, Breastfeeding, and more. LLUMC-Murrieta served **138** mothers in 2014.

Objectives

1. To prepare women and their partners for pregnancy, labor and childbirth
2. Increase the proportion of pregnant women who attend a series of prepared childbirth classes.
3. Increase the proportion of infants who are breastfed.

CPR Community Awareness

Identified Community Need: Heart disease as a leading cause of death.

During National CPR Day Loma Linda University and AMR partnered to provide education and demonstration of 2 hand CPR to the community. The event was held at Loma Linda University Medical Center- Murrieta with a total of **42** community members in attendance.

Objectives

1. Educate the community on steps to take for cardiac arrest victims.

Family Health Fair

Identified Community Need: Increase awareness health awareness in families and provide onsite screenings.

Going on its 3nd year the Family Health Fair is an annual event that invites the community to come learn more about their health. This year, the health fair provided free heart health screenings including blood cholesterol, heart echocardiograoms, Body Mass Index testing, blood pressure tests. In addition, free dental screenings were also provided. Colon Cancer Education; Diabetes education and blood sugar testing were offered. Booths also included Prostate cancer screenings, Mother and Baby education, Breast Health education and healthy child lunches and weights.

The fair included a farmer's market promoting local, fresh organic healthy foods. Family activities such as rock climbing wall, jumping house, obstacle course, petting zoo, live music, face painting, ER services education, Cardiac Education, Water Bottles (rethink your drink), raffle prizes that promoted health such as sonicare toothbrushes and pedometers and exercise equipment were offered to the **2,500** families that were in attendance. Breast health resources, community support groups, cancer support groups and other non-profits were represented. The LLU BMC provided consultations. Pediatric care, urology, GI education, police, fire and CHP were present and giving education to the community on safety**.**

Objectives

1. Increase awareness around health and wellbeing to families.
2. Increase access to health services.

Healthy Valley Coalition

Identified Community Need: Increase multi-sectorial partnerships in a community to implement a collective approach to improving overall health.

The Healthy Valley Coalition was established in 2014 with the mission to grow, promote and increase community health and awareness in Murrieta, Temecula and the surrounding communities of this valley. It is a collaboration of community partners from local businesses, non-profit organizations, hospitals, city and county representatives and active citizens. The coalition will focus on healthy eating, children's health and wellness, access to care and chronic health issues in our Community.

The vision of the Healthy Valley Coalition is to support the improvement of the health of Southwest Riverside communities. The mission is to provide individuals, businesses and institutions access to information, resources, ideas and initiatives that support the wellness community. The Healthy Valley Coalition will focus on aging, chronic illness education, children's health services and behavior health initiatives emphasizing prevention and identifying disparities. A total of **54** members gather to meet and move the coalition forward.

Objectives

1. Improved access to quality, affordable healthy foods and beverages and activity in community settings.
2. Improved community and organization policies related to healthy eating and active living.

3. Increases awareness, knowledge, skills, motivation and utilization among community members around healthy eating and active living.
4. Increase awareness, knowledge, and skills motivation and utilization among community members around healthy eating and active living.

Joint Replacement Education

Identified Community Need: Post-operative complications due to lack of education

The Orthopedic Team provides pre-operative Joint Replacement Surgery Class that explains in detail what to expect before, during and after joint replacement surgery. The Orthopedic Team highly recommends that both the patient and the care plan partner attend the Joint Replacement Surgery Class. The patient will have the opportunity to learn more about the surgery and recovery, as well as have any questions and concerns addressed. The class is designed to cover

basic information about preoperative testing and what to expect during and after the hospital stay. The class will also review pre- and post-operative exercises and will demonstrate medical adaptive equipment recommended during the recovery. In total, **100** individuals attended the classes in 2014.

Objectives

1. Increase the proportion of persons who report that their health care providers have satisfactory communication skills
2. Reduce the proportion of adults who engage in no leisure-time physical activity.
3. Increase the proportion of people with disabilities who participate in social, spiritual, recreational, community and civic activities to the degree that they wish

Newborn Necessities Education

Identified Community Need: Improving the well-being of mothers, infants, and children is an important public health goal for the United States.

The Newborn Necessities course is a parent's boot camp to caring for a newborn. Expert's help build confidence in caring for a newborn. This hands-on course is designed to provide the tools and knowledge necessary to understand a newborn's needs. The course topics covered in this course include: sleep patterns, feeding cues, the fourth trimester, introduction to pets, diapering options, nutrition, breastfeeding, bottle feeding, newborn appearance and abilities, common myths about newborns, the happiest baby on the block's five "s, swaddling, bathing, and baby wearing. In 2014, **58** parents participated attended the boot camp.

Objectives

1. Increase the proportion of infants who are breastfed.
2. Increase the proportion of pregnant women who receive early and adequate prenatal care.

Prevention Plus

Identified Community Need: High substance abuse rates in Riverside County among teens that termed low level offenders.

The Prevention Plus is a program occurring across Riverside County as required education for teens that are low level offenders. This gives the child the opportunity to be educated on alcohol and drug use and to learn about different career paths, instead of placing the child in a detention center and is assigned to a probation officer during the course. Students learn to: have a greater understanding of patient care and outcomes related to drug and alcohol use and injuries, gain an understanding of medical equipment utilized in emergent situations and are given the opportunity to handle each device, and gain knowledge of the medical profession and the different position with in the hospital. In 2014, **23** teens participated in the program.

Objectives

1. Increase the proportion of adolescents who perceive great risk associated with substance abuse.
2. Increase the proportion of adolescents who have an adult in their lives with whom they can talk about serious problems.
3. Increase the proportion of persons who need alcohol and/or illicit drug treatment

Smoking Cessation

Identified Community Need: Tobacco use is linked to leading causes of death such as cancer and cardiovascular disease.

This education program offers an overview of the side effects associated with smoking and nicotine addiction. It identifies the importance of smoking cessation programs and how to identify resources to fit the participant's personality and personal goals. Our class welcomed and made a difference in the lives of **3** community members.

Objectives

1. Increase smoking cessation attempts using evidence-based strategies by adult smokers.

Stress Management

Identified Community Need: Cardiac disease is the leading cause of death in the Inland Empire.

This education program reviews the causes and effects of stress on the heart and provides techniques on stress management for patients that have heart disease or have had a stroke. In 2014, we made a difference in the lives of **10** community members.

Objectives

1. Increase the proportion of adults who self-report good or better health.

Weight loss Support Group

Identified Community Need: High rates of obesity in the Inland Empire.

A support group for patients that are preparing or getting ready for a weight loss procedure or have already had one. These meetings are an opportunity to make friends, learn healthy living tips, enjoy a supportive environment and ensure the success of a new healthy lifestyle. In 2014, **90**individuals participated in the support group.

Objectives

1. Increase the proportion of adults who self-report good or better health.
2. Increase the proportion of adults who are at a healthy weight.

Weight loss Surgery Education

Identified Community Need: High rates of obesity in the Inland Empire.

This program is designed to educate the general public on Weight Loss Surgery and other weight loss solutions. Education is focused on general knowledge of obesity, the effects of obesity, causes of obesity, long term effects of obesity, medically supervised weight loss, surgical options for weight loss, and lifestyle changes. In 2014, **105** community residents attend the educational sessions.

Objectives

1. Increase the proportion of adults who self-report good or better health.
2. Increase the proportion of adults who are at a healthy weight.

2014 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 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, 10-year national objectives for improving the health of all Americans.

For 3 decades, Healthy People 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 County Health 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. The *Rankings* look at a variety of measures that affect health such as the rate of people dying before age 75, high school graduation rates, unemployment, limited access to healthy foods, air and water quality, income, and rates of smoking, obesity and teen births.

Based on data available for each county, the Rankings are unique in their ability to measure the overall health of each county in all 50 states on the many factors that influence health, and they have been used to garner support among government agencies, healthcare providers, community organizations, business leaders, policymakers, and the public for local health improvement initiatives. 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-informed 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 County Health 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 2014 rankings. We are actively working with the County of Riverside to achieve similar results. Knowing that overall health of a community cannot be achieved along, LLUH is working actively with the counties to identify collective impact measurements that can be used to align interventions with other sectors such as education, transportation, the business community, and pubic safety.

We are slowly making system changes and the health of our region is improving. Take a look at the most recent data!

The table below reflects the changes per year for health outcomes and health factors for San Bernardino and Riverside County.

2010 2015 County Health Rankings

	San Bernardino						Riverside					
	2010	2011	2012	2013	2014	2015	2010	2011	2012	2013	2014	2015
Health Outcomes	45	44	41	44	40	37	27	29	32	27	26	24
Mortality	37	35	36	32	32	30	30	27	28	25	25	23
Morbidity	48	49	46	51	48	50	32	34	36	41	38	38
Health Factors	50	56	46	46	45	47	40	42	42	36	38	39
Health Behaviors	48	48	45	46	44	44	36	33	39	33	34	32
Clinical Care	54	56	50	52	50	52	50	54	43	46	48	48
Social & Economic Factors	37	40	39	39	39	36	31	29	29	31	31	29
Physical Environment	54	55	55	46	53	53	62	54	54	41	48	49

Source: CountyHealthRankings.org

Loma Linda University Medical Center - Murrieta has identified specific indicators and metrics to use to evaluate whether the interventions have been successful. Indicators align with the system's goals along with Healthy People 2020.

Community Benefit and Economic Value

For over a century, Loma Linda University Health System 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 2014, Loma Linda University Children's Hospital obtained a separate license making them the newest addition to our system.

Valuation of Community Benefit

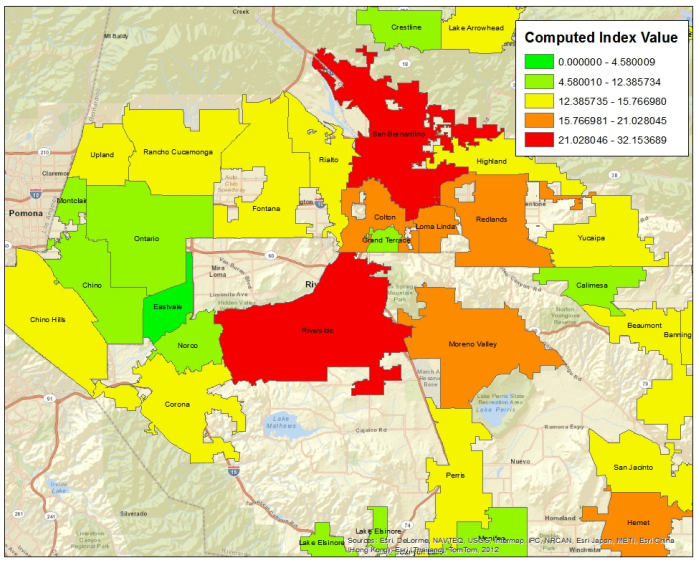
Year 2014 –SB697 Valuation – Cost-Based

Loma Linda University Medical Center - Murrieta	
Charity Care	$1,778,840
Medi-Cal and Other Means Tested Government Programs	$4,338,211
Community Health Development	$283,041
Health Professional Education	$0
Subsidize Health Services	$0
Research	$0
Total Community Benefit Economic Value	**$ 6,400,092**

LLUMC –Murrieta 2015 Priority Update

Creating a Healthier Community in 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? and, 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 of Highest Need

- Riverside

Identified Community Needs

- Lack of affordable 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;
- Growing Hispanic population and increase in the elderly population; and
- Disproportionate share of children living in poverty and homelessness

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 ULCA 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.

Loma Linda University Health 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 for 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 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

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

Improved health status for children living in Inland Empire.

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 compromise more than 39 percent of our population, 33 percent of our families live at poverty level, and 44 percent 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 percent.

Our mission at Loma Linda University Health 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.

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. In one clinic, 22% of two year olds are overweight or obese. With each year of life there is a 2% increase in children with unhealthy weight with nearly 50% of 15 year olds over. 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 disease 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 percent likelihood of being overweight as an adult.

Meeting the health needs of our children will require a symphony of care and coordinated

response from healthcare 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.

Loma Linda University Health recognizes that our children are our future. LLUH 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

1. 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.
2. OK Kids or Outreach to "K"ommunity Kids focuses the integration of young pediatricians in training into communities supportive services focusing on whole child, specifically addressing the issues of lifestyle living, childhood safety and teen pregnancy and parenting.
3. Safe Kids Program is the Loma Linda chapter of the national organization with focuses on safety education of children and parent to reduce the avoidable death statistics. In childhood, Accidents and unintentional injuries are ranked as the #1 cause of death in childhood.
4. Camp Good Grief – An intensive camp that provides emotional support and grief counseling for children who have suffered family losses
5. Operation Fit is a week long summer day camp at the university recreational center that gives children a hands on exposure to wellness through healthy choices of nutrition and physical activity.
6. BodyWorks, is a national program that provides health education with regards to physical activity, nutritional choices, and goal setting for well-being in teenagers and parents.
7. Lactation Consultations provide the one to one coaching for the new mothers seeking breast feeding skills to increase the health of their infants with regards to and an early

obesity prevention

8. 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 the each city.
9. Adopt- A-School Model provides a saturation of efforts for success in domains of academics, nutrition, physical activity, and even a school garden.
10. 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.
11. Walk with the Doc Program is a national physical education connecting physicians with their community promoted through the multiple community efforts including the California Medical Association that address the sedentary lifestyle of communities.
12. Community Based Prevention Plus Clinics will provide the opportunity for community's and healthcare providers to create a rich educational forum for lifestyle transformation.
13. Inland Empire Children's Health Initiative is a regional coalition promoting health insurance coverage for children.
14. 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.
15. 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.

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 - Improved breastfeeding rates at 6 months. Reduce obesity in the community by creating awareness of healthy lifestyle choices. Improve family's ability to achieve wellness in their own neighborhoods and schools.

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.

Chronic Disease Management

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 management is a broad term that encompasses many different models for improving care for people with chronic disease. Elements of a structured chronic disease management 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 to displace 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. Implement a regional community resource model using 211 that expands the health systems capacity to address basic resource needs often at the root causes of poor health.

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

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

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

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

7. Pilot 3 models of collaborative community based health promotion, preservation and disease prevention models.

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

9. Offer flu vaccinations to the community through health fairs and other community settings.

Evaluation Indicators

Short Term – Decreased 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. Healthy People 2020 Objectives

Whole Behavioral Health Care

Identified Need:

Inappropriate utilization of Emergency Departments for 5150's 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.

Behavioral Health Care:

Behavioral health includes both mental health and substance use disorders and is a state of successful performance of mental function, resulting in productive activities, 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 disorders 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 people's ability to maintain good physical health. Behavioral illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors**.**

Loma Linda University Health (LLUH), as a faith-based healthcare leader, is building partnerships with interfaith communities to change the health status in our region. Participation in a community of faith significantly improves the likelihood for congregation members of becoming healthy, and staying healthy. LLUH is helping faith communities to redefine themselves as 'health centers,' where the whole person is treated: emotionally, spiritually, relationally, and physically.

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.

Loma Linda University Health 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 our faith-based organizations (FBOs). At the intersection of faith and health are communities who value healing the whole person. Loma Linda University Medical

Center and the Behavioral Medicine Center are teaming up with the, 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 are 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 resource clergy and faith leaders in a more effective outreach to their own members.

Objectives

1. Increase the proportion of primary care facilities that provide behavioral health treatment onsite 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

Create a behavioral health task force.

1. The development of specialized resources and identification of best practices for the promotion, prevention, and critical interventions as those can be delivered by those in direct ministry.

2. The development of 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.

3. The development of 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.

4. The Implementation of the "Moses Principle Intervention". Even Moses needed that someone 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.

5. The implementation of 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.

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

7. Provide information and referral services for Veterans experiencing PTSD through faith communities.

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

9. 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.

10. Chemical Dependency's 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 their presence of their peers, and other patient families is a way to engage children in the healing process.

11. Behavioral Health Screenings geared towards 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.

12. 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 due to 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.

13. SHIELD Behavioral Health Trainings- Trainings are often geared towards community members, law enforcement, medical providers, teachers, or faith based leaders, who work with adolescents in some scope. The clinical therapist equip 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.

14. *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.

15. Substance Abuse Support Groups

    a. Alcoholics Anonymous
    b. Narcotics Anonymous
    c. Pain Pills Anonymous

16. Master Each New Direction (MEND) is an outpatient program developed for children with severe chronic illness to live into adulthood. MEND helps them learn tools to deal with or avoid stress. In MEND kids understand and accept the unique challenges of living with 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.

Appendix A: Charity Care and Financial Assistance Policy

LOMA LINDA UNIVERSITY HEALTH CHARITY CARE
AND FINANCIAL ASSISTANCE POLICY
ADOPTED AT ALL THREE LICENSED HOSPITALS

CATEGORY: FINANCE

CODE: C-22
EFFECTIVE: 05/2011
REPLACES: 05/2008

SUBJECT: CHARITY CARE

PURPOSE:

The purpose of this policy is to define the criteria, which will be used by Loma Linda University Medical Center, Loma Linda University Children's Hospital, Loma Linda University East Campus Hospital, Loma Linda University Heart and Surgical Hospital and Highland Springs Medical Plaza (hereinafter collectively "LLUMC") to comply with the requirements of the California Hospital Fair Pricing Policies Act.

California acute care hospitals must implement policies and practices that conform to California law, including requirements for written policies providing discounts and Charity Care to financially qualified patients. This policy is intended to meet such legal obligations and provides for both Charity Care and discounts to patients who financially qualify under the terms and conditions of the LLUMC Charity Care/Discount Payment Policy.

SCOPE OF POLICY:

This policy pertains to financial assistance provided to patients by LLUMC. All requests for financial assistance from patients, patient families, physicians or hospital staff shall be addressed in accordance with this policy. This policy does not apply to physician services rendered at LLUMC with the exception of emergency physicians who provide services within LLUMC's Emergency Department. The emergency physicians at LLUMC have adopted a separate policy that provides discounts to uninsured patients or patients with high medical costs whose income is at, or is below 350% of the Federal Poverty Level.

PHILOSOPHY:

As a faith-based organization, LLUMC strives to meet the health care needs of patients in its geographic service area. The LLUMC Mission is "To Continue the Healing Ministry of Jesus Christ and to Make Man Whole." LLUMC's Mission is expressly demonstrated through this Charity Care/Discount Payment Policy.
The first and foremost responsibility of LLUMC is to see that its patients receive compassionate, timely, and appropriate medical care with consideration for patient privacy, dignity, and informed consent.

LLUMC regularly provides hospital services to patients who live locally in and around Loma Linda, CA. As a major teaching university and tertiary hospital, LLUMC also serves as a regional resource, caring for complex patient needs and regularly accepts transfers from many other hospitals. LLUMC also offers many highly specialized treatment programs, some of which are unique. To help meet the needs of its patients, LLUMC is committed to providing access to financial assistance programs when patients are uninsured or underinsured and may need help in paying their hospital bill. These programs include government sponsored coverage programs, Charity Care, and discounted payment Charity Care, as defined herein.

DEFINITION OF TERMS:

Charity Care: Charity Care is defined as any medically necessary inpatient or outpatient hospital service provided to a patient who has an income below 200% of the current federal poverty level and who has established qualification in accordance with requirements contained in the LLUMC Charity Care/Discount Payment Policy.

Discount Partial Charity Care Payment: Discount Payment through the Charity Care/Discount Payment Policy is defined as partial Charity Care which results from any medically necessary inpatient or outpatient hospital service provided to a patient who is uninsured or whose insurance coverage does not otherwise provide a discount from the usual, customary and reasonable rates of LLUMC; and 1) desires assistance with paying their hospital bill; 2) has an income at or below 350% of the federal poverty level; and 3) who has established qualification in accordance with requirements contained in the LLUMC Charity Care/Discount Payment Policy.

Federal Poverty Level (FPL) Guideline: The FPL guidelines establish the gross income and family size eligibility criteria for Charity Care and Discounted Payment status as described in this policy. The FPL guidelines are updated periodically by the United States Department of Health and Human Services.

Good Faith Estimate: The amount quoted by LLUMC Registration staff to an uninsured patient or their family representative prior to, or at the time services are rendered, represents a reasonable approximation of the actual price to be paid by the patient or family representative for services received at LLUMC. Registration staff will make their best efforts to develop and quote a Good Faith Estimate; however, registration staff may not be able to fully predict the actual medical services that will be subsequently ordered by the patient's attending, treating or consulting physicians.

International Services Department: All international charity cases must be reviewed and approved by the International Charity Committee consistent with its annual budget criteria. (Reference Policy C-51, "International Benefit")

LLUMC Charity Care/Discount Payment Policy Qualification Requirements: Depending upon individual patient qualification, LLUMC financial assistance may be granted for Charity Care or discount partial Charity Care payment. If a person requests Charity Care or a discounted payment, and fails to provide information that is reasonable and necessary for LLUMC to make a determination, LLUMC may consider that failure in making its determination. Financial assistance may be denied when the patient or other responsible family representative does not meet the LLUMC Charity Care/Discount Payment Policy qualification requirements.

Medically Necessary Services: Financial assistance under this policy shall apply to medically necessary services but would exclude unique technology services where medically efficacious alternative therapies are available. Examples include: 1) Cosmetic and/or plastic surgery services; 2) Infertility services; 3) Vision correction; 4) Proton therapy; 5) Robotic procedures; 6) Orthotics/Prosthetics, or 7) Other services that are primarily for patient comfort and/or patient convenience.

Patient's Family: The following shall be applied to all cases subject to the LLUMC Charity Care/Discount Payment Policy:

1. For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the California Family Code, and dependent children under 21 years of age, whether living at home or not.

1.1 Domestic Partner: A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division, and, at the time of filing, all of the following requirements are met:

a. Both persons have a common residence.
b. Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
c. The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
d. Both persons are at least 18 years of age.
e. Either of the following: Both persons are members of the same sex, one or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over the age of 62.
f. Both persons are capable of consenting to the domestic partnership.

2. For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

A. GENERAL PATIENT RESPONSIBILITIES

1. To Be Honest: Patients must be honest and forthcoming when providing all information requested by LLUMC as part of the financial assistance screening process. Patients are required to provide accurate and truthful eligibility documentation reasonably necessary for financial assistance coverage through any government coverage program or the LLUMC Financial Assistance Program. Honesty implies and requires full and complete disclosure of required information and/or documentation.

2. To Actively Participate and Complete Financial Screening: All uninsured patients and those who request financial assistance will be required to complete a Financial Assistance Application. Prior to leaving LLUMC, patients should verify what additional information or documentation must be submitted by the patient to LLUMC. The patient shares responsibility for understanding and complying with the document filing deadlines of LLUMC or other financial assistance programs.

3. To pay any or All Required Out-of-Pocket Amounts Due: Patients should expect and are required to pay any or all amounts due at the time of service. Said amounts due may include, but are not limited to:

3.1 Co-Payments

3.2 Deductibles

3.3 Deposits

3.4 MediCal/Medicaid Share of Cost Amounts

3.5 Good Faith Estimates

4. To Share Responsibility for Hospital Care: Each patient shares a responsibility for the hospital care They receive. This includes follow-up in obtaining prescriptions or other medical care after discharge.

The patient also shares a responsibility to assure that arrangements for settling the patient account have been completed. It is essential that each patient or their family representative cooperates and communicates with LLUMC personnel during and after services are rendered.

B. HOSPITAL PROCESS and RESPONSIBILITIES

1. Eligibility under the LLUMC Charity Care/Discount Payment Policy is provided for any patient whose family income is less than 350% of the current federal poverty level, if not covered by third-party insurance or, if covered by third-party insurance which does not otherwise afford the patient a discount from standard hospital rates as provided in the LLUMC charge description master.

2. The LLUMC Charity Care/Discount Payment Policy utilizes a single, unified patient application for both full Charity Care and discount payment. The process is designed to give each applicant an opportunity to receive the maximum financial assistance benefit for which they may qualify. The Financial Assistance Application provides patient information necessary for determining patient qualification by the hospital and such information will be used to qualify the patient or family representative for maximum coverage available through government programs and/or under the LLUMC Charity Care/Discount Payment Policy.

3. Eligible patients may qualify for LLUMC Charity Care/Discount Payment Policy by following application instructions and making every reasonable effort to provide LLUMC with documentation and health benefits coverage information such that LLUMC may make a determination of the patient's qualification for coverage under the appropriate program. Eligibility alone is not an entitlement to qualification under the LLUMC Charity Care/Discount Payment Policy. LLUMC must complete a process of applicant evaluation and determine qualification before full Charity Care or discount payment Charity Care may be granted.

4. The LLUMC Charity Care/Discount Payment Policy relies upon the cooperation of individual patients who may be eligible for full or partial assistance. To facilitate receipt of accurate and timely patient financial information, LLUMC will use a Financial Assistance Application. All patients unable to demonstrate financial coverage by third-party insurers will be offered an opportunity to complete the Financial Assistance Application. Uninsured patients will also be offered information, assistance and referral to government sponsored programs for which they may be eligible. Insured patients who have not received a discount through their insurance coverage may also be eligible for financial assistance. Any patient who requests financial assistance will be asked to complete a Financial Assistance Application.

5. The Financial Assistance Application should be completed as soon as there is an indication the patient may be in need of financial assistance. The application form may be completed prior to service, during a patient stay, or after services are completed and the patient has been discharged.

5.1 Completion of a Financial Assistance Application provides:

a. Information necessary for LLUMC to determine if the patient has income sufficient to pay for services;
b. Documentation useful in determining qualification for financial assistance; and
c. An audit trail documenting LLUMC's commitment to providing financial assistance.

5.2

5.2 A completed Financial Assistance Application is not required if LLUMC, in its sole discretion, determines it has sufficient patient financial information from which to make a financial assistance qualification decision.

C. QUALIFICATION: FULL CHARITY CARE AND DISCOUNT PAYMENT CHARITY CARE:

1. Qualification for full or discount payment financial assistance shall be determined solely by the patient's and/or patient family representative's ability to pay. Qualification for financial assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion. While financial assistance shall not be provided on a discriminatory or arbitrary basis, LLUMC retains full discretion, consistent with laws and regulations, to establish eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance.

2. LLUMC will provide direct assistance during registration to patients or their family representative to facilitate completion of the Financial Assistance Application. Completion of the Financial Assistance Application and submission of any or all required supplemental information may be required for establishing qualification for financial assistance.

3. Recognizing that LLUMC provides a high volume of lower acuity emergency and urgent care services to the local community, efforts are made to reduce the burden of application in certain cases. Although charges for emergency medical care can be quite high, such cases are less frequent than many other minor care visits. When the emergency or urgent care visit charges are less than $5,000, the patient or family representative may only be required to submit a completed and signed Financial Assistance Application. Tax returns or recent pay stubs may not be required in such cases. However, in the event charges exceed $5,000, the patient or family representative must provide proof of income documents in the form of either a federal income tax return or copies of at least two recent pay stubs.

4. It may be necessary for the patient and/or family representative to subsequently deliver supporting documentation to LLUMC. Instructions for submission of supporting documents will be provided to the patient at the time a Financial Assistance Application is completed. The patient and/or patient family representative who requests assistance in meeting their financial obligation to LLUMC shall make every reasonable effort to provide information necessary for LLUMC to make a financial assistance qualification determination. The Financial Assistance Application and required supplemental documents are submitted to the Patient Business Office. The location of this office shall be clearly identified on the application instructions.

5. LLUMC will provide personnel who have been trained to review Financial Assistance Applications for completeness and accuracy. Application reviews will be completed as quickly as possible considering the patient's need for a timely response.

6. Factors considered when determining whether an individual is qualified for financial assistance pursuant to this policy may include:

6.1 No insurance coverage under any government program or other third-party insurer, which has provided the patient or family representative a discount from the usual, customary and reasonable rates of LLUMC;

6.2 Family income based upon federal income tax returns, recent pay stubs, or other relevant information provided by the patient in the absence of said documents;

6.3 Family size

7. Financial Assistance qualification may be granted for Charity Care or discount payment depending upon the patient or family representative's level of qualification as defined in the criteria of this Charity Care/Discount Payment Policy. A financial assistance determination will be made only by approved LLUMC personnel according to the following levels of authority:

7.1	Manager of Patient Business Office:	Accounts less than $50,000
7.2	Director of Patient Business Office:	Accounts less than $100,000
7.3	Executive Director of Business Office:	Accounts less than $250,000
7.4	Vice President, Revenue Cycle:	Accounts greater than $250,000

8. Once determined, Financial Assistance qualification will apply to the specific services and service dates for which application has been made by the patient and/or patient family representative. In cases of continuing care relating to a patient diagnosis which requires on-going, related services, LLUMC, at its sole discretion, may treat continuing care as a single case for which qualification applies to all related on-going services provided by LLUMC. Other pre-existing patient account balances outstanding at the time of a qualification determination by LLUMC will be included as eligible for write-off at the sole discretion of LLUMC management.

9. Patient obligations for Medi-Cal/Medicaid Share of Cost payments will not be waived under any circumstances. However, after collection of the patient Share of Cost portion, any non-covered or other unpaid balance relating to a Medi-Cal/Medicaid Share of Cost patient may be considered for Charity Care.

10. Patients between 201% and 350% of FPL will not pay more than Medicare would typically pay for a similar episode of service. This shall apply to all medically necessary hospital inpatient, outpatient, recurring and emergency services provided by LLUMC.

D. FULL CHARITY AND DISCOUNT PAYMENT - INCOME QUALIFICATION LEVELS

1. If an uninsured patient's family income is 200% or less of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, the patient qualifies for full Charity Care.

2. If the patient's family income is between 201% and 350% of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, the following will apply:

2.1 Uninsured Patient. If the services are not covered by any third-party payer so that the patient ordinarily would be responsible for the full-billed charges, the patient's payment obligation will be a percentage of the gross amount the Medicare program would have paid for the service if the patient were a Medicare

beneficiary. The actual percentage paid by any individual patient shall be based on the sliding scale shown in Table 1 below:

TABLE 1
Sliding Scale Discount Schedule

Family Percentage of FPL	Discount off M/Care Allowable
201 – 260%	75%
261 – 320%	50%
321 – 350%	25%

2.2 Insured Patient.

a. If the services received are covered by a third-party payer such that the patient is responsible for only a portion of the billed charges (i.e., a deductible or co-payment), and the insured patient's insurance plan does not have a contract with LLUMC, then the patient's payment obligation will be an amount equal to the difference between what insurance has paid and the gross amount that Medicare would have paid for the service if the patient were a Medicare beneficiary (i.e., if insurance has paid more than the Medicare allowable amount, the patient will owe nothing further, but if the patient's insurance has paid less than the Medicare allowable amount, the patient will pay the difference between the insurance amount paid and the Medicare allowable amount); or

b. If the services provided by LLUMC are covered by a third-party payer and the patient has received a discount as a result of said third-party payer coverage, than no further discount will be provided and the patient shall be responsible for payment of any or all co-payment or deductible amounts owed as required by the patient's insurance coverage. If the patient/guarantor has experienced a catastrophic event which has resulted in their inability to pay any or all co-payment or deductible amounts owed, the patient/guarantor can complete a Financial Assistance Application and provide tax returns or other documentation which demonstrates the need for further discounting of their co-payments or deductibles.

3. If the patient's family income is greater than 350% of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, the following will apply:

3.1 Uninsured Patient. If the services are not covered by any third-party payer so that the patient ordinarily would be responsible for the full-billed charges, the total patient payment obligation will be an amount equal to 100% of the gross amount the Medicare program would have paid for the service if the patient were a Medicare beneficiary.

3.2 Insured Patient.

a. If the services received are covered by a third-party payer such that the patient is responsible for only a portion of the billed charges (i.e., a deductible or co-payment), and the insured patient's insurance plan does not have a contract with LLUMC, then the patient's payment obligation will be an amount equal to the difference between what the third-party payer has paid and 100% of what Medicare would have paid if the patient were a Medicare beneficiary; or

b. If the services provided by LLUMC are covered by a third-party payer and the patient has received a discount as a result of said third-party payer coverage, then no further discount will be provided and the patient shall be responsible for payment of any or all co-payment or deductible amounts owed as required by the patient's third-party payer coverage.

c. If the patient/guarantor has experienced a catastrophic event which has resulted in their inability to pay any or all co-payment or deductible amounts owed, the patient/guarantor can complete a Financial Assistance Application and provide tax returns or other documentation which demonstrates the need for further discounting of their co-payments or deductibles.

E. SPECIAL CHARITY CARE CIRCUMSTANCES

1. If the patient is determined by LLUMC Registration staff to be homeless and without third-party payer coverage, he/she will be deemed as automatically eligible for Charity Care.

2. Deceased patients who do not have any third-party payer coverage, an identifiable estate or for whom no probate hearing is to occur, shall be deemed automatically eligible for Charity Care.

3. Patients seen in the emergency department, for whom LLUMC is unable to issue a billing statement, may have the account charges written off as Charity Care (i.e., the patient leaves before billing information is obtained). All such circumstances shall be identified on the patient's account notes as an essential part of the documentation process.

4. LLUMC deems those patients that are eligible for government sponsored low-income assistance programs (e.g. MediCal/Medicaid, Healthy Families, California Children's Services and any other applicable state or local low-income program) to be automatically eligible for full Charity Care when payment is not made by the governmental program. For example, patients who qualify for Medi-Cal/Medicaid as well as other programs serving the needs of low-income patients (e.g. CHDP, Healthy Families, and some CCS) where the program does not make payment for all services or days during a hospital stay are eligible for Financial Assistance coverage. Under LLUMC's Charity Care/Discount Payment Policy, these types of non-reimbursed patient account balances are eligible for full write-off as Charity Care. Specifically included as Charity Care are charges related to denied stays or denied days of care. All Treatment Authorization Request (TAR) denials provided to Medi-Cal/Medicaid and other patients covered by qualifying low-income programs, and other denials (e.g. restricted coverage) are to be classified as Charity Care.

4. Any evaluation for financial assistance relating to patients covered by the Medicare Program must include a reasonable analysis of all patient assets, liabilities, income and expenses, prior to eligibility qualification for the Financial Assistance Program. Such financial assistance evaluations must be made prior to service completion by LLUMC. Notwithstanding the preceding, the portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b)

5.

which is not covered by insurance or any other payer including Medi- Cal/Medicaid, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as Charity Care if:

5.1 The patient is a beneficiary under Medi-Cal/Medicaid or another program serving the health care needs of low-income patients; or

5.2 The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.

6. Any uninsured patient whose income is greater than 350% of the current FPL and experiences a catastrophic medical event may be deemed eligible for financial assistance. Such patients, who have higher incomes, do not qualify for routine full Charity Care or discount payment care. However, consideration of a catastrophic medical event may be made on a case-by-case basis. The determination of a catastrophic medical event shall be based upon the amount of the patient liability at billed charges, and consideration of the patient's income and assets as reported at the time of occurrence. Management shall use reasonable discretion in making a determination based upon a catastrophic medical event. As a general guideline, any account with a patient liability for services rendered that exceeds $200,000 may be considered for eligibility as a catastrophic medical event.

7. Any account returned to LLUMC from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill, may be deemed eligible for Charity Care. Documentation of the patient or family representative's inability to pay for services will be maintained in the Charity Care documentation file.

F. CRITERIA FOR RE-ASSIGNMENT FROM BAD DEBT TO CHARITY CARE

1. All outside collection agencies contracted with LLUMC to perform account follow-up and/or bad debt collection will utilize the following criteria to identify a status change from bad debt to Charity Care:

1.1 Patient accounts must have no applicable insurance (including governmental coverage programs or other third-party payers); and

1.2 The patient or family representative must have a credit and/or behavior score rating within the lowest 25th percentile of credit scores for any credit evaluation method used; and

1.3 The patient or family representative has not made a payment within 150 days of assignment to the collection agency;

1.4 The collection agency has determined that the patient/family representative is unable to pay; and/or

1.5 The patient or family representative does not have a valid Social Security Number and/or an accurately stated residence address in order to determine a credit score

2. All accounts returned from a collection agency for re-assignment from Bad Debt to Charity Care will be evaluated by LLUMC Billing Department personnel prior to any re-classification within the hospital accounting system and records.

G. PATIENT NOTIFICATION

1. Once a determination of eligibility is made, a letter indicating the determination status will be sent to the patient or family representative. The determination status letter will indicate one of the following:

1.1 Approval: The letter will indicate the account has been approved, the level of approval and any outstanding amount owed by the patient. Information and directions for any further patient actions will also be provided.

1.2 Denial: The reasons for eligibility denial based on the Financial Assistance Application will be explained to the patient. Any outstanding amount owed by the patient will also be identified. Contact information and instructions for payment will also be provided.

1.3 Pending: The applicant will be informed as to why the Financial Assistance Application is incomplete. All outstanding information will be identified and the notice will request that the information be supplied to LLUMC by the patient or family representative.

H. PAYMENT PLANS

1. When a determination of discount has been made by LLUMC, the patient shall have the option to pay any or all-outstanding amount due in one lump sum payment, or through a scheduled term payment plan.

2. LLUMC will discuss payment plan options with each patient that requests to make arrangements for term payments. Individual payment plans will be arranged based upon the patient's ability to effectively meet the payment terms. As a general guideline, payment plans will be structured to last no longer than 12 months. LLUMC shall negotiate in good faith with the patient; however there is no obligation to accept the payment terms offered by the patient. No interest will be charged to qualified patient accounts for the duration of any payment plan arranged under the provisions of the Charity Care/Discount Payment Policy.

3. Once a payment plan has been approved by LLUMC, any failure to pay all consecutive payments due during a 90-day period will constitute a payment plan default. It is the patient or guarantor's responsibility to contact the LLUMC Patient Business Office if circumstances change and payment plan terms cannot be met. However, in the event of a payment plan default, LLUMC will make a reasonable attempt to contact the patient or their family representative by telephone and also give notice of the default in writing. The patient shall have an opportunity to renegotiate the extended payment plan and may do so by contacting a Patient Business Office representative within Fourteen (14) Days from the date of the written notice of extended payment plan default. If the patient fails to request renegotiation of the extended payment plan within Fourteen (14) Days, the payment plan will be deemed inoperative and the account will become subject to collection.

4. Preferably, all payment plans should be processed through an outside electronic funds Transfer (EFT) vendor. In the event, however, the patient or family representative expresses a willingness to pay under a payment plan, without going through an outside EFT vendor, LLUMC will endeavor to accommodate such requests provided the patient pays the Extended Payment Plan via cash, check, money order or credit card.

I. DISPUTE RESOLUTION

1. In the event that a dispute arises regarding Financial Assistance Program qualification, the patient may file a written appeal for reconsideration with LLUMC. The written appeal should contain a complete explanation of the patient's dispute and rationale for reconsideration. Any or all**48** additional relevant documentation to support the patient's claim should be attached to the written appeal.

2. Any or all appeals will be reviewed by the Executive Director of the Patient Business Office. The Executive Director shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the Executive Director shall provide the patient with a written explanation of findings and the determination. All determinations by the Executive Director shall be final. There are no further appeals.

Public Notice

J. POSTING

1. LLUMC shall post notices informing the public of the Charity Care/Discount Payment Policy. Such notices shall be posted in high volume inpatient, and outpatient service areas of LLUMC, including but not limited to, the emergency department, billing office, inpatient admission and outpatient registration areas or other common patient waiting areas of LLUMC. Notices shall also be posted at any location where a patient may pay their bill. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance.

1.1 These notices shall be posted in English and Spanish and any other languages that are representative of 5% or greater of patients in LLUMC's service area.

2. A copy of this Charity Care/Discount Payment Policy will be made available to the public upon reasonable request. LLUMC will respond to such requests in a timely manner.

K. FULL CHARITY CARE AND DISCOUNT PAYMENT REPORTING

1. LLUMC will report actual Charity Care provided in accordance with this regulatory requirement of the Office of Statewide Health Planning and Development (OSHPD) as contained in the Accounting and Reporting Manual for Hospitals, Second Edition. To comply with regulation, LLUMC will maintain written documentation regarding its Charity Care criteria, and for individual patients, LLUMC will maintain written documentation regarding all Charity Care determinations. As required by OSHPD, Charity Care provided to patients will be recorded on the basis of actual charges for services rendered.

2. LLUMC will provide OSHPD with a copy of this Charity Care/Discount Payment Policy, which includes the full Charity Care, and discount payment policies within a single document. The Charity Care/Discount Payment Policy also contains: 1) all eligibility and patient qualification procedures; 2) the unified application for full Charity Care and discount payment; and 3) the review process for both full Charity Care and discount payment. These documents shall be supplied to OSHPD every two years or whenever a significant change is made.

L. OTHER

1. Confidentiality -It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will implement this policy should be guided by these values.

2. Good Faith Requirements - LLUMC makes arrangements for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative is complete and accurate. Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, or purposely inaccurate

information has been provided by the patient or family representative. In addition, LLUMC reserves the right to seek all remedies, civil and criminal, from those patients or family representatives who have provided fraudulent or purposely inaccurate information in order qualify for the LLUMC Financial Assistance Program.

4. Credit and Collection Policy - LLUMC has established a Credit and Collection Policy. All actions by LLUMC in obtaining credit information regarding a patient/responsible party or in connection with referring a patient/responsible party to an external collection agency shall be consistent with the Credit and Collection Policy.

Appendix B: California's Community Benefit Law

California's Community Benefit Law is popularly known as SB697. It is found in the state's Health and Safety Code, Section 127340-127365. The law got its start in response to the increasing interest in the community contributions of not-for-profit hospitals. The California Association of Catholic Hospitals and the California Healthcare Association co-sponsored Senate Bill 697 (Torres), which was signed into law by Governor Wilson in September 1994.

How hospitals meet their "social obligation" has been the subject of discussion for many years. Since 1969, not-for-profit hospitals have been guided, to a large extent, by Internal Revenue Service (IRS) rulings concerning the "community benefit standard." The IRS standard, however, fails to encompass the full scope of benefits that hospitals provide their communities. Therefore, various other approaches to recording community benefits have been proposed. SB 697 requires private not-for-profit hospitals in California to describe and document the full range of community benefits they provide in the state.

SB 697 extends beyond simple documentation and valuation of community benefits. A key feature of the legislation is its requirement of a community planning process. Hospitals must conduct community needs assessments and then develop annual community benefit plans—with a view to the needs that have been identified.

The Office of Statewide Health Planning and Development (OSHPD) is responsible for the implementation of the legislation. More recently, OSHPD has closed the office that supported SB697 and has scattered its duties to existing offices.

OSHPD, in its first report to the legislature on compliance with SB697, said that overall, California's not-for-profit hospitals have demonstrated a serious commitment to fulfilling the requirements of the legislation. Many hospitals submitted plans ahead of schedule and some that were exempt from the legislation complied on a voluntary basis. Unquestionably, SB 697 has been very successful in heightening hospitals' awareness of their community benefit obligations and directing attention to a community benefit planning process.

There is another dimension of community benefit that could not be easily captured in the hospitals' formal community benefit plan. Based on public comments from community forums held throughout the state and discussions with the first SB 697 Advisory Group, it was evident that SB 697 has served as a remarkable catalyst for collaborative relationships and efforts among hospitals, health-oriented organizations, local health departments, and other agencies in the community. To assess the total value of their contributions, one must consider how communities benefit when hospitals lend their organizational capacity and expertise in collaborative efforts to improve the health of the community, thus building "social capital" for their communities.

SB 697 redefines the community benefit standard for California's not-for-profit hospitals. The legislation has encouraged these hospitals to work with community partners to build healthier communities. This is a challenging task given the rapidly changing healthcare environment, and the pressures hospitals face in a competitive market. With its emphasis on needs assessment, priority setting, and planning in collaboration with the community, the SB 697 legislation provides a conductive framework for meaningful community benefit contributions by non-profit hospitals. (This section was adapted from OSHPD's report to the legislature.)

California Codes: Health And Safety Code, Section 127340-127365 127340.

The Legislature finds and declares all of the following:

(a) Private not-for-profit hospitals meet certain needs of their communities through the provision of essential health care and other services. Public recognition of their unique status has led to favorable tax treatment by the government. In exchange, nonprofit hospitals assume a social obligation to provide community benefits in the public interest.

(b) Hospitals and the environment in which they operate have undergone dramatic changes. The pace of change will accelerate in response to health care reform. In light of this, significant public benefit would be derived if private not-for-profit hospitals reviewed and reaffirmed periodically their commitment to assist in meeting their communities' health care needs by identifying and documenting benefits provided to the communities, which they serve.

(c) California's private not-for-profit hospitals provide a wide range of benefits to their communities in addition to those reflected in the financial data reported to the state.

(d) Unreported community benefits that are often provided but not otherwise reported include, but are not limited to, all of the following:1) Community-oriented wellness and health promotion; 2) Prevention services, including, but not limited to, health screening, immunizations, school examinations, and disease counseling and education; 3) Adult day care; 4) Child care; 5) Medical research; 6) Medical education; 7) Nursing and other professional training; 8) Home-delivered meals to the homebound; 9) Sponsorship of free food, shelter, and clothing to the homeless; 10) Outreach clinics in socioeconomically depressed areas.

(e) Direct provision of goods and services, as well as preventive programs, should be emphasized by hospitals in the development of community benefit plans. 127345. As used in this article, the following terms have the following meanings: 1) "Community benefits plan" means the written document prepared for annual submission to the Office of Statewide Health Planning and Development that shall include, but shall not be limited to, a description of the activities that the hospital has undertaken in order to address identified community needs within its mission and financial capacity, and the process by which the hospital developed the plan in consultation with the community; 2) "Community" means the service areas or patient populations for which the hospital provides health care services; 3) Solely for the planning and reporting purposes of this article, "community benefit" means a hospital's activities that are intended to address community needs and priorities primarily through disease prevention and improvement of health status, including, but not limited to, any of the following: 1) Health care services, rendered to vulnerable populations, including, but not limited to, Charity Care and the un-reimbursed cost of providing services to the uninsured, underinsured, and those eligible for Medi-Cal, Medicare, California Children's Services Program, or county indigent programs; 2) The un-reimbursed cost of services included in subdivision (d) of Section 127340; 3) Financial or in-kind support of public health programs; 4) Donation of funds, property, or other resources that contribute to a community priority; 5) Health care cost containment; 6) Enhancement of access to health care or related services that contribute to a healthier community; 7) Services offered without regard to financial return because they meet a community need in the service area of the hospital, and other services including health promotion, health education, prevention, and social services; 8) Food, shelter, clothing, education, transportation, and other goods or services that help maintain a person's health.

(d) "Community needs assessment" means the process by which the hospital identifies, for its primary service area as determined by the hospital, unmet community needs.

(e) "Community needs" means those requisites for improvement or maintenance of health status in the community.

(f) "Hospital" means a private not-for-profit acute hospital licensed under subdivision (a), (b), or (f) of Section 1250 and is owned by a corporation that has been determined to be exempt from taxation under the United States Internal Revenue Code. "Hospital" does not mean any of the following: 1) Hospitals that are dedicated to serving children and that do not receive direct payment for services to any patient; 2) Small and rural hospitals as defined in Section 124840.

(g) "Mission statement" means a hospital's primary objectives for operation as adopted by its governing body.

(h) "Vulnerable populations" means any population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medi-Cal, Medicare, California Children's Services Program, or county indigent programs.127350. Each hospital shall do all of the following: 1) By July 1, 1995, reaffirm its mission statement that requires its policies integrate and reflect the public interest in meeting its responsibilities as a not-for-profit organization; 2) By January 1, 1996, complete, either alone, in conjunction with other health care providers, or through other organizational arrangements, a community needs assessment evaluating the health needs of the community serviced by the hospital, that includes, but is not limited to, a process for consulting with community groups and local government officials in the identification and prioritization of community needs that the hospital can address directly, in collaboration with others, or through other organizational arrangement. The community needs assessment shall be updated at least once every three years; 3) By April 1, 1996, and annually thereafter adopt and update a community benefits plan for providing community benefits either alone, in conjunction with other health care providers, or through other organizational arrangements; 4) Annually submit its community benefits plan, including, but not limited to, the activities that the hospital has undertaken in order to address community needs within its mission and financial capacity to the Office of Statewide Health Planning and Development. The hospital shall, to the extent practicable, assign and report the economic value of community benefits provided in furtherance of its plan. Effective with hospital fiscal years, beginning on or after January 1, 1996, each hospital shall file a copy of the plan with the office not later than 150 days after the hospital's fiscal year ends. The reports filed by the hospitals shall be made available to the public by the office. Hospitals under the common control of a single corporation or another entity may file a consolidated report.127355. The hospital shall include all of the following elements in its community benefits plan: 1) Mechanisms to evaluate the plan's effectiveness including, but not limited to, a method for soliciting the views of the community served by the hospital and identification of community groups and local government officials consulted during the development of the plan;2) Measurable objectives to be achieved within specified timeframes; 3) Community benefits categorized into the following framework: a) Medical care services; b) Other benefits for vulnerable populations; c) Other benefits for the broader community; d) Health research, education, and training programs.

5) Non-quantifiable benefits. 127360. Nothing in this article shall be construed to authorize or require specific formats for hospital needs assessments, community benefit plans, or reports until recommendations pursuant to Section 127365 are considered and enacted by the Legislature. Nothing in this article shall be used to justify the tax-exempt status of a hospital under state law. Nothing in this article shall preclude the office from requiring hospitals to directly report their charity activities. 127365. The Office of Statewide Health Planning and Development shall prepare and submit a report to the Legislature by October 1, 1997, including all of the following: a) The identification of all hospitals that did not file plans on a timely basis; b) A statement regarding the most prevalent characteristics of plans in terms of identifying and emphasizing community needs; c) Recommendations for standardization of plan formats, and recommendations regarding community benefits and community priorities that should be emphasized.

These recommendations shall be developed after consultation with representatives of the hospitals, local governments and communities.

Appendix C: Terms and Definitions – 2014 (Reported May 2015)

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 there from; 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

Interventions carried out or supported and are subsidized by the health care organizations, for the express purpose of improving community health. Such services do not generate inpatient or outpatient bills, although there may be a nominal patient fee or sliding scale fee for these services.

Community Health Improvement – These activities 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 need and are provided despite a financial loss. These services are provided because they meet an identified community need and if were not available in the area they would fall to the responsibility of government or another not-for-profit organization.

Financial and In-Kind Contributions – Contributions that include donations and the cost of hours donated by staff to the community while on the organization's payroll, the indirect cost of space donated to tax-exempt companies (such as for meetings), and the financial value (generally measured at cost) of donated food, equipment, and supplies. Financial and in-kind contributions are given to community organizations committed to improving community health who are not affiliated with the health system.

Community Building Activities – Community-building activities include interventions the social determinants of health such as poverty, homelessness, and environmental problems.

Health Professions Education and Research

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.

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).

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