St. Joseph Health, St. Mary Medical Center

Fiscal Year 2013 COMMUNITY BENEFIT REPORT

PROGRESS ON FY12 - FY14 CB PLAN/IMPLEMENTATION STRATEGY REPORT

St. Joseph Health
St. Mary

TABLE OF CONTENTS

[1] Non-financial summary of accomplishments are referred to in SB 697 as non-quantifiable benefits.

EXECUTIVE SUMMARY

Our Mission
To extend the healing ministry of Jesus in the tradition of the Sisters of St. Joseph of Orange by continually improving the health and quality of life of people in the communities we serve.

Our Vision
We bring people together to provide compassionate care, promote health improvement, and create healthy communities.

Our Values
The four core values of St. Joseph Health -- Service, Excellence, Dignity, and Justice -- are the guiding principles for all we do, shaping our interactions with those whom we are privileged to serve.

Introduction - Who We Are and Why We Exist

St. Joseph Health, St. Mary (SJH St. Mary) is a comprehensive 210-bed nonprofit medical center serving the high desert region of San Bernardino County, CA. The hospital is located in Apple Valley and has been serving residents and addressing community need for over 50 years. SJH St. Mary is part of St. Joseph Health headquartered in Irvine, CA. SJH St. Mary is the largest provider of acute care services and the only local nonprofit hospital serving the region. A listing of hospital services includes: 24-hour Emergency Services, Comprehensive Cardiac Services, an Outpatient Surgery Pavilion, Mobile Health Services, Diabetes Education, Level II Neonatal Intensive Care, Robotic-Assisted Surgery Program and a Center for Wound Care & Hyperbaric Medicine. The hospital is a STEMI receiving center and is Baby Friendly designated. The hospital's Advocacy, Community Health and Healthy Community programs are well known for their success addressing health and community need. The hospital employs over 1,700 and is one of the area's largest employers. To address a hospital bed shortage and better serve the region SJH St. Mary is building a second hospital campus in the city of Victorville. This new 128 bed hospital will serve communities located on the west side of Highway 15 who are currently without a local hospital.

The primary and secondary service areas of SJH St. Mary consist of nearly 400,000 residents living in the communities of Adelanto, Apple Valley, Barstow, Hesperia, Lucerne Valley, Phelan, Oak Hills, Victorville and mountain communities including Big Bear, Lake Arrowhead, Lake Gregory and Wrightwood. The 2010 US Census reports a 19.1% increase in population between 2000 and 2010. Hispanic residents now comprise 49.2% of the total population with the African American population estimated at 8.9%. Data from the hospital's interpreter services program indicates Spanish and Arabic are the two most commonly requested non-English languages for discussing healthcare. The region is impacted by a slowly improving economy. The area's unemployment rate is 11% in Apple Valley and as high

as 16% in Adelanto (with the state average of 8.5% reported by the state's Employment Development Department for July 2013). According to an April 2013 census, the county's homeless population is the second largest in the region. Community Benefit programs provided by the hospital are the most comprehensive in the area and include direct grants and grant writing assistance to community partners who care for the homeless, need food, or abuse drugs and alcohol. The hospital's community health and healthy community efforts are recognized by public health and county agencies as a cornerstone of the local safety net. Community benefit programs include: three fixed community clinics (offering prenatal and primary care) as well as a mobile medical service, education on chronic disease, women's health services (including cancer screenings well baby visits and counseling) enrollment of the uninsured into safety net health insurance, coordinating volunteer health services provided by partners, grant writing assistance and direct grants. Additionally, SJH, St. Mary is San Bernardino County Public Health's lead partner that expands community clinics serving the poor; conducts health insurance education/enrollment campaigns and partners creating a culture of "health and fitness" through four (4) local *"Healthy City"* initiatives.

In FY13 St. Mary Medical Center (SMMC), a non-profit hospital in a rural community, incurred $12,655,666 in Medicare unpaid costs—a 44% increase from FY12. The hospital provided $7,494,274 in financial assistance, and it completed 12,900 encounters. In addition, the hospital invested over $4.2M in upstream community benefit programs. In FY13 SMMC invested a total of $12,534,347 in community benefit; however, total community benefit investment was ($1,914,662) net of hospital quality assurance fee and other exchanges.

Organizational Commitment - Community Benefit Governance and Management Structure

The SJH St. Mary's Community Benefit (CB) Committee is a formal committee of the hospital's Board of Trustees (BOT) which oversees the direction of programs serving community needs. The CB Committee meets quarterly to review and discuss progress implementing community benefit programs as well as programs exclusively serving the needs of the poor. A hospital board member chairs the CB Committee. Hospital representatives include the President and Chief Executive Officer, the Vice President for Mission Integration as well as the Director of Community Health and Healthy Communities. Additionally, members include representatives from public health, community leaders with local knowledge of health and social needs and disparities in care. The committee includes a representative from one of the county's managed Medi-Cal programs. Committee activities include, but are not limited to (1) reviewing health data and community needs, (2) providing feedback on the effectiveness of hospital and community interventions, (3) discussions expanding partnerships and providing input developing interventions, and (4) serving as advocates for program support and

resources. The CB Committee reports to the hospital's BOT recommendations on how CB priorities address community needs, updates on programs assisting the poor, awards of grants and expanded collaboration at local and county levels. In FY13 the committee recruited new members to the committee engaging a breastfeeding advocate from the county's WIC program, a leader from the region's largest church and a community organizer with expertise in policies banning the local sale of synthetic marijuana (named SPICE and Bath Salts). Additionally, the committee approved a health forecasting project in partnership with the UCLA Center for Health Forecasting and was updated by Molina and Mission City on efforts opening community clinics in the old-town center of Victorville. These clinics will serve low income communities and support Covered California efforts.

Planning For the Uninsured and Underinsured

Data provided to the hospital by Inland Empire Health Plan and representatives of Covered California estimate as many as 80,000 local uninsured men, women and children. SJH St. Mary is the sole Victor Valley representative on a county-wide initiative serving the uninsured with health insurance education and enrollment services. In FY13 the hospital enrolled 410 children and its three (3) community clinics provided 38,000 patient encounters to the uninsured in the communities of Adelanto, Apple Valley, Hesperia and Victorville. The hospital supports a county-wide initiative opening community clinics with three new clinics now operating in the Victor Valley. Expansion of clinics is one strategy to address the region's access problems reported as 120 physicians per 100,000 persons the worst in California. In FY13 the hospital added in its discharge planning department a position that specializes in scheduling uninsured and self-pay patients to county run clinics and the county hospital. This new position also assists homeless patients to enroll in Social Security Disability benefits. Additionally, the hospital employs staff that enrolls patients qualifying for health insurance and other social services. Hospital staff (particularly the interpreter department rounding on limited English patients) refers uninsured/self pay hospital patients to a community enroller. In turn this enroller educates the patient on health insurance programs and connects them with local community clinics for low cost follow-up care. At least one local physician offers a monthly free clinic caring for the uninsured. The hospital reimburses physicians for providing specialty care to uninsured persons hospitalized. The hospital provides transportation to patients needing this service. The hospital teaches local partners (schools, churches, clinics) to enroll the uninsured with health insurance.

Patient Financial Assistance Program

The mission of St. Joseph Health is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they

lack health insurance. That is why SJH St. Mary has a **Patient Financial Assistance Program (FAP)** that provides free or discounted services to eligible patients. In FY13, SJH St. Mary provided **$7,494,000** in charity care serving 12,900 patients. One way SJH St. Mary informs the public of its FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible.

Community – Defining the Community

SJH St. Mary's Community Benefit Service Area is defined as serving the Victor Valley region of San Bernardino County with a total population of 430,795 as reported by 2010 U.S Census Data. The larger communities of Apple Valley, Hesperia and Victorville comprise the hospital's primary service area and the smaller communities of Adelanto, Barstow, Helendale, Lucerne Valley, Oro Grande, Phelan and Oak Hills and Wrightwood make-up the hospital's secondary service area. The hospital's primary and secondary service areas currently serve residents of three (3) of San Bernardino county's five (5) supervisory districts.

The region is 90% desert and the largest nearest metropolitan area, the City of San Bernardino, is 40 miles away. The service area is noted as having significantly higher percentages of indigent and uninsured populations when compared with both state and national levels. Additionally, residents suffer from heart disease, diabetes, adult obesity and stroke at levels well above California and national benchmarks. Over 90% of the hospital's community benefit area has been identified as "High Need" from scoring and aggregating socioeconomic indicators (e.g. income, race, family size) contributing to health disparities. With some exceptions, these health and social conditions are largely homogenous across San Bernardino County. For this reason nonprofit hospitals in San Bernardino are reporting similar increases in chronic diseases and overwhelmed safety net providers. These common challenges coupled with less funding are fostering greater collaboration between hospitals, county health agencies, universities and local governments. An example includes hospital collaboration with the UCLA Fielding School of Public Health. Medical researchers will model and forecast the prevalence of significant diseases to the year 2035 for the county and the hospital's specific service area. The project's aim is providing evidence-based data to hospitals for short and long-term strategic community benefit planning.

As mentioned the hospital's service area is comprised of four (4) major communities with some unique demographic, economic and health characteristics. The total population of the hospital's primary and secondary service area (400,000) is approximately equivalent to that in the city of Oakland. These communities have recently begun economic collaboration in response to the difficult economy and loss of redevelopment funds. Retail development has picked up for Apple Valley, Hesperia and Victorville with Adelanto lagging with little new activity. Very few new housing developments are in progress and most construction projects are commercial rehabilitation. The region is undergoing major highway and overpass improvement which improves traffic flow and provides additional economic opportunity to Apple Valley, Hesperia and Victorville. A detailed look at each community follows.

Victorville - The 50th largest city in California has a 2010 US Census reported population of 115,903. The city is approximately 74 square miles in size at an elevation of 2,726 ft. Demographic data reports 47.8% of residents are Hispanic with White 28.3% followed by Blacks at 16%. Over 30% of residents are between the ages of 0 to 19 years of age which as a percentage is larger than reported at the county level. Economic data reports the median income in Victorville is $52, 983 (among African American families just $44,767) with poverty highest (30%) in African American families followed by Hispanic (16%) and White (9%). City government addressed budget deficits with program consolidation and staff reductions. City tax revenue is returning as a result of increases in retail sales with some new housing starts. Home prices are increasing however 40% of sales are identified as "distressed," the result of bank foreclosure. The city is home to the area's major community college, Victor Valley Community College, and several for-profit colleges including Azusa Pacific and Chapman. The city continues developing an intermodal transportation hub named Southern California Logistics Airbase (SCLA) from the former George Air Force Base. The SCLA economic hub seeks major investors and employers from the aviation and manufacturing sectors. The city has formed a "Healthy Victorville" campaign in partnership with county public health, SJH, St. Mary, Desert Valley Hospital, Kaiser and Victor Global Medical Center. The campaign is urging increased city investments in policy, parks and non-motorized transportation, to improve health. The hospital partners with food pantries including The Lords Table, Samaritan Helping Hands, Victor Rescue Mission, and shelters including Family Assist, A Better Way Domestic Violence and Victor Homeless shelter to help those in crisis. Each year SJH St. Mary awards grants to several of these partners including Catholic Charities for its immigration expertise. Additionally, the hospital partners with local community clinics offering low cost health services. This includes St. John of God offering substance abuse care and Mission City clinic offering behavioral health. Health data obtained from surveying residents identifies a 3% increase to 18.9% in alcohol (binge drinking) a 1% increase to 20% in tobacco use and a 4% increase to 18.9% of residents self-reporting poor mental health. The hospital's Community Health department has its mobile medical service providing weekly

care to the area's uninsured which is now estimated at 21.7% of the population. Services of the mobile program include: primary care, immunizations, cancer screenings, diabetes care and health insurance enrollment. The hospital partners with Victor Community Dental Program with grants enabling them to provide dental care to adults and children. The hospital partners with local schools to implement family obesity programs. In April 2013 the hospital partnered with the County Health to assist the area's homeless. The hospital's support included a survey of what health and social services the homeless needed more of. Their response was employment, greater access to donated food and access to vision care. The feedback is being used by the hospital and food pantry partners to secure grant funds expanding food access. Four large pantry programs are coordinating resources to expand donated food. Additionally, one pantry has acquired property with plans of creating a comprehensive homeless care center.

Hesperia - has 90,173 residents as reported by the 2010 Census. The city is 73 square miles at an elevation of 3,186 feet. The city has no hospital and residents are dependent on accessing acute care at Victorville and Apple Valley hospitals 10 to 15 miles away. There are a reported 26,431 households with 21.9% of black families living in poverty followed by 20.9% for Hispanic and 9.6% for White families. These poverty rates are higher than county and state levels. Household income is $51,676, (lower than county and state levels) with Hispanic family income reported at $42,897, Black at $49,185 and White at $61,795. An estimated 35.8% of residents are between the ages of 0-19 years of age a higher percentage than reported at the county and state level. The percentage of students who are reported as overweight/obese is 41% slightly higher than the county and state ratings of 39.3% and 38% respectively. Hesperia is in the early stages of a "Healthy Hesperia" campaign that includes city representatives, public health, SJH St. Mary and representatives from the school and park and recreation districts. The city has started a weekly farmers market, invested in additional miles of bicycle lanes and is the only city supporting breastfeeding with a designated room in its City Hall. The hospital works closely with Hesperia school district to enroll uninsured children and to run obesity programs. The school district has one of the most engaged Spanish speaking parent groups which partners with the hospital to promote health literacy, nutrition and health insurance enrollment campaigns. The hospital partners with the Victor Valley Transportation Authority (VVTA) with regard to public transportation and health care access. VVTA has a dedicated bus route enabling residents of Barstow to access St. Mary for health services not provided at its community hospital. Additionally, VVTA is piloting a twice weekly bus route to Arrowhead County Hospital a distance of approximately 40 miles. This service is intended to enable low income patients (enrolled in the county's "Arrow Care" health insurance program) to access health services at the county hospital. The hospital is partnering with public health to increase the volume of uninsured patients cared for at its Hesperia Federally Qualified Health Center. The hospital schedules uninsured patients requiring a physician's follow-up care at the clinic. The hospital's Community Health

department operates a clinic providing uninsured persons primary care, immunizations, well baby visits, cancer screening services, counseling and education, and diabetes self care. The hospital has also begun assisting a faith based program operated from Holy Family Church to conduct resident organizing on immigration reform. The hospital has advocated to city leaders its concern about approving liquor and tobacco licenses on streets where availability is prevalent. The hospital provides grant support to a community garden that donates its produce to local food pantries. The hospital partners with a Hesperia physician who provides pro-bono care to uninsured patients at a monthly clinic. The physician has been nominated with the hospital's 2013 Justice Award for this work.

Apple Valley - has 69,135 residents as reported by the 2010 Census. The Town is 73.5 square miles at an elevation of 2,946 feet with 23,598 households with 69% White, 29.2% Hispanic and 9.1% Black and 2.9% Asian. Approximately 31% of residents are between the ages of 0-19 years just higher than the county average and residents aged 50 to 85 years (a total of 35%) make up a higher percentage of residents than reported at the county and state level. The senior community has a high prevalence of adult obesity, problems accessing specialty care, diabetes and physical limitations. Asian household income is reported at $86,719 which is higher than county and state levels. Median household income is $56,547 which is higher than the county but lower than the state level. Hispanics and Blacks suffer unemployment rates of 17.0% and 20.9% respectively, nearly double the 9% rate for White residents. The Town of Apple Valley was the first community to begin a Healthy City campaign. As a key partner the Town has received grant funds to expand park and recreation programs, develop health promotion policies and install exercise equipment in neighborhood parks. The hospital sponsors several fitness events each year. SJH St. Mary works closely with the school district and two school-based family resource centers to enroll the uninsured and jointly run obesity programs. The hospital hosts Catholic Charities on its campus enabling patients and residents in crisis to receive food, utility and housing vouchers. The hospital supports the town's Police Activity League with grants. The PAL program serves at-risk youth with mentoring and physical activity resources and provides parenting education. The hospital operates a community clinic serving uninsured residents with primary care, education and counseling, immunizations, health insurance enrollment, diabetes self-care, well baby visits, breastfeeding support and cancer screening services. The hospital has provided senior residents a free care center catering to their health, education and social needs. This "Senior Select" program reports the largest membership in the region offering weekly educational programs. The hospital works with United Way in support of local nonprofit programs and to implement health insurance enrollment campaigns at schools and health fairs. The hospital partners in a senior health fair with Apple Valley Fire District and a family disaster education program with the LDS church. The hospital is on the board of the Chamber of Commerce.

Adelanto – has 31,765 residents as reported by the 2010 Census. The city is 56 square miles and at an elevation of 2,871 feet with 58.3% Hispanic, 43% White 20% Black. There are 7,809 households. Over 40% of residents are between the ages of 0 to 19 years several percentage points higher than county and state levels and conversely, fewer residents are aged 50 years and older than what is reported at county and state levels. Median household income is $41,475 with Black families earning the lowest - only $28,310 which is almost half the county and state rate for Black households. Unemployment is 15.75% and as high as 28.8% for households of two or more races. The city has few employers, no high school or college, very few retailers generating sales tax revenue and it has several prisons. Only 11.5% of residents are reported to have attained college degrees significantly less than the county and state levels. The hospital works closely with City leaders who recently formed a Healthy City campaign. This campaign includes city, hospital and nonprofit representatives as well as school leaders. Projects have included the expansion of a local park with new playground equipment and the region's only SPICE and Bath Salt ordinance. This city regulation prohibits the local sale of "Synthetic Marijuana" subject to the loss of one's business license. The hospital operates a community clinic serving low residents and partners with schools with family obesity programs. The hospital also provides grant funds allowing a food pantry to acquire and distribute donated fruits and vegetables. The hospital provides grant support to programs serving youth including a Boys and Girls Club. Additionally, the hospital helps fund a summer swim program at the only public pool in the community. The hospital's influence in the community is significant given its smaller size and the high needs residents face. The hospital successfully partnered with Molina to open a community health clinic and Catholic Charities to open a field office. The Catholic Charities staff is providing services to persons who have family members detained in a local Immigration and Custom's Enforcement Center (ICE) operated by the US Department for Homeland Security. The hospital is working with city leaders on the expansion of fresh produce as a Healthy City project. The hospital is an executive member of its Chamber of Commerce.

Barstow - has 22,639 residents as reported by the 2010 Census. The city is located midway between Los Angeles and Las Vegas and is 41 square miles in size at an elevation of 2,178 feet. There are 8,085 households with 52% White, 42% Hispanic and 14% Black. Economic data indicates 27% of families live below the federal poverty level with the highest levels reported in households with young children. Black families have the highest rates of poverty at 29.2% followed by Hispanic at 23% and Whites at 16.9%. The city is 31 miles east of SJH St. Mary. Barstow has a 30 bed hospital providing its residents 24 hour Emergency Room services, as well as OB and respiratory care. Patients with specialty care needs travel to SJH St. Mary for treatment. The community is supported with a public health clinic offering some primary and behavioral health services, immunizations and health education. The county continues to work to obtain federal funding to operate as a Federally Qualified Health Center. The hospital partners with Desert Manna Homeless and Food Pantry program the lead agency

serving the homeless and hungry of several smaller desert communities including: Baker, Hinkley and Landers. The hospital has been developing grant opportunities to expand the delivery of donated food to households in need. This desert region supports virtually no local produce so transportation of donated food is essential to programming. Desert Manna was recently awarded a refrigerated truck enabling it to travel consistently to the county's Food Bank, a roundtrip distance of 110 miles. The hospital has also worked with leaders at Barstow Community Hospital and County Public Health to designate the area as a "Medically Underserved Area" for purposes of obtaining grants, starting a FQHC clinic and assisting with physician recruitment.

Community Needs & Assets Assessment Process and Results

Summary of Community Needs and Assets Assessment Process and Results

The hospital's community health assessment is one of the region's most comprehensive. As the Victor Valley's only local nonprofit hospital, numerous social agencies rely on its data for grant writing. The hospital's collection of primary data obtained directly from hundreds of residents provides a local health profile not duplicated by other health assessments. The hospital conducts its assessments in consultation with St. Joseph Health (SJH) and contracts with Professional Research Consultants (PRC) a national leader with health surveys. Survey results are shared with community partners including a collaboration of hospitals and public health officials, leaders from numerous service organizations, residents, and representatives from local government. The hospital employs a mapping process to identify high need neighborhoods where health disparities will be the most severe. This mapping process was developed by Catholic Healthcare West and is known as a Community Needs Index. The quantitative process involves aggregating five socioeconomic indicators: resident income, culture, education, insurance and housing to identify communities with high need. The hospital uses these community need maps in selecting areas to target grants, operate programs serving residents and recruit partners. The hospital has advocated that its community health needs assessment process be used to identify and target communities across the county where high disparities are barriers to health, social and economic improvement.

Primary health data is collected using a 156 question community health survey based on the CDC's Behavioral Risk Factor Surveillance System (BFRSS). PRC works with the hospital to develop a sampling plan representative of the region's population and large enough to be statistically stable. In 2011 the number of local households sampled via a telephone survey was 750. The hospital's health data is shared with numerous partners including other hospitals (as part of Community Benefit collaborative established by the Hospital Association of Southern California), nonprofit partners seeking data for grant writing, Medi-Cal providers, residents, physician partners and representatives of local government. Resident feedback is

obtained by focus groups including additional paper-based surveys of low income and homeless persons.

Findings from the PRC health survey identified health priorities and recommended areas of intervention. These recommendations were based on data gathered through the assessment and the guidelines set by Healthy People 2020. In several cases the prevalence of disease in the hospital's secondary service area is higher as a result of residents encountering barriers to accessing care. The findings of the health survey were discussed by the Community Benefit Committee and with community leaders to identify priorities. Findings were shared with the county's public health department to continue advocacy for community clinics and shared with city leaders to advocate for creation of local Healthy City campaigns. Four Healthy City campaigns are now in place. Finally, data was provided to residents for discussion and education and with community partners for the purposes of securing grant funds. Resident feedback was conducted in Adelanto, Apple Valley and Victorville in English and Spanish. Residents remain concerned that more good paying jobs is the region's number one social condition and increasing educational attainment and improved transportation is also ranked high.

Significant Health and Social Conditions and Hospital Response addressing needs

Areas of Opportunities identified by 2011 Community Health Needs Assessment and response by hospital
***Access to Healthcare –** Lack of insurance, Difficulty Accessing HealthCare Services, Emergency Room Utilization, Perceptions of local healthcare services **(Response – open clinics and expand clinic care)** * Priority Program chosen by hospital and community
Cancer – Deaths (Lung, Prostate, Female Breast, Colorectal) (**Response – continue screenings for low income)**
***Diabetes –** Deaths, Prevalence **(Response – comprehensive program serving the uninsured) *** Priority Program chosen by hospital and community
Disability – Activity Limitations **(Response – support four local Healthy City campaigns)**
Dementias – Alzheimer's Disease Deaths **(Response – new support group in Senior Program)**
Education – Attendance at Health Promotion Events **(Response – Healthy City campaigns)**
Family Planning – Birth to teens **(Response - selective support of Planned Parenthood)**
Heart Disease & Stroke – Deaths, Hypertension **(Response – Cardiac Health campaign including AHA partnership)**
Injury & Violence – Motor Vehicle Crash Deaths, Firearm-related Deaths, Homicides, Violent Crime, including Domestic Violence **(Response – Healthy City campaigns promote safety in policies, grants to shelters)**
***Maternal & Infant Health –** Prenatal Care & Low Birth-weight **(Response – improve maternal care programs including behavioral health and breastfeeding) *** Priority Program as chosen by hospital and community partners
***Nutrition & Overweight** – Fruit & Vegetable Consumption, Overweight/Obesity **(Response – child obesity and Healthy City campaigns) *** Priority Program chosen by hospital, community and Public Health Dept.
Oral Health – Dental Visits (Adults) **(Response – support partner expansion of dental services including effort to integrate in area's only FQHC)**
Respiratory Disease – Chronic Lower Respiratory Disease Deaths, Pneumonia/Influenza Deaths (**response – Healthy City campaigns promoting fitness and exercise, reduce prevalence of licensed tobacco outlets)**
Substance Abuse – Cirrhosis/Liver Disease Deaths **(Response – Healthy City campaigns – support St. John of God's inpatient substance abuse treatment programs; reduce prevalence of licensed alcohol outlets)**
Vision – Blindness/Trouble Seeing, Routine Vision Care **(Response – support local Lions Club with its vision program)**

An asterisk * denotes a priority program in the hospital's FY12-FY14 Community Benefit Plan. Priority programs are developed to achieve measurable outcomes. Grant funding is also prioritized to these programs.

Identification and Selection of DUHN Communities

Communities with Disproportionate Unmet Health Needs (DUHN) are defined by zip codes and census tracts where underlying economic and social barriers affect the overall health of the community and where the prevalence and severity of disease is higher than the general population within the hospital's service area. Rather than relying solely on health data, SJH St. Mary uses a Community Needs Index (CNI) to pinpoint neighborhoods by scoring five (5) prominent barriers: percentage of population that is elderly and living in poverty, what percentage of the population is unemployed, education attainment, and percentage of persons with health insurance the culture and language of the population. A score of 1.0 indicates the lowest socio-economic barriers, while a score of 5.0 represents an area with significant barriers. Health research between CNI scores and hospital utilization show a correlation between high need and high use. For this reason SJH St. Mary targets community benefit resources to these communities using its advocacy, health programs and grants to address as many determinants of health as possible. Listed below are communities with CNI scores of 5.0 including key community needs and assets the hospital works with.

DUHN Group and Key Community Needs and Assets Summary Table

DUHN Population Group or Community	Key Community Needs	Key Community Assets
Residents living in north Adelanto	*Expand availability of health and social services for disparities in care; enroll the uninsured* *Expand availability of employment opportunities addressing poverty* *Improve transportation services for low income persons accessing care* *Address food insecurity, obesity, diabetes; increase availability of complete streets, park and recreation programs, to spur physical activity*	*Public Health, Molina & St. Mary Clinics Catholic Charities & Adelanto Schools City of Adelanto, Healthy Adelanto Campaign, Chamber of Commerce, Victor Valley Transit Authority, Boys & Girls Club of Victor Valley, High Desert Outreach Center, Christ the Good Shepherd Church, San Bernardino County Pre-School Dept., Victor Union High School District, Institute for Public Strategies, Women, Infant and Children program, San Bernardino County First 5.*
Residents living in Yucca Loma and Vista Loma communities of Apple Valley including residents between Navajo and Central.	*Expand access to health and social services for disparities in care; enroll the uninsured* *Expand education and employment opportunities addressing poverty* *Food insecurity, obesity, diabetes Increase availability of parks, recreation programs, complete streets and bike lanes to spur physical activity*	*St. Mary Clinic, Catholic Charities, Apple Valley Schools, Paul Swick Family Resource Center, Phoenix Academy Family Resource Center, Feed My Sheep Food Ministry, Our Lady of the Desert Church, Apple Valley Sheriff, Town of Apple Valley, Healthy Apple Valley Campaign, San Bernardino County Pre-School Services Department (Head Start), Sunset Hills Foundation, San Bernardino County Public Health, Police Activities League.*

DUHN Group and Key Community Needs and Assets Summary Table (cont'd)

DUHN Population Group or Community	Key Community Needs	Key Community Assets
Residents living in City of Hesperia in particular residents in village of Hesperia; excludes communities of Oak Hills	*Expand availability of health and social services for disparities in care; enroll the uninsured* *Expand availability of employment opportunities addressing poverty* *Improve transportation services for low income persons accessing care* *Address food insecurity, obesity, diabetes* *Increase availability of complete streets, park and recreation programs, to spur physical activity*	*San Bernardino County Public Health, St. Mary & La Salle Clinics, High Desert Primary Care, Hesperia Schools, City of Hesperia, Healthy Hesperia Campaign, Hesperia Chamber of Commerce, Victor Valley Transit Authority, Hesperia Park and Recreation District, Holy Family Church, San Bernardino County Pre-School Dept., Institute for Public Strategies, Community Health Action Network, Dr. Aparna Sharma, Dr. Arvind Salwan.*
Residents living in old town Victorville from D street up 7th street to Highway 15	*Expand access to low cost health and social services addressing disparities in care; enroll the uninsured;* *Expand education and employment opportunities addressing poverty* *Food insecurity, obesity, diabetes* *Increase availability of parks, recreation programs, complete streets and bike lanes to spur physical activity*	*Mission City and St. Mary Clinics, St. John of God and Samaritan Helping Hands, The Lords Table, St. Joan of Arc Church, City of Victorville, Healthy Victorville campaign, County Public Health, Desert Valley Hospital, Victor Global Medical Center, Victorville Chamber of Commerce, Feed My Sheep Food Ministries, Victor Rescue Mission, Community Action Partnership of San Bernardino County, Mission City Clinic Network, Victor Valley Services Dental Program, Molina Health, Victor Community Services Council.*
Low income residents living in Barstow; residents needing specialty health services	*Expand low cost health services* *Expand food to homeless*	*San Bernardino County Public Health Department, Barstow Community Hospital, Victor Valley Transport Authority, Desert Manna Food and Homeless Program, Community Action Partnership of San Bernardino County, Barstow School District*

Priority Community Health Needs

After collecting regional and local feedback on health and social needs the following priorities were identified. By addressing (1) Access to care, the hospital could assist in a region-wide effort to expand access and meet a local need of Adelanto residents that additional health services were needed to address high rates of obesity and diabetes. Additionally, the opening

of community clinics would assist hospitals to reduce high patient volumes in Emergency Rooms. By selecting (2) Obesity, the hospital was addressing a significant health identified from the CHNA. Additionally, the hospital had expertise addressing obesity. Finally, the selection of obesity aligned with a public health campaign to address weight and heart disease on a county-wide basis. The hospital's selection of (3) Breastfeeding, was selected to improve maternal outcomes; improve the hospital's Baby Friendly efforts while also addressing child health and obesity. The hospital's work with Breastfeeding continued a regional collaborative created when the hospital obtained its Baby Friendly designation. The selection of (4) Diabetes, was the result of the disease identified as a significant health issue from the CHNA and feedback from a managed Medi-Cal insurance provider (IEHP) that uncontrolled diabetes was resulting in patients making multiple visits to local hospital emergency rooms. Additionally, residents in Adelanto identified the need for better diabetes care during their advocacy for more local health providers. The hospital did not select creating new jobs which in 2008-09 was commonly cited because of the poor economy. Likewise the hospital did not prioritize working to open Adelanto's first high school given this expertise lies with the Victorville High School District. The list below outlines the hospital's work with its priority programs.

- ***Access to Care – Two (2) new clinics serving the poor and providing critical services***

  A new community clinic opened in old-town Victorville by Mission City Community Network (MCCN). The MCCN clinic provides low cost primary care and behavioral health twice a week – approximately 20 patients. Patient referrals are in place with the hospital and the county's behavioral health department. Molina Health will open their second local clinic. The clinic will be located in the poorer section of Victorville, feature 10 exam rooms and be opened by October. Molina's Adelanto clinic now serves 300 patients per month. Efforts referring patients needing follow-up care has improved between the hospital and county health. In the most recent six month period the hospital has connected 600 uninsured patients to local community clinics or the county hospital for follow-up care. County public health and MCCN improved their admissions process allowing these patients obtain better care.

- ***Breast Feeding – recognized by Public Health for excellence in Baby Friendly work***

  Representatives from San Bernardino County public health, WIC and a county-wide breastfeeding coalition recognize the hospital's breastfeeding outreach as the most comprehensive in the region. The program is achieving 80% compliance (within the hospital) following the 10 Steps of Baby Friendly while also improving the percentage of mothers providing breast-milk to their children. The program received grant funding from the county's First 5 Commission to expand breastfeeding education, lactation support and to increase access to breast pumps for mothers whose infants are admitted to the hospital or as recommended by their physician for supplemental feedings.

- ***Child Obesity - 30% of at-risk children benefit; program to be expanded by county***

  30% of at-risk children tracked in a school based intervention dropped one weight classification by year end. The obesity program is the largest campaign (257 children) in San Bernardino County and considered a model intervention by public health and Loma Linda Medical Center. As a result, the county's Pre-School Services Division (PSD) (which provides Head Start education to 6,000 low income children county-wide) will expand the campaign across its programs. The hospital is assisting PSD and new partners on piloting efforts. Approximately 20% of PSD's total child enrollment (6,000) is projected to be overweight or obese (n=1,200). In response to increased rates of adult obesity (from 27% to 33.9%), the hospital will begin tracking and reporting Body Mass Index measures of parents.

- ***Diabetes – the most comprehensive program serving uninsured Diabetes***

  The hospital's comprehensive program (across 5 clinic sites) continues providing ongoing care to 186 uninsured diabetes with a goal of increasing those who have an HgA1C less than 7. The prevalence of diabetes regionally has increased 3.9% to 15.3% in 2012 as reported in the hospital's CHNA. Prior to starting this program none of these patients had any recommended screening exams for diabetes. The program has increased the percentage of uninsured diabetes completing annual screenings to 29%, with 94% completing Hemoglobin A1c, 29% completing an annual dilated eye exam and 98% completing a foot exam.

COMMUNITY BENEFIT PLANNING PROCESS

Summary of Community Needs Assessment Process and Results

SJH St. Mary conducts community needs assessments following a standard process developed by SJH. Primary and secondary health data is collected after developing a sampling plan for data determined to be representative of the hospital's service area. The typical sampling plan has included collection of data from randomized telephone calls to between 400 to 750 local households. The hospital partners with Professional Research Consultants (PRC) to conduct the survey analyze results and report health data. Primary data is collected and compared with secondary health data collected at the county, state and national levels including measures established in Healthy People 2020. The hospital is a lead member of a health assessment collaborative with representatives from county government, public health, Loma Linda Medical Center, UCLA Health Forecasting project and other hospitals. The hospital presents findings from its health assessment to Public Health leaders in a focus group setting. The hospital partners with High Desert Resource Network and engages up to 50 local nonprofits and social organizations. Leaders of these agencies assist the hospital to prioritize significant health findings as well as social and economic concerns. The hospital partners with local agencies to conduct focus groups with residents living in DUHN communities. The hospital partners with SJH in developing a CNI to identify neighborhoods with the highest

barriers to care. The focus group sessions conducted in the DUHN communities are conducted in English and Spanish and facilitated to discuss health findings and the pressing social and economic needs of the resident's community. The process of collecting and analyzing health data and conducting feedback sessions at the county, local and neighborhood levels enables the hospital to identify regional and community specific needs. For example, health data reporting higher levels of child and adult obesity was presented to the public health who in turn offered to partner with resources and funding to address the problem regionally. Focus group sessions with non-profit leaders identified access to care as a key issue across the hospital's service area. Community feedback sessions in Adelanto highlighted the need for more comprehensive diabetes care as well as increased access to parks, recreation and healthy foods. SJH St. Mary anticipates that implementation strategies may change and therefore a flexible approach is best suited for the development of its response to CHNA findings. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by SJH St. Mary in the enclosed CB Plan/Implementation Strategy.

Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. We are committed to continue our Mission through community benefit programs and by funding other non-profits through our Care for the Program managed by St. Joseph Health. Furthermore, SJH St. Mary will endorse local non-profit organization partners to apply for funding through the St. Joseph Health, Community Partnership Fund. Organizations that receive funding provide specific services and resources to meet the identified needs of underserved communities through St. Joseph Health communities. The table below is a partial example of local programs that received funding to address health and social needs.

Grant Assistance to meet other Community Needs

Area of Need	Partner	Grant Award
Homelessness/Domestic Abuse	A Better Way Domestic Violence Shelter – old town Victorville	$25,000
Homelessness/Food/Utility Assistance	St. John of God HealthCare Services – old town Victorville	$25,000
Dental services for low income families	Victor Community Services Dental Program – High Desert wide	$75,000

ST. MARY MEDICAL CENTER
FY12 – FY14 Community Benefit Plan/Implementation Strategies
FY13 Accomplishments

Initiative: *ACCESS TO CARE*

Description: *recruit and support opening of community clinics serving low income and uninsured in the Victor Valley region of San Bernardino County.*

Key Community Partners: *San Bernardino County Public Health, Community Clinic Association of San Bernardino County, Molina Health, Mission City Community Network, City of Victorville, Victor Global Medical Center, Healthy High Desert, and Daily Press Newspaper.*

Goal (Anticipated Impact[2]): *assist opening four (4) community clinics by FY14. Future CHNA report a decrease in patients using hospital Emergency Rooms two or more times as year.*

Target Population (Scope): *poor and uninsured persons living nearby new clinic and uninsured persons discharged from hospital needing a medical home for follow-up care.*

How will we measure success? Outcome Measure (Evaluation Plan[3]):
Number of clinics opened, number of patients seen at clinics, clinic services meeting needs of low income patients.

Three-Year Target: 4 community clinics open

Strategy 1: Recruit clinic partners willing to open clinics in DUHN communities
Strategy Measure 1: 10 partners

Strategy 2: Recruit local stakeholders for advocacy and patient referral
Strategy Measure 2: 10 local partners per clinic

Strategy 3: Patient volume at clinics
Strategy Measure 3: Increase patient volume at clinics

FY13 Accomplishments expanding Access to Care:

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[2] **Anticipated Impact** is equivalent to **Goal**. Language is used for clarity with regard to IRS Proposed Rule (2013)
[3] **Evaluation Plan** is equivalent to **Outcome Measure**. Language is used for clarity with regard to IRS Proposed Rule (2013)

The hospital recruited the clinic expertise of (1) Mission City Community Network and (2) Molina Health to old-town Victorville. This area has been designed a DUHN community in the hospital's health assessment. Molina is actually opening its second clinic after its Adelanto clinic started in early 2012. Both new clinics will be serving persons on Medi-Cal or the uninsured with a sliding scale fee. Molina's Victorville clinic will include ten (10) exam rooms and the partner is aggressively marketing their services to the uninsured as part of Covered California. Partners referring patients to Molina include: St. Mary's Healthy Communities Department, Adelanto School District, Community Health Action Network, and Victor Community Dental Services Program. Mission City has opened a community clinic across from Victor Global Medical Center and is providing primary care and behavioral health services once a week. Partners referring patients to this clinic include: SJH St. Mary's Case Management and Community Health Departments, San Bernardino County Department of Behavioral Health, St. John of God Healthcare Services, Victor Community Dental Services Program, Victor Community Services Council and Inland Empire Health Plan. The Mission City clinic is staffed with a psychiatrist once a week with a caseload of 20 patients. The Molina clinic in Adelanto reports a monthly caseload of 300 patients. The hospital will work with Molina to create referral partners and targets inpatient volume in FY14. Molina's Victorville clinic is expected to open in October. The hospital reports the percentage of persons self reporting using hospital Emergency Rooms two or more times per year has declined from 10.5% in 2007 to 9.7% in 2012. While positive, the region is still higher then the southern California region reported at 4.9% and the national level reported at 6.5%. (Data source: 2012 PRC health assessment southern California region).

Initiative: ***BREASTFEEDING***

Description: *Lead by the community health department, the program builds upon practices the hospital put in place when it achieved Baby Friendly designation. The program focuses on (1) hospital maintains 80% compliance on following the 10 STEPS of Baby Friendly, and (2) the percentage of mothers providing breast milk to their infants at six months increases. The program achieves the first objective by training and rounding on hospital staff and providing education to new mothers during their hospital stay. Once discharged the program tracks mothers for follow-up and provides outpatient education and lactation support. In FY13 the program reports increasing the percentage of mothers providing breast milk to their infants at six months to 35% (an increase from 25% reported in FY12). The program has surpassed the 29% goal established in increasing breastfeeding rates. (For 2010 WIC reports an exclusive breastfeeding rate for San Bernardino County at 58.7%).*

Key Community Partners: *Hospital nurses in Labor and Delivery, San Bernardino County Public Health and Women Infant and Children's program, Loma Linda Medical Center, First 5 of San Bernardino, and Inland Empire Breastfeeding Coalition.*

Goal (Anticipated Impact[4]): *Maintain Baby Friendly practices; increase breastfeeding to infants up to six months to 29% by FY14.*

Target Population (Scope): *Mothers and newborns discharged from hospital.*

How will we measure success? Outcome Measure (Evaluation Plan[5]): *The percentage of mothers self-reporting they provide breast milk to infants at least 50% of feedings at six months. The development of other breastfeeding education and tracking programs offered to the community. Health data indicating that breastfeeding rates in the area have achieved the Healthy People 2020 target of: 60% of infants breastfed at six months.*

Three-Year Target: *Increase breastfeeding at six months to 29% or higher.*

Strategy 1: *Maintain Baby Friendly practices on inpatient units and prenatal clinic.*
Strategy Measure 1: *Number of Baby Friendly 10 STEPS with 80% compliance or greater.*

Strategy 2: *Provide professional and peer support for breastfeeding mothers.*
Strategy Measure 2: *% of mothers providing breast milk at feedings at one month after delivery.*

Strategy 3: *Educate mothers prenatally about lactation.*
Strategy Measure 3: *the number of women who receive education prenatally.*

FY13 Accomplishments improving Breastfeeding:
The hospital's program has been recognized as a health promotion best practice by San Bernardino County Public Health, WIC and members of a county-wide breastfeeding coalition. The program is the only regional effort that systematically tracks and reports breastfeeding rates in the region. In FY13 the program's focus has been prenatal education and post discharge follow-up by Certified Lactation Consultants. These efforts have increased the percentage of mother's breastfeeding their infants at six months from 25% to 35% in 2012. The program received first time grant support from the county's First 5 Commission to increase access of breast pumps. The Healthy Hesperia campaign reports the establishment of a designated breastfeeding room for employees within its city building, a first for the region. Breastfeeding experts from WIC have been added to the hospital's Community Benefit Committee to facilitate collaboration between the programs.

Initiative: ***DIABETES***

Description: *Provide comprehensive diabetes care to uninsured persons with the primary diagnosis of Diabetes across five clinic sites.*

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[4] **Anticipated Impact** is equivalent to **Goal**. Language is used for clarity with regard to IRS Proposed Rule (2013)
[5] **Evaluation Plan** is equivalent to **Outcome Measure**. Language is used for clarity with regard to IRS Proposed Rule (2013)

Key Community Partners: *Inland Empire Health Plan, St. Joseph Orange and Puente de la Salud clinic.*

Goal (Anticipated Impact[6]): *Increase the percentage of diabetic patients with an HgA1C less than 7.*

Target Population (Scope): *Uninsured and low income persons with a primary diagnosis of Diabetes.*

How will we measure success? Outcome Measure (Evaluation Plan[7]):
Number of Diabetic patients with HgA1C less than 7; increasing percentage of patients meeting recommended screening requirements of annual eye and foot exams. The development of comprehensive diabetes programs by community partners. Community health data reporting the prevalence of diabetes and patients with diabetes are achieving targets established by Healthy People 2020 – achieving 10% reduction in diabetes prevalence and 10% decrease in the proportion of diabetics with HgA1c values greater than 9.

Three-Year Target: *Increase percentage of diabetic patients with HgA1C less than 7.*

Strategy 1: *Increase access to Medical Care.*
Strategy Measure 1: *% of patients completing all recommended annual screenings.*

Strategy 2: *Increase Access to Nutrition Therapy.*
Strategy Measure 2: *% of patients with 5% weight loss in six months.*

Strategy 3: *Increase Access to Diabetes self-management education.*
Strategy Measure 3: *number of participants in support classes.*

Strategy 4: *Increase accuracy and completeness of program data reporting.*
Strategy Measure 4: *% of data entered into patient database.*

FY13 Accomplishments addressing Diabetes in low income and uninsured:
The program served 186 uninsured and low income patients with a primary diagnosis of Diabetes. Patients were identified for the program from the five clinics operated by the hospital's Community Health department. Prior to care at these clinics, none of these patients had any of the recommended screening exams for diabetes including: a Hemoglobin A1c, a dilated eye exam or an annual foot exam. At year end 29% of patients had completed all three

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[7] **Evaluation Plan** is equivalent to **Outcome Measure**. Language is used for clarity with regard to IRS Proposed Rule (2013)

screening exams with 94% completing a Hemoglobin A1c measurement <7, indicating improved control of their chronic disease. Establishing a partner clinic at St. Joseph Orange, Puente de la Salud was significant to provide eye exams. The program now seeks grant funds as the only regional Diabetes program serving the poor.

Other Community Benefit Programs

Program: *Providing specialty care to uninsured persons hospitalized for care.*

Description: *Reimbursement to physicians caring for uninsured persons admitted to hospital.*

Key Community Partners: *Local Cardiologists and Surgeons.*

Goal (Anticipated Impact[8]): *Uninsured patients receive health care equal to those with health insurance.*

Target Population (Scope): *Uninsured persons.*

How will we measure success? Outcome Measure (Evaluation Plan[9]):
# of patients provided care.
A future date when all persons have a source of health insurance to pay for their care.

FY13 Accomplishments:
The percentage of uninsured patients has increased to 21.9% according to the hospital's 2012 CHNA. In partnership with physicians, health services are provided to uninsured persons who have no source to pay. Each month the hospital reimburses physicians (from a charity care pool) for providing care to the uninsured at a rate of 120% of Medicare. The most common need is cardiology care.

Program: *Providing transportation services to patients.*

[8] **Anticipated Impact** is equivalent to **Goal**. Language is used for clarity with regard to IRS Proposed Rule (2013)
[9] **Evaluation Plan** is equivalent to **Outcome Measure**. Language is used for clarity with regard to IRS Proposed Rule (2013)

Description: low income persons need transportation upon hospital discharge to their home or to their next source of care. The hospital contracts with several local transportation companies to facilitate the transportation needs of patients. Approximately 80% of travel is local in the region with the remaining 20% out of the region in order to access specialty care or the services of the county hospital located 40 miles away.

Key Community Partners: *local contracted medical transportation companies.*

Goal (Anticipated Impact[10]): *Low income patients access social and health services with assistance of transportation paid by hospital.*

Target Population (Scope): *Low income, uninsured persons, the homeless, elderly patients with no local family support.*

How will we measure success? Outcome Measure (Evaluation Plan[11]):
# of patients needing services per month; patients accessing services as needed; cost per month.

FY13 Accomplishments:
The need to assist the poor needing transportation continues. In a recent survey of 45 local nonprofits, improved transportation was identified as a key need across the region. Although the local transportation authority (VVTA) has started a bus service from the region to/from Arrowhead Medical Center (the county hospital) persons needing local transport is chronic. The hospital is partnering with VVTA to look at options to improve the transport of persons needing medical care. It has been reported that patients needing specialized wound care services (in order to prevent amputation) have reported "no transportation" as a reason for missing treatments.

[10] **Anticipated Impact** is equivalent to **Goal**. Language is used for clarity with regard to IRS Proposed Rule (2013)
[11] **Evaluation Plan** is equivalent to **Outcome Measure**. Language is used for clarity with regard to IRS Proposed Rule (2013)

FY13 Community Benefit Investment

FY13 COMMUNITY BENEFIT INVESTMENT
St. Mary Medical Center
(ending June 30, 2013)

CA Senate Bill (SB) 697 Categories	Community Benefit Program & Services[12]	Net Benefit
Medical Care Services for Vulnerable[13] Populations	Financial Assistance Program (FAP)	$7,494,274
	(Charity Care-at cost)	
	Unpaid cost of Medicaid[14]	($13,702,090)
	Unpaid cost of other means-tested government programs	-
Other benefits for Vulnerable Populations	Community Benefit Operations	$0
	Community Health Improvements Services	$220,104
	Cash and in-kind contributions for community benefit	$937
	Community Building	-
	Subsidized Health Services	$3,841,211
	Total Community Benefit for the Vulnerable	***$4,062,252***
Other benefits for the Broader Community	Community Benefit Operations	$183,996
	Community Health Improvements Services	$26,068
	Cash and in-kind contributions for community benefit	$303
	Community Building	$20,413
	Subsidized Health Services	$0
Health Professions Education, Training and Health Research	Health Professions Education, Training & Health Research	$122
	Total Community Benefit for the Broader Community	***$230,902***
	TOTAL COMMUNITY BENEFIT ***(excluding Medicare)***	($1,914,662)
Medical Care Services for the Broader Community	Unpaid cost to Medicare[15] ***(not included in CB total)***	$12,655,666

[12] Catholic Health Association-USA Community Benefit Content Categories, including Community Building.
[13] CA SB697: "Vulnerable Populations" means any population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medicaid, Medicare, California Children's Services Program, or county indigent programs. For SJHS, we exclude Medicare as part of Community Benefit total and only include it below the line for SB697 reporting purposes.
[14] As a rural hospital, St. Mary Medical Center is reimbursed via the Hospital Fee program. This exchange enables SMMC to recover costs from a low reimbursement of Medicaid. In FY13 SMMC invested a total of $12,534,347 in community benefit; however, total community benefit investment was ($1,914,662) net of hospital quality assurance fee and other exchanges.
[15] Unpaid cost of Medicare is calculated using our cost accounting system. In Schedule H, we use the Medicare cost report.

Telling Our Community Benefit Story: Non-Financial[16] Summary of Accomplishments

Hospital employees volunteer and serve in the community. Examples include executives serving on the boards of St. John of God Health Care Services, Victor Community Services Council, The United Way, Victor Community Dental Program, Desert Trails School Board, The Apple Valley Police Activity League and the Chambers of Commerce in Adelanto and Apple Valley. At the county level, hospital staff represents the region on initiatives including education and enrollment of the uninsured, the development of a county-wide effort to improve health and recruit physicians to the region, a health career program enabling MPH students to obtain Health City experience on policy and high school students to complete volunteer internships. Hospital employees are also mentoring at-risk children at local schools and donating food and clothing to partners serving the needy. Additionally, hospital staff donates their expertise and offers free education on diabetes including education on self care and dancing. Employees donate time in a Healthy Apple Valley campaign to promote heart care. Event proceeds are invested by the Town to install exercise equipment at local parks. The hospital is a sponsor of the area's largest free 5K run, walk and skate event sponsored by Healthy Hesperia. The hospital used advocacy and grant funds to expand a park and community garden in Adelanto. The hospital runs a twice monthly farmers market open to employees and the public. The hospital is donating two of its old medical vans to the Lastonnac Clinic to use as health clinics in poorer neighborhoods in Orange and Riverside Counties. The hospital is a member of the Bishop's Health Committee at the Diocese of San Bernardino and Riverside Counties. This committee concerns itself with promoting health and justice assisting the poor. Throughout the year the hospital and employees conduct food and clothing drives that are supporting local programs serving the poor.

[16] Non-financial summary of accomplishments are referred to in SB 697 as non-quantifiable benefits.