St. Joseph Health, St. Mary Medical Center

Fiscal Year 2014 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 values of St. Joseph Health -- Service, Excellence, Dignity and Justice, along with the value of Hospitality which was provided by the Brothers of St. John of God -- are the guiding principles for all we do, shaping our interactions with those whom we are privileged to serve.

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. The hospital is located in Apple Valley and has been serving residents of San Bernardino County for 58 years. SJH St. Mary is a health ministry of St. Joseph Health headquartered in Irvine, CA, and is co-sponsored with the Brothers of St. John of God. SJH St. Mary is the community's largest provider of acute care services and the High Desert's only nonprofit hospital. 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, a Robotic-Assisted Surgery Program and a Center for Wound Care & Hyperbaric Medicine. The hospital is designated as a STEMI Receiving Center by Inland Counties Emergency Medical Agency and received the Baby Friendly designation by the World Health Organization. In FY14 the hospital provided $24,678,003 in community benefit, and reports an additional $9,754,242 loss in Medicare. Highlights of the hospital's Community Benefit program include:

- ❒ Improving access to care through the operation of three health clinics and a mobile medical program serving low income neighborhoods in Adelanto, Apple Valley, Hesperia and Victorville. These clinic resources served 47,192 patient encounters providing primary care, cancer screenings, immunizations, diabetes and breastfeeding education as well as midwifery care and health insurance enrollment assistance. The clinic's expertise in maternal care is noteworthy especially since 90% of patients are low income. In FY14 the clinic's birth outcomes again surpassed national patient quality rankings in primary Cesarean Section (11.7% vs. 23% nationally), Pre-term Delivery (5.67% vs. 11.55% nationally) and low birth rate (4.61% vs. 7.99% nationally). The hospital also supported two partners each of whom opened community health clinics serving the poor - one in north Adelanto and the second in old town Victorville. These new clinics bring expanded health services to these low income populations;

- ❒ Expanding health profession education with five college universities serving 463 students while starting a health career collaborative in partnership with three high schools and two hospitals. The high school work is supported by a OSHPD grant developing health career opportunities for minority students;

- ❒ Starting a homeless care program assisting with access to housing, medical supplies outpatient care, medication and transportation resources. The hospital's program also is coordinating work conducted with a new county homeless program (named HOPE) where the homeless are case managed and receive behavioral health and housing assistance programs;

- ❒ Donations of three vehicles (retired by the hospital) that have been placed into service by community partners to: (1) provide a mobile emergency command center to a local fire department, (2) a mobile health clinic serving churches ministering to the poor, (3) a transportation shuttle serving low income seniors and the disabled enabling successful access to medical care, social services and food stores;

- ❒ Organizing four Healthy City campaigns in collaboration with San Bernardino County Public Health and the communities of Adelanto, Apple Valley, Hesperia and Victorville. Each campaign is making improvements to their community's food and physical environment. The physical and food environments of San Bernardino County are ranked 45th out of 57 California counties in promoting health (County Health Rankings published by the University of Wisconsin Population Health Institute www.countyhealthrankings.org);

- ❒ Implementing four initiatives addressing (1) access to care barriers in poor neighborhoods, (2) increasing the adoption of breastfeeding practices, (3) reducing child obesity in schools, and (4) teaching diabetes education and self-care to the poor. Each of these four programs achieved its targeted goal. However access to care issues is still significant and the prevalence of adult obesity and diabetes has increased from results obtained in the 2011 CHNA.

SJH, St. Mary employs over 1,700 and one of the region's largest employers. As the region's market leader providing health services, SJH St. Mary is planning a second hospital campus (expected completion in 2017 or 2018) in the City of Victorville. When open, the new hospital will expand health services to communities who currently are 20 or more minutes from the nearest hospital.

The primary and secondary service areas served by the hospital encompass over 400,000 residents living in the communities of Adelanto, Apple Valley, Barstow, Hesperia, Lucerne Valley, Phelan, Oak Hills, Victorville 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 followed by Arabic as the two most commonly requested non English languages for discussing healthcare. The region is still feeling the effects of a slowing improving economy. As of July 2014 the county's unemployment rate was reported at 9.0% and higher than the state rate of 7.8% and the national rate of 6.5%. Cities in the hospital's service area continue to report unemployment rates as high as 13.2% in Adelanto. An April 2013 count of the county's homeless identified the Victor region as having the second largest population of chronic homeless. Community Benefit programs provided by the hospital are the most comprehensive in the area and include direct grants to partners providing health and social services to the area's poor. The hospital's Community Health and Healthy Community programs are recognized in San Bernardino County as some of most successful. Examples include

operation of fixed and mobile clinics serving the poor, breastfeeding education, child obesity and healthy city campaigns.

ORGANIZATIONAL COMMITMENT
Community Benefit Governance Structure

The SJH St. Mary 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 board member chairs the CB Committee with additional board members appointed terms. Hospital representatives include the President and Chief Executive Officer and the Vice President for Mission Integration as well as the Director of Community Health and Healthy Communities. Additionally, members include community leaders with local knowledge of health and social needs and staff from county public.

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 on expanding partnerships and providing input developing interventions with measurable improvements, and (4) serving as advocates for program support and resources. The CB Committee reports to the hospital's BOT (1) recommendations on how CB priorities address community needs, (2) updates on programs assisting the poor, (3) awards of hospital grants to community partners and (4) information on how community partners are addressing social and health needs in the region.

In FY14 the CB committee spent considerable time assessing CHNA results and feedback provided by community stakeholders as well as efforts to understand regional health issues and staying current on efforts implementing priority programs in the FY12-FY14 CB plan. Additionally, the committee received presentations from county public health about plans to open community health centers in Adelanto and Hesperia with a second partner opening a behavioral health clinic in old town Victorville. Additional presentations highlighted collaborative efforts on developing a food bank and community programs assisting the homeless.

PLANNING FOR THE UNINSURED AND UNDERINSURED
Patient Financial Assistance Program

One way St. Joseph Health, St. Mary informs the public of 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.

Our mission 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 St. Joseph Health, St. Mary has a **Patient Financial Assistance Program (FAP)** that provides free or discounted services to eligible patients. In FY 14, SJH St. Mary provided **$6,203,860** in charity care and **14,851 encounters.**

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 are hoping to 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 to provide 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 Lord's Table, Samaritan's Helping Hands, Victor Valley Rescue Mission, and shelters including Family Assistance Program, A Better Way Domestic Violence and Victor Valley 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 Community Network, Inc. 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 Valley Community Dental Service 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 Transit 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 Health Center a 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 Activities 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 sponsored successful grant applications to the St. Joseph Community Partnership Fund enabling increase quantities of food donations to reach the area's poor.

COMMUNITY NEEDS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

The hospital's community health assessment (CHNA) is 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. Highlights of how the hospital's CHNA are conducted are outlined below:

- **Mapping process identifies communities with greatest unmet health needs**. 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.

- **Collecting primary health data with a comprehensive health survey.** 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.

- **Obtaining feedback from local health professionals.** 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 as they develop a comprehensive health improvement plan.

On the following page a table of the significant health and social issues identified by the CHNA is provided in addition to the hospital's response to each need. St. Joseph Health, St. Mary anticipates that implementation strategies may change and therefore, a flexible approach is best suited for the development of its response to the St. Joseph Health, St. Mary CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by St. Joseph Health, St. Mary in the enclosed CB Plan/Implementation Strategy.

Summary of Community Needs Assessment Process and Results (con't)

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

The hospital's CHNA uses mapping to identify high need communities. Communities with Disproportionate Unmet Health Needs (DUHN) are communities defined by zip codes and census tracts where there is a higher prevalence or severity for a particular health concern than the general population within our ministry 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 *9,594 persons* *82% poverty* *75% of persons over 25 years old with less than a high school education*	*Expand health and social services;* *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*	*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, WIC program, San Bernardino County First 5.*
Residents living in Yucca Loma and Vista Loma communities of Apple Valley including residents between Navajo and Central. *1,093 persons* *62% poverty* *71% of persons over 25 years old with less than a high school education*	*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.*

Identification and Selection of DUHN Communities (con't)

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 *2,077 persons* *54% poverty* *80% of persons over 25 years old with less than a high school education*	*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, St. Mary High Desert Medical Group, 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 *3,730 persons* *69% poverty* *85% of persons over 25 years old with less than a high school education*	*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 Valley Rescue Mission, Community Action Partnership of San Bernardino County, Mission City Community Network, Inc., Victor Valley Community Dental Service Program, Molina Health, Victor Valley Community Services Council.*
Low income residents living in Barstow; residents needing specialty health services *1,861 persons* *69% poverty* *50%of persons over 25 years old with less than a high school education*	*Expand low cost health services* *Expand food to homeless*	*San Bernardino County Public Health Department, Barstow Community Hospital, Victor Valley Transit 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 four (4) priorities were identified and addressed in the hospital's FY12-FY14 Community Benefit plan:

- **Access to care**, the hospital could assist in a region-wide effort to expand access and meet a local need of Adelanto residents where 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 and address chronic diseases in the community;

- **Breastfeeding** was selected to improve maternal outcomes; improve the hospital's Baby Friendly efforts and also addressing child health and obesity. The hospital's work with Breastfeeding continues a regional collaborative created when the hospital obtained its Baby Friendly designation while working with an Inland Empire Breast Feeding Coalition;

- **Obesity**, the hospital began addressing a significant health identified from the CHNA. Additionally, with assistance from St. Joseph Health and with resources provided by partners the hospital developed a comprehensive set of programs in schools, with physicians to address obesity and develop partners to expand the program;

- **Diabetes** was identified as a significant health issue from the CHNA and feedback from a managed Medi-Cal insurance provider (IEHP) reporting uncontrolled diabetes was resulting frequent hospital ER visits. Additionally, residents in Adelanto identified the need for better diabetes care during meeting with the hospital when discussing CHNA results.

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 Valley Community Dental Service Program – High Desert wide	$75,000
Substance Abuse	St. John of God HealthCare Services	$50,000
Homelessness/Food/Utility Assistance	Catholic Charities	$50,000

Addressing the Needs of the Community

FY12 – FY14 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY14 Accomplishments

The hospital developed a three year community benefit plan with four (4) health initiatives. Each of the initiatives was comprehensively developed with goals, proposed health outcomes and, where appropriate, aligned with Healthy People 2020 and a target population. Initiatives were selected to address unmet health needs. Progress implementing each initiative is described below including a short evaluation of the program's impact.

Initiative #1: Access to Care - recruit and open community clinics

Description: The recruitment of clinic operators to open or expand community health clinics in DUHN communities serving persons with primary and specialty care.

Key Community Partners: Azusa Pacific Nursing program, Borrego Community Health Foundation, Century 21 Fairway Realty, Healthy Adelanto, Healthy Hesperia, Healthy High Desert, Healthy Victorville, Inland Behavioral Health, Inland Empire Health Plan, Kids Come First Community Health Center, Kaiser Permanente, Loma Linda University Medical Center, Mission City Community Network, Inc., Molina, San Bernardino County Community Clinic Association, San Bernardino County Public Health

Goal (Anticipated Impact[2]): Open four community health clinics providing primary and specialty care in low income communities of the high desert region of San Bernardino County.

Target Population (Scope): the uninsured and those patients with Medi-Cal health insurance

How will we measure success? Outcome Measure (Evaluation Plan[3]):
The number of clinics opened serving the poor; primary and specialty care services not offered by hospital clinics and meeting community health needs as identified in the hospital's CHNA. The number of clinics opened who refer patients to hospital clinics and who offer health services to the poor that build on what the hospital is doing with breastfeeding, child obesity and diabetes.

Three-Year Target: 4 clinics opened

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

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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)

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

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

FY14 Accomplishments: Two clinics opened.

Clinic 1: Molina Health opened a clinic in old-town Victorville. The hospital advocated to Molina that this location would serve a very low income population and be near a low cost dental provider also serving the poor. The clinic has a sliding scale fee for uninsured patients and treats patients with Molina health insurance (a managed Medi-Cal product in San Bernardino County). The clinic provides primary care services with plans offering a free shuttle service to assist patients meet health and social needs. Molina's Victorville clinic supports a smaller clinic the company opened in Adelanto in 2013.

Clinic 2: San Bernardino County Public Health relocated a community clinic to north Adelanto and is providing primary care services including referrals for behavioral health to its sister clinic located in Hesperia. Both county health clinics are federally funded to achieve Federally Qualified Health Center status, serve the uninsured and see patients with Medi-Cal insurance. Each county clinic can refer patients requiring specialty health care to the county hospital. The Adelanto clinic serves a DUHN community with a poverty rate of 82%. The hospital's access to care initiative surpassed its three year target of opening four clinics. Currently, five clinics have opened serving low income persons and four of the five clinics are physically located in DUHN communities: Molina and Public Health in Adelanto and Mission City Community Network, Inc., and Molina in old-town Victorville. A community clinic guide for public use is under development in an effort to support patient volume at each clinic. Only two of the five clinics provide behavioral health services. Neither of the two county clinics has oral health integrated into its practice.

This access to care initiative achieved its 3 year program goal to recruit 4 community clinics to the region to assist in serving the poor. Three clinic operators run 5 local clinics. The strategy of forming a local community clinic collaborative has been discussed in an effort to improve referrals and coordination of care.

Initiative #2: Breastfeeding – increase percentage of mothers' providing breast milk to infants up to 6 months as part of hospital's Baby Friendly designation

Description: Led by the hospital's midwifery program named Healthy Beginnings run from the hospital's community health department, the program builds upon practices the hospital put in place when it achieved Baby Friendly designation. International Board Certified Lactation consultants provide inpatient and outpatient lactation support for women and their newborn infants. The program focuses on (1) hospital maintains 80% compliance following the 10 STEPS of Baby Friendly and (2) the percentage of mothers providing breast milk to their infants at 6 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 FY14 the program reports increasing the

percentage of mothers providing breast milk to their infants at 6 months to 35% (an increase from 25% reported in FY13). The program has surpassed the 29% goal established in increasing breastfeeding rates.

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, Inland Empire Breastfeeding Coalition.

Goal (Anticipated Impact[4]): Maintain Baby Friendly practices; increase breastfeeding to infants up to 6 months to 27% by FY14. Achieve Baby Friendly re-designation by World Health Organization in FY14. Secure one funder to support the program.

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 6 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 (6) months; the number of funders supporting the program, and hospital designation as Baby Friendly.

Three-Year Target: Increase breastfeeding at 6 months to 27% 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

FY14 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 successfully reports increasing exclusive breastfeeding at 6months of age to 36% which surpasses the program goal of 27%. The program provided 14,612 inpatient and outpatient visits. The program is the only regional effort that systematically tracks and report breastfeeding rates in the region. In FY14 the program's focus has been prenatal education and post discharge follow-up by Certified Lactation

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

Consultants. These efforts have increased the percentage of mother's breastfeeding their infants at 6 months from 25% to 35% in 2014. 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. The hospital was recertified Baby Friendly in 2014. The program is funded by First 5 of San Bernardino for FY15. Community support by accommodating workplace breastfeeding is still a need. The program reports that the hospital is successfully achieving eight of the 10 Baby Friendly steps at 80% compliance or greater.

Initiative #3: – Nutrition, Physical Activity and Weight Status (child obesity)

Description: The hospital's nutrition, physical activity and obesity reduction program is recognized as a best practice by San Bernardino County Public Health. The program serves low income children enrolled in federally run Head Starts and state run pre-school programs. The program is led by a Registered Dietitian (RD) who instructs school staff to incorporate nutrition education and increased physical activity into the school day. Additionally, at-risk children are identified by the RD by conducting Body Mass Index (BMI) measurements. Parents of children with BMI measures in the overweight and obese categories receive medical nutrition counseling. Counseling sessions are conducted at the hospital, at the school or at the family's home. Additional elements of the program include engaging families to advocate for increased access to healthy foods and safe recreation. This healthy city work is funded in partnership with San Bernardino County Nutrition Department. Five physicians also refer overweight or obese children to the program's Registered Dietitian.

Key Community Partners: San Bernardino County Pre-Schools Service Department, Apple Valley Unified School District, Azusa Pacific Nursing Program, First 5 of San Bernardino, Hesperia Unified School District, High Desert Pediatrics, La Salle Medical Group, Radiant Medical Group, San Bernardino County Department of Public Health, Squash4Friends, St. Mary High Desert Medical Group.

Goal (Anticipated Impact[6]): Percentage of at-risk children moving downward in weight classification while maintaining the number of children maintaining a healthy weight.

Target Population (Scope): Low income children enrolled in Head Start and state-run pre-schools

How will we measure success? Outcome Measure (Evaluation Plan[7]): The number of overweight or obese children who drop one weight classification each program year using the Healthy People 2020 target to 10% or greater. Each year the program achieved 10% or greater of at-risk and dropping one weight classification as called for by Healthy People 2020. In FY14 17% of at-risk children dropped one weight classification by program end. Additionally, the program received 100% grant support from First 5 San Bernardino allowing expansion into 13 classrooms. Finally, the program successfully identified two partners (County Pre-School Department and Azusa Pacific University) who

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

expanded the program county-wide in 60 school sites outside the hospital's service area. As a result nearly 1,400 children ages 2-5 years old have been identified as overweight or obese in the county's federal Head Start programs. Additional grant funding would be required to staff Registered Dietitian's to provide nutrition counseling to serve this volume of children. PSD is considering this strategy as a grant request to support their families outside of the hospital's service area.

Three-Year Target: Adoption of program by school partners

Strategy 1: Recruit local schools to implement Healthy For Life Jr. in classrooms
Strategy Measure 1: Number of schools implementing Healthy For Life Jr. program

Strategy 2: Recruit physician partners to refer at risk children for counseling
Strategy Measure 2: # of physician partners

Strategy 3: Recruit grant partners to support program
Strategy Measure 3: the # of grant partners

FY14 Accomplishments addressing child obesity: 17% of at-risk children dropped one weight classification by year end. 36% of families self-report adopting healthier eating habits as a result of medical nutrition counseling sessions. The program is recognized in the county as a best practice and is grant funded by First 5 of San Bernardino. The hospital's program is fully funded in FY15. A hospital partner has identified 1,400 children and families needing nutrition counseling county-wide however additional staff time in the form of Registered Dietitians are needed for case management.

Initiative: ***Diabetes Care to the Poor***

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

Key Community Partners: Inland Empire Health Plan, St. Joseph Orange and Puente de la Salud clinic.
Goal (Anticipated Impact[8]): 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[9]):
The 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

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

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. The program has surpassed initial program goals however additional resources are needed. The hospital needs clinical partners to assist providing comprehensive diabetes screenings especially in the primary care setting but also for low income and uninsured persons who are unable to manage their disease. The hospital will begin partnering with one physician group (St. Mary High Desert Medical Group) in an effort to address diabetes care. The hospital is also attempting to recruit El Sol to use Community Health Workers in providing diabetes education especially in the Hispanic community.

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.

FY14 Accomplishments addressing diabetes:

The hospital funds the diabetes program with support from grant funders including St. Joseph Health Community Partnership Fund. The program provided 1,110 community screenings which surpassed a target of 500. The program case managed and tracked 143 patients and 59% of patients met criteria in annual foot and eye exams and 63% of patients demonstrated improvements in HgA1C levels. Patients are being tracked and education provided. The hospital requires medical partners to assist in a comprehensive diabetes program. San Bernardino County Public Health's Hesperia Health Center may offer a location for diabetes education to be provided. Additional clinical partners are needed as the prevalence of diabetes has increased to 15%, nearly twice the state average.

Other Community Benefit Programs and Evaluation Plan

Program#1: Subsidized: Emergency & Trauma Care

Description: Uninsured and homeless individuals that come to our hospital and require referral and assistance connecting with outpatient care including a physician or housing service.

Key Community Partners: the hospital's Care Management Department, local skilled nursing facilities, convalescent hospitals, transportation services, durable medical equipment vendors, local doctors, and pharmacies.

Goal (Anticipated Impact[10]): Not having insurance should not be an impediment to receiving medically necessary care; our ministry helps on a case by case basis regardless of the ability to pay. Our rationale is that by assisting with outside partners we can better achieve a successful medical outcome for our neighbors that may not qualify for health insurance coverage for various reasons.

Target Population (Scope): Uninsured and homeless persons

How will we measure success? Outcome Measures:
The number of persons assisted;
The number of partners providing assistance; and
The number of patients who, without assistance and follow-up care, would likely return to hospital ER

FY14 Accomplishments: 496 Letters of Agreement executed by our Care Management Department providing follow-up medical support for our most vulnerable populations – uninsured and homeless. Total Community Benefit expense: $1,519,957.

Program#2: Healthcare Professions: Nursing and Physical Therapy Students

Description: Students enrolled in a higher education institution that requires completed clinical hours to receive a degree or a certificate that is required by state law, accrediting body or health profession society.

Key Community Partners: Clinical Education Department, Azusa Pacific University, Everest College, Loma Linda University, Mohave College and Victor Valley Community College.

Goal (Anticipated Impact[11]): Providing a clinical setting for students to complete their clinical hours.

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

Target Population (Scope): Students requiring completion of clinical hours to receive a degree or a certificate that is required by state law, accrediting body or health profession society, in this case the Board of Registered Nursing

How will we measure success? Outcome Measure: 463 nursing and physical therapy students completing their clinical hours at the hospital from five higher learning institutions. Total Community Benefit expense $419,384.

FY14 Accomplishments:

Between these five institutions, 463 nursing and physical therapy students completed a total of 38,432 clinical hours at the hospital. Providing a clinical setting for undergraduate/vocational training to students enrolled in an outside organization. The hospital also started sponsoring a high school health career program.

Program#3: Support Services: Transportation: Caravan Services

Description: When patients require transportation services after being released, this added service allows them to continue receiving medically necessary care.

Key Community Partners: Local Caravan Services and other medical transportation providers

Goal (Anticipated Impact[12]): Connect patients needing transportation to follow-up services

Target Population (Scope): Low income individuals

How will we measure success? Outcome Measure:

2,134 trips were provided with a total Community Benefit cost of $217,439.

FY14 Accomplishments:

The hospital continues to seek partnerships to provide these services in ways that allow persons to receive needed care. The hospital is working with the local transit authority and with a nonprofit agency to assess improving patient transportation given the barrier transportation is for low income persons.

Program#4: Cash and In-Kind Contributions

Description: provides in-kind services donated to community organizations or to the community at large. This includes the hours contributed by staff to the community while on hospital time and the cost of supplies. Donations in this category must be restricted to programs or activities that would qualify as community benefit if provided by the organization itself.

[12] **Anticipated Impact** is equivalent to **Goal**. Language is used for clarity with regard to IRS Proposed Rule (2013)

Key Community Partners: Catholic Charities, St. John of God, Adelanto Swim Program, Squash4Friends, High Desert Homeless Shelter, Apple Valley Police Activities League, Victor Valley Domestic Violence, Inc./ "A Better Way", Victor Valley Community Services Council, Victor Valley Dental Service Program, El Sol, Lifestream, Relay for Life, Adelanto Chamber of Commerce, City of Adelanto, Camp Erin, Pro-Bono Clinic, Town of Apple Valley's Heart Games, Kiwanis, Rotary of Apple *Valley, Rotary of Victorville, Lestonnnac Free Medical Clinic and the Apple Valley Fire Protection District.*

Goal (Anticipated Impact[13]):

Donations of hospital resources assist community partners to more effectively operate their programs in the region.

Target Population (Scope): Broader Community

How will we measure success? Outcome Measure:

These combined totaled $148,993 for 7,591 encounters, and of these encounters, 2,372 were unduplicated.

FY14 Accomplishments:

Three vehicles were donated to Apple Valley Fire Protection District, Lestonnac Free Medical Clinic and Victor Valley Community Services Council. These vehicles will now be used as a mobile command post for disaster preparedness, for transporting seniors and people with disabilities and to increase access to healthcare services for the low income, uninsured and underserved individual. As a ministry we participated in community boards including: A Better Way Domestic Violence Program, City of Adelanto, and the Victor Valley Community Dental Service Program. Hospital leaders support numerous organizations including Rotary of Apple Valley and Rotary of Victorville. The hospital hosts periodic blood drives and supports numerous health events.

[13] **Anticipated Impact** is equivalent to **Goal**. Language is used for clarity with regard to IRS Proposed Rule (2013)

FY14 Community Benefit Investment

FY14 COMMUNITY BENEFIT INVESTMENT
St. Joseph Health, St. Mary
(ending June 30, 2014)

CA Senate Bill (SB) 697 Categories	Community Benefit Program & Services[14]	Net Benefit
Medical Care Services for Vulnerable[15] Populations	Financial Assistance Program (FAP) (Charity Care-at cost)	$6,203,860
	Unpaid cost of Medicaid[16]	$12,640,217
	Unpaid cost of other means-tested government programs	
Other benefits for Vulnerable Populations	Community Benefit Operations	$0
	Community Health Improvements Services	$265,382
	Cash and in-kind contributions for community benefit	$119,487
	Community Building	$0
	Subsidized Health Services	$4,756,137
	Total Community Benefit for the Vulnerable	***$23,985,083***
Other benefits for the Broader Community	Community Benefit Operations	$204,110
	Community Health Improvements Services	$35,275
	Cash and in-kind contributions for community benefit	$29,506
	Community Building	$4,645
	Subsidized Health Services	$0
Health Professions Education, Training and Health Research	Health Professions Education, Training & Health Research	$419,384
	Total Community Benefit for the Broader Community	***$692,920***
	TOTAL COMMUNITY BENEFIT *(excluding Medicare)*	$24,678,003
Medical Care Services for the Broader Community	Unpaid cost to Medicare ***(not included in CB total)***[17]	$9,754,242

[14] Catholic Health Association-USA Community Benefit Content Categories, including Community Building.
[15] 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.
[16] Accounts for Hospital Fee. The pledge/grant (separate from the quality assurance fee) is reported in Cash and In-kind Contributions for other vulnerable populations.
[17] 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[18] Summary of Accomplishments

Hospital leaders volunteer and serve in the community in a variety of ways including providing health education or providing leadership to nonprofit partners. Examples include serving on the boards of St. John of God Health Care Services, Victor Valley Community Services Council, The United Way, Victor Valley Community Dental Service Program, Desert Trails School Board, The Apple Valley Police Activities League and the Chambers of Commerce in Adelanto and Apple Valley.

One notable example of executive service involves the hospital's Finance Director serving as a board member of the Victor Valley Community Dental Service Program. His financial expertise played a central role helping the organization regain its financial footing. The clinic is the community's only provider of free dental services to the poor and a valuable referral partner of the hospital. Recent CHNA health data reporting oral care indicates that only 57% of High Desert adults access a dentist on an annual basis. By comparison, the state average is reported at 75%. When the state of California stopped Denti-Cal benefits (as part of cutting Medi-Cal to address the state's budget deficit) the clinic needed financial guidance. A financial plan has allowed the dental clinic to transition to a new business model and thankfully Denti-Cal has been restored by the state. Over time this clinic may expand as a result of new leadership and its better understanding of its financial position.

Hospital leaders who serve as board members at St. John of God Healthcare Services have helped this partner secure grants assisting the poor. The first grant allows the agency to expand its substance abuse and counseling services. St. John of God is the region's only provider of a 90 day inpatient recovery program. The grant assists persons who have recovered from substance abuse transition to housing and jobs. The hospital facilitated a second grant enabling St. John of God to receive donations of food and produce to better feed the poor. In April 2014, St. John of God's work was recognized by Bishop Gerald Barnes of the Diocese of San Bernardino County through the Amar Es Entregarse Award.

In 2014 the hospital received recertification as a Baby Friendly by the World Health Organization. The recertification validates the hospital and community progress made to promote breast feeding practices. The hospital's clinic staff now works with county WIC offices to assist mothers with breastfeeding education and lactation support. In March 2014 the hospital became a smoke free campus which supports local Healthy City efforts to also address second hand smoke concerns. The hospital served as an advocate in city efforts to prohibit tobacco and e-cigarette use in parks and supported San Bernardino County's recent ban of Spice and Bath Salts.

The hospital hosts a region-wide effort to develop a standard health career pipeline for high school students with particular focus on minority students. The hospital co-sponsors a regional campaign known as Healthy High Desert. This campaign is promoting health thru fitness and health events, city governments passing health promotion policies and changes to the physical environment to promote healthier eating and fitness. In FY14 the hospital obtained grant funds allowing each healthy city to install an outdoor gym in one low income neighborhood.

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