St. Joseph Health, St. Mary

Fiscal Year 2017 COMMUNITY BENEFIT REPORT

PROGRESS ON FY15 - FY17 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

As a ministry founded by the Sisters of St. Joseph of Orange, St. Joseph Health, St. Mary lives out the tradition and vision of community engagement set out hundreds of years ago. The Sisters of St. Joseph of Orange trace their roots back to 17th century France and the unique vision of a Jesuit Priest named Jean-Pierre Medaille. Father Medaille sought to organize an order of religious women who, rather than remaining cloistered in a convent, ventured out into the community to seek out "the Dear Neighbors" and minister to their needs. The congregation managed to survive the turbulence of the French Revolution and eventually expanded not only throughout France but throughout the world. In 1912, a small group of the Sisters of St. Joseph traveled to Eureka, California, at the invitation of the local Bishop, to establish a school. A few years later, the great influenza epidemic of 1918 caused the sisters to temporarily set aside their education efforts to care for the ill. They realized immediately that the small community desperately needed a hospital. Through bold faith, foresight and flexibility, in 1920, the Sisters opened the 28 bed St. Joseph Hospital Eureka and the first St. Joseph Health ministry.

St. Joseph Health, St. Mary has been meeting the health and quality of life needs of the local community for over 60 years. Serving the San Bernardino county communities of Adelanto, Apple Valley, Hesperia and Victorville, St. Joseph Health, St. Mary is a Baby Friendly designated 212 bed acute care hospital providing quality care in: 24-hour emergency services, comprehensive cardiac programs, outpatient surgery pavilion, pediatric care, physical, occupational and speech therapy, senior programs, community clinics offering mobile primary care, midwifery and family health, a chest pain emergency center, open heart surgery program, Level II neonatal intensive care, diagnostic imaging services, American Diabetes Association certified education and self-management care, physical referral services, robotic-assisted surgery program, wound care and hyperbaric medicine. In March 2017 the hospital was nationally recognized by the Women's Choice for patient safety – a top 15% ranking. The hospital is the Victor-valley's remaining local

non-profit hospital providing nearly 400,000 residents with community benefit services. With over 1,500 employees committed to realizing the mission, St. Joseph Health, St. Mary is one of region's largest employers.

Strategic Direction

As we move into the future, St. Joseph Health, St. Mary is committed to furthering our mission and vision while transforming healthcare to a system that is health-promoting and preventive, accountable in its inevitable rationing decisions, integrated across a balanced network of care and financed according to its ability to pay. To make this a reality, over the next five years (FY14-18) St. Joseph Health, St. Mary are strategically focused on two key areas to which the Community Benefit (CB) Plan strongly align: population health management and network of care.

Community Benefit Investment

St Joseph Health, St. Mary invested $33,186,177 in community benefit in FY 2017 (FY17). For FY17, St. Joseph Health, St. Mary had an unpaid cost of Medicare of $16,218,715.

Overview of Community Health Needs and Assets Assessment

In response to unmet health-related needs (identified from a 2014 Community Health Needs Assessment), St. Joseph Health, St. Mary's FY15-FY17 Community Benefit Plan focuses on four (4) programs serving the broader and underserved members of the community.

1. **Expanding health access to rural and vulnerable populations** responds to marked shortages in primary and specialty care across the hospital's service area. The region's supply of physicians is one of the lowest in the state of California with 120 physicians per 100,000 residents. SJH hospitals across southern California have identified shortages of both primary care and psychiatry. The hospital's Victor-valley assessment cites 41.5% of respondents report access issues.

   Access issues are exacerbated by San Bernardino County's only county funded safety net hospital located 45 miles away. The hospital addresses physician shortages (by developing its networks of care), providing qualifying patients with medications via the federal 340B pharmacy voucher program and addressing patient transportation issues with contracted vendors and collaboration with the public bus system.

   Communities within the hospital's service area are designated by Health and Human Services' Health Resources Services Administration (HRSA) as Medically Underserved Areas (MUA) and Medical Health Professional Shortage Areas (HPSA) for primary care and mental health. These workforce shortages have the Riverside and San Bernardino region expanding its medical programs. The University Of California's Riverside School of

Medicine is operational. The California University of Science and Medicine's School of Medicine (based in Colton, CA) has plans to open in 2018.

Hospital responses to assess issues include:

- Expanding primary and specialty networks with outpatient services for greater community benefit. Expansion of mobile and fixed clinic services occurred in Apple Valley and Hesperia. An additional mobile medical unit is underway with OSHPD permitting. The additional clinic site will serve the rural community of Lucerne Valley by Fall 2017.

- Creating a Faith & Wellness campaign engaging local churches to improve the health of their congregations. Additionally, the community clinics integrated legal aid services available for clinic and family resource program patients. The legal service is weekly and open to community referrals.

- Expanding public recognition of community clinic services. The hospital works with Federally Qualified Health Centers operated by Borrego Health, Mission City Community Network and San Bernardino County Public Health along with Molina clinics serving low income populations in Adelanto, Apple Valley, Barstow, Hesperia and Victorville. Local Healthy City campaigns advertise clinic openings and include newspaper coverage. Community events are organized in low-income neighborhoods with clinic representatives providing education and clinical screenings.

- Continuing health insurance enrollment efforts with hospital-based enrollers coupled with community-wide campaigns engaging insurance agents, county office Medi-Cal enrollers and staff of San Bernardino County's Community Clinic Association.

2. **Expanding Diabetes Services** addresses this chronic condition impacting 15.3% of the community. The hospital consolidated its diabetes programs offering expanded care to hospital and community clinic patients as well as patients referred by physicians of St. Mary High Desert Primary Care offices. Additionally, the hospital diabetes program is developing best practices in a regional diabetes initiative among St. Joseph Hospitals serving Orange County.

Hospital response to increasing prevalence of diabetes includes:

- Expanding referrals of patients with uncontrolled diabetes from physicians at with St. Mary High Desert Primary Care.

- Recruiting and training health partners on diabetes care in poorer communities by reaching families at faith communities, schools, senior centers and apartment complexes.

- Providing nutrition, physical education and pre-diabetes screenings to low income residents and assisting faith communities in establishing healthy eating policies and health promotion programs.

- Assisting food pantries to obtain and distribute supplies of fruits and vegetables that improve the nutritional intake of food insecure families living in "healthy food deserts".

- Advocating to city and county leaders that prospective fixed and mobile retailers sell fruits and vegetables.

3. Improving Mental Health Care where 18.4% of residents self-reported their mental health as either fair or poor a 3.9% increase over 2007 and significantly higher than the national rate of 11.7%. The hospital's service area is federally listed as a Health Professions Shortage Area for mental health providers.

Hospital response to mental health issues include:

- Leading a local mental health collaborative addressing gaps in services with a goal of improved understanding and coordination of care among hospitals, patients, outpatient providers and law enforcement.

- Partnering with county behavioral health programs and contracted partners to increase public awareness of local mental health resources.

- Providing outpatient behavioral counseling to community clinic patients and grant funding the area's only 90-day treatment facility so addicts receive counseling, psychiatry assessment and access to psychotropic drugs.

- Creating state and local advocacy to increase government and private investment in improved mental health care. Partners include hospitals, the Hospital Association of

Southern California, San Bernardino County Department of Behavioral Health, the National Alliance of Mental Illness and law enforcement agencies.

4. **Addressing Obesity and Nutrition** since 37% and 33% of residents are identified as either overweight or obese and the region's environment includes access and poverty issues related to obtaining healthy foods and accessing safe places to recreate.

Hospital responses to adult and child obesity include:

- Expanding obesity and healthy campaigns in schools, churches and community settings to promote nutrition education and physical activity with adults and children.

- Implementing a San Bernardino County Public Health funded Communities of Excellence campaign directed at improving neighborhood access to fresh fruits and vegetables and improved street, park and neighborhood safety. The hospital is implementing the program in Adelanto, Apple Valley, Hesperia, Snowline and Victorville.

- Developing bilingual athletes into ZUMBA instructors, runners and other exercise trainers in neighborhoods with limited or no recreation. Free resident-led physical activity occurs three and four times per week serving north Adelanto and old town Victorville residents with plans to expand in Apple Valley, Hesperia and Snowline.

- Partnering with elementary schools in promoting student fitness. This includes providing 5th grade students with a SQORD wearable activity tracker and supporting school districts offering USDA Summer Meals and low cost recreation during summer break.

Due to the fast pace at which the community and health care industry change, St. Joseph Health, St. Mary anticipates some implementation strategies may evolve and therefore, a flexible approach is best suited for the development of its response to the St. Joseph Health, St. Mary Community Health Needs Assessment (CHNA).

On an annual basis St. Joseph Health, St. Mary evaluates its CB Plan, specifically its strategies. Due to the fast pace at which the community and health care industry change, St. Joseph Health, St. Mary anticipates that implementation strategies may evolve and therefore, a flexible approach is best suited for the development of its response to the St. Joseph Health, St. Mary Community Health Needs Assessment (CHNA). On an annual basis St. Joseph Health, St. Mary evaluates its

CB Plan and makes adjustments as needed to achieve its goals/outcome measures, and to adapt to changes in resource availability.

Community Plan Priorities/Implementation Strategies

In FY17 the hospital implemented the following strategies addressing priorities as developed in its FY15-FY17 Community Benefit Implementation Plan.

- **Expanding Access to Care to the poor**
  - Provided a total of 28,704 clinical encounters including 5,754 encounters using mobile medical services for primary and specialty care
  - Re-opened a Hesperia clinic serving low income and uninsured residents
  - Expanded mobile clinic services to a second low income community in Apple Valley and commenced planning to add additional mobile services to support schools and rural communities
  - Initiated expanded Family Resource programs including legal services that addresses a social determinant of health (poverty).

- **Expanding Diabetes Care to the poor**
  - Provided 1,327 total clinical encounters for diabetes care
  - 286 patients managing uncontrolled diabetes through education and counseling
  - 175 patients referred for diabetes care from physician partners
  - 560 support group encounters
  - Expanded partnership with specialty care and Centers of Excellence programs
  - Facilitated donations of 760,000 pounds of fruits and vegetables to local programs serving the poor coupled with education and pre-diabetes screenings

- **Improving Mental Health**
  - Provided 3,145 total clinical encounters providing mental health care
  - Provided 562 counseling visits in the clinic's Bridges for Families program
  - Advocated a county policy change proposing tele-psychiatry for Emergency room care
  - Grant funded integrated counseling for Depression and Post Traumatic Stress Disorder in the community's only 90-day addiction recovery program for 242 patients
  - Grant funded a community partner who provided 882 counseling encounters with at-risk youth and their parents/guardians

- **Decreasing Obesity**
  - Provided 6,519 total encounters for obesity with local physical activity and weight loss campaigns in four communities especially bilingual adult women living in north Adelanto and old town Victorville
  - Average weight loss among a core group of Adelanto women is 12 pounds per participant

- Women self-report improved health status from "Poor to Good" to Very Good to Excellent" at Adelanto and Victorville exercise programs
- Assisted City of Adelanto in walking path installation as part of a public campaign supporting fitness and park use and the Adelanto School District which opened a swimming pool that served over 2,000 users
- Engaged 286 5th and 6th grade students in a sustained physical activity campaign where 44% of children (n=125) engaged in weekly syncing and 89% of students were active and moving on weekends

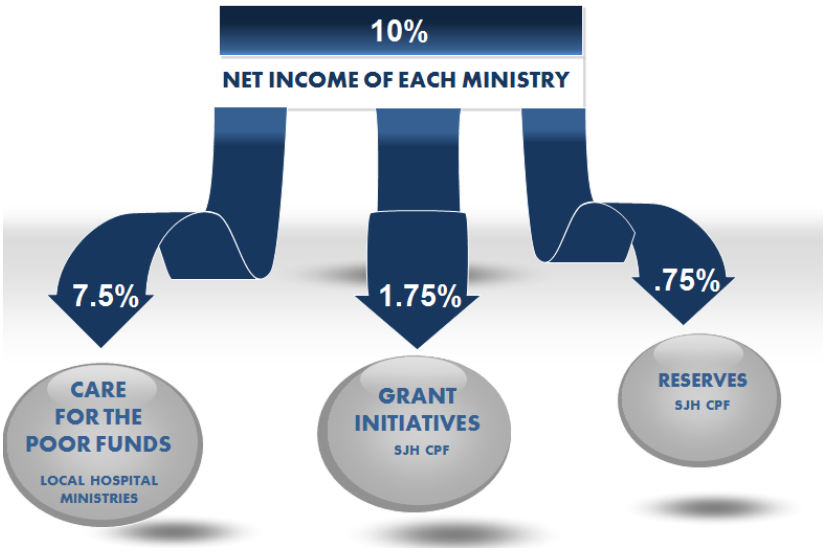
ORGANIZATIONAL COMMITMENT

Community Benefit Governance Structure

St. Joseph Health, St. Mary dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and underserved.

In 1986, St. Joseph Health created the St. Joseph Health Community Partnership Fund (SJH CPF) (formerly known as the St. Joseph Health System Foundation) to improve the health of low-income individuals residing in local communities served by SJH hospitals.

Figure 1. Fund distribution



Each year St. Joseph Health, St. Mary allocates 10% of its net income (net unrealized gains and losses) to the St. Joseph Health Community Partnership Fund. (See Figure 1). 7.5% of the contributions are used to support local hospital Care for the Poor programs. 1.75% is used to support SJH Community Partnership Fund grant initiatives. The remaining .75% is designated toward reserves, which helps ensure the Fund's ability to sustain programs into the future that assist low-income and underserved populations.

Furthermore, St. Joseph Health, St. Mary will endorse local non-profit organization partners to apply for funding through the St. Joseph Health Community Partnership Fund. Local non-profits that receive funding provide specific services and resources to meet the identified needs of underserved communities throughout St. Joseph Health hospitals' service areas and provide reports on how they are impacting the community.

Community Benefit Governance and Management Structure

St. Joseph Health, St. Mary further demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration. The Vice President of Mission Integration and Director of Healthy Communities are responsible for coordinating implementation of California Senate Bill 697 provisions and Federal 501r requirements as well as providing the opportunity for community leaders and internal hospital Executive Management Team members, physicians and other staff to work together in planning and implementing the Community Benefit Plan.

The Community Benefit (CB) Management Team provides orientation for all new Hospital employees on Community Benefit programs and activities, including opportunities for community participation. New employees are provided orientation on community benefits and ways they may participate or support. Additionally, the employee newsletter features stories of community benefit work throughout the year. These stories serve to educate staff on the hospital's work.

A charter approved in 2007 establishes the formulation of the Community Benefit Committee at St. Joseph Health, St. Mary. The role of the Community Benefit Committee is to support the Board of Trustees in overseeing community benefit. The Committee acts in accordance with a Board-approved charter. The Community Benefit Committee is charged with developing policies and programs that address identified needs in the service area particularly for underserved populations, overseeing development and implementation of the Community Health Needs Assessment and Community Benefit Plan/Implementation Strategy Reports, and overseeing and directing the Community Benefit activities.

The Community Benefit Committee has a minimum of eight members including three members of the Board of Trustees. Current membership includes six members of the Board of Trustees and seven community members. A majority of members have knowledge and experience with the populations most likely to have disproportionate unmet health needs. The Community Benefit Committee generally meets quarterly.

Roles and Responsibilities

Senior Leadership

A. CEO and Vice President for Mission Integration are directly accountable for CB performance.

Community Benefit Committee (CBC)

- CBC serves as an extension of trustees to provide direct oversight for all charitable program activities and ensure program alignment with "Advancing the State of the Art of Community Benefit" (ASACB) Five Core Principles. It includes diverse community stakeholders. Trustee members on CBC serve as 'board level champions'.

- The committee provides recommendations to the Board of Trustees regarding budget, program targeting and program continuation or revision.

Community Benefit (CB) Department

B. Manages CB efforts and coordination between CB and Finance departments on reporting and planning.
C. Manages data collection, program tracking tools and evaluation.
D. Develops specific outreach strategies to access identified Disproportionate Unmet Health Needs (DUHN) populations.
E. Coordinates with clinical departments to reduce inappropriate ER utilization.
F. Advocates for CB to senior leadership and invests in programs to reduce health disparities.

Local Community

G. Partnership to implement and sustain collaborative activities.
H. Formal links with community partners.
I. Provide community input to identify community health issues.
J. Engagement of local government officials in strategic planning and advocacy on health related issues on a city, county, or regional level.

PLANNING FOR THE UNINSURED AND UNDERINSURED

Patient Financial Assistance Program

The St. Joseph Health (SJH) Financial Assistance Program helps to make our health care services available to everyone in our community needing emergent or medically necessary care. This includes people who do not have health insurance and are unable to pay their hospital bill, as well as patients who do have insurance but are unable to pay the portion of their bill that insurance does not cover. In some cases, eligible patients will not be required to pay for services; in others, they may be asked to make partial payment.

At St. Joseph Health, St. Mary, our commitment is to provide quality care to all our patients, regardless of their ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance or are worried about their ability to pay for their care. This is why we have a Financial Assistance Program for eligible patients. In FY17, St. Joseph Health, St. Mary ministry, provided $1,869,217 free and discounted care following a policy providing assistance to patients earning up to 500% of the federal poverty level. This resulted in 6,766 patients receiving free or discounted care.

For information on our Financial Assistance Program click:

http://www.stmaryapplevalley.com/Patients-Visitors/For-Patients/Billing-and-Payment/Patient-Financial-Assistance.aspx

Medi-Cal (Medicaid)

St. Joseph Health, St. Mary provides access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California. In FY17, St. Joseph Health, St. Mary ministry, provided $25,535,421 in Medicaid shortfall.

COMMUNITY

Defining the Community

St. Joseph Health, St. Mary provides the Victor Valley and Barstow communities with access to advanced care. The facility is the only St. Joseph Health hospital operating in San Bernardino County. The hospital's service area extends from Highway 58 and the 15 freeway in the north, Highway 395 and the 15 freeway in the south, unincorporated communities including Lucerne Valley in the east and unincorporated communities of El Mirage in the west. Our Hospital Total Service Area includes the cities of Adelanto, Apple Valley, Barstow, Hesperia Oro Grande and Victorville and several smaller unincorporated communities including Helendale, Lucerne Valley, Oak Hills, Phelan, Snowline communities and Wrightwood. This includes a population of approximately 430,000 people, an increase of 2.3% from the prior assessment. A full copy of the CHNA can be found at www.stmaryapplevalley.com.

The SJH St. Mary 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 social and health disparities. Areas within the hospital's primary and secondary service areas are listed as Medically Underserved Areas including the community of Barstow and Adelanto. Additionally, the region is listed as a Medical Health Professional Shortage Area for mental health. With some exceptions, these health and social conditions are largely homogenous across San Bernardino County. For this reason nonprofit hospitals in San Bernardino are similar increases in chronic disease and social disparities. In response a county-wide health improvement plan has

been developed which the hospital is active in. This plan prioritizes improving (1) education, (increasing graduation rates) (2) the economy (reducing poverty) (3) safety (improving school and community safety) and (4) health & wellness (reducing obesity).

A detailed look at major population centers served by the hospital follows including a map depicting the hospital's primary and secondary service follows on the next pages.

Apple Valley - has 69,135 residents as reported by the 2010 Census. The town is the home community to SJH. St. Mary. 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 start a Healthy City campaign. The hospital and its physician partners provide education services to the town's senior population offering senior programs. The program reports the largest membership in the region offering weekly educational, health promotion and social programs to its members. The Town sponsors health events including weight loss challenges, programs providing free eye glasses and supports a summer meals program offered at Phoenix Academy School. In FY16 the town started early work on an employee wellness program.

The hospital operates a fixed community clinic and a mobile medical service providing weekly care to Apple Valley's uninsured and/or low income. The mobile medical program serves neighborhoods located near the James Woody-Michael Martin recreation center along Navajo Road and the Phoenix Academy elementary located on Thunderbird Road.

Victorville - The state of California's 50th largest city 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%). The city leads a "Healthy Victorville" campaign in partnership with county public health, SJH, St. Mary, Desert Valley Hospital, Kaiser, Victor Global Medical Center and Mission City clinic. The collaboration promotes health and improves neighborhoods with a focus on public safety and access to parks, recreation and healthy foods. The city loans park facilities to the hospital and residents for health education and free ZUMBA® programs. The city provides and employee wellness program.

The hospital runs a weekly medical clinic serving the poor living in old-town Victorville while also supporting community partners providing food, housing, utility assistance, youth services and domestic violence care. The hospital supports efforts of Mission City Community Network in expanding its primary care, behavioral health and dental programs. Additionally, Molina Health operates a primary care clinic serving low income patients. Both clinics expand access to care in the low-income community of old-town Victorville.

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 has formed a "Healthy Hesperia" campaign that includes city representatives, public health, SJH St. Mary and representatives from the school and park and recreation districts. The hospital operates a community clinic serving the poor and located near the city's poorest neighborhood. City leaders are advocating health and fitness including sponsoring city-wide weight loss challenges and exercise events.

The hospital supports a food collaborative to open a small food bank run from a commercial site in Hesperia. The collaborative numbers 25 pantries working under the direction of Food Bank experts with San Bernardino County's Community Action Partnership Program. Weekly Food pickups include USDA and salvage products. Efforts continue to increase the supply of fruits and vegetables to poor residents who are food insecure.

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.

The community is designated as Medically Underserved by HRSA. 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 college, and few retailers generating sales tax revenue, with several prisons in operation. The city recently zoned approval to grow marijuana with hopes this improves the city's finances.

An estimated 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 formed a Healthy City campaign. This campaign includes city, hospital and nonprofit representatives as well as local school leaders. The city loans facilities allowing the hospital and residents to receive health education, clinical screenings and free ZUMBA® programs.

The hospital operates a community clinic serving the poorest neighborhoods identified by the hospital's needs assessment. Services include primary care, education, counseling, nutrition and prenatal care. Additionally, the hospital awards grants to partners serving persons experiencing a variety of economic, health and social crisis. The community has no Urgent Care or specialty care providers. San Bernardino County operates a community clinic and a Women, Infant and Children office provides services. In 2017, a local contracted mental health provider opened to counsel seriously ill adults.

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 St. Joseph Health, 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 40 miles to St. Joseph Health, St. Mary for treatment or, must travel an additional 45 miles to access care at the county's safety net hospital Arrowhead Regional Medical Center. Two recent FQHC clinics have opened. One is operated by Borrego and the second by Mission City Community Network. Both report plans operating mobile medical and dental services into the community and at schools.

Hospital Total Service Area

The community served by the Hospital is defined based on the geographic origins of the Hospital's inpatients. The Hospital Total Service Area is comprised of both the Primary Service Area (PSA) as well as the Secondary Service Area (SSA) and established based on the following criteria:

- PSA: 70% of discharges (excluding normal newborns)
- SSA: 71%-85% of discharges (draw rates per ZIP code are considered and PSA/SSA are modified accordingly)
- Includes ZIP codes for continuity
- Natural boundaries are considered (i.e., freeways, mountain ranges, etc.)
- Cities are placed in PSA or SSA, but not both

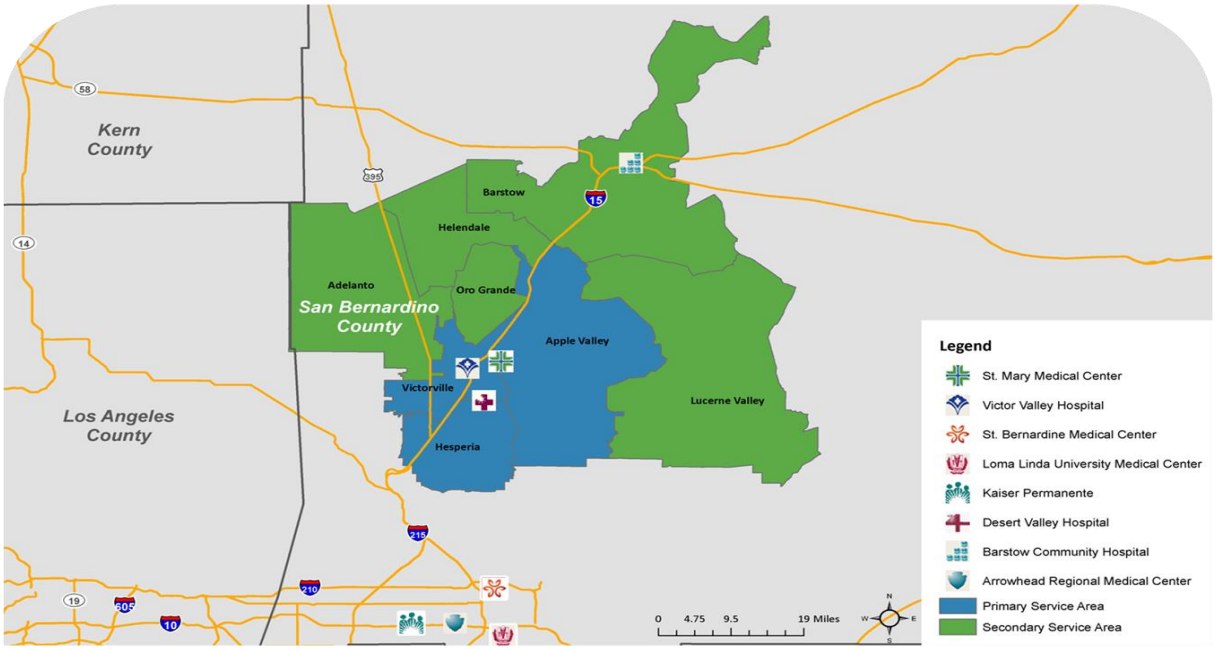
The Primary Service Area ("PSA") is the geographic area from which the majority of the Hospital's patients originate. The Secondary Service Area ("SSA") is where an additional population of the Hospital's inpatients resides. The PSA is comprised of Apple Valley, and portions of Hesperia and Victorville. The SSA is comprised of census tracks in Hesperia and western Victorville, the cities of Adelanto and Barstow and the unincorporated communities of Helendale, Lucerne Valley, Phelan, Pinon Hills, Snowline and Wrightwood.

Table 1. Cities and ZIP codes

Cities	ZIP codes
Adelanto	92301
Apple Valley	92307, 92308
Barstow	92311
Helendale	92342
Hesperia	92344
Lucerne Valley	92356
Oro Grande	92368
Victorville	92392, 92394, 92395

Figure 1 (below) depicts the Hospital's PSA and SSA. It shows the location of the Hospital as well as the other hospitals serving the community.

Figure 1. St. Joseph Health, St. Mary Hospital Total Service Area



Community Need Index (Zip Code Level) Based on National Need

The Community Need Index (CNI) was developed by Dignity Health (formerly known as Catholic Healthcare West (CHW)) and Truven Health Analytics. The Community Needs Index (CNI) identifies the severity of health disparity for every zip code in the United States and demonstrates the link between community need, access to care, and preventable hospitalizations.

CNI aggregates five socioeconomic indicators that contribute to health disparity (also known as barriers):

- Income Barriers (elder poverty, child poverty and single parent poverty);
- Culture Barriers (non-Caucasian limited English);
- Educational Barriers (% population without HS diploma);
- Insurance Barriers (insurance, unemployed and uninsured);
- Housing Barriers (housing, renting percentage).

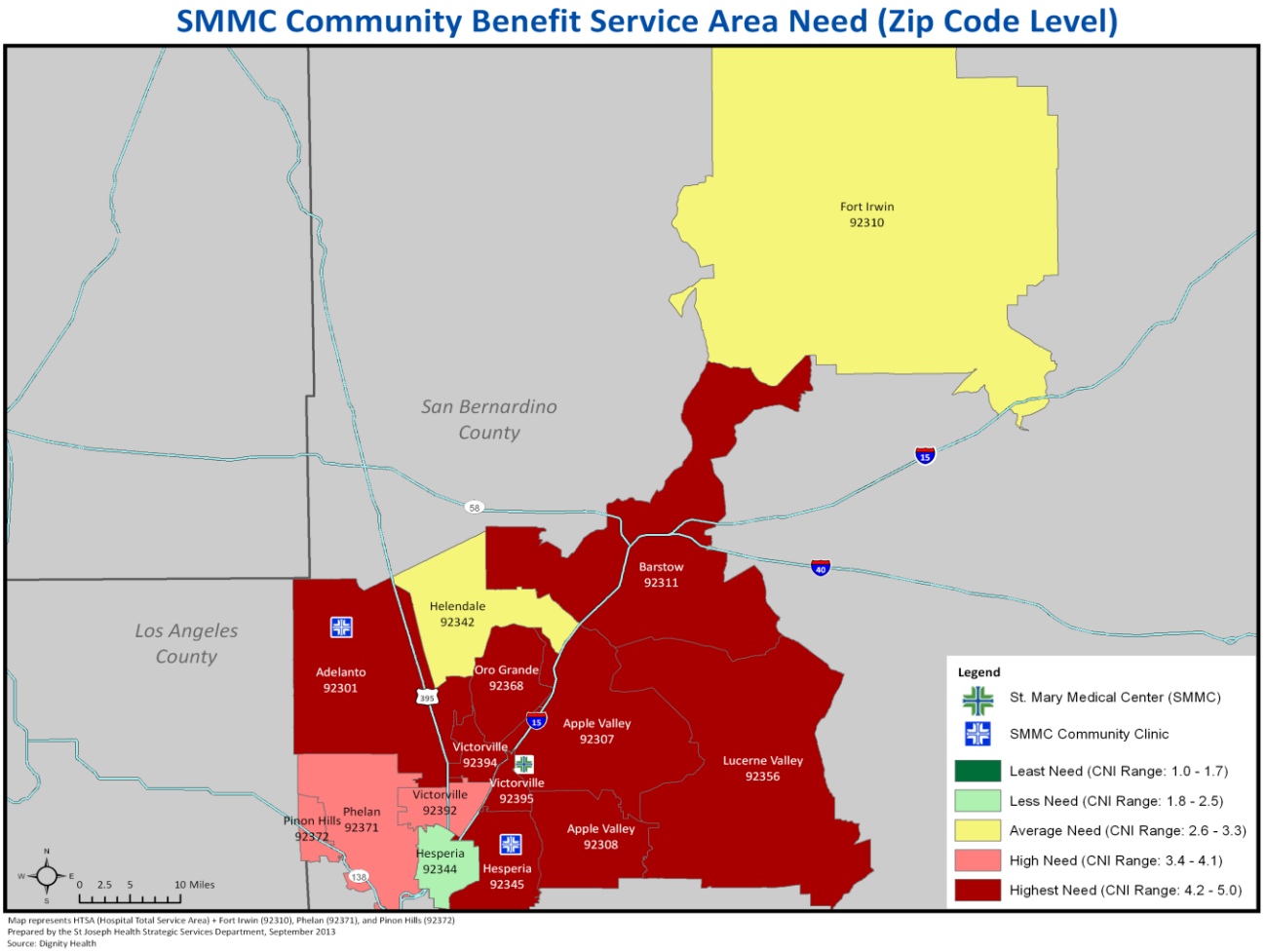
This objective measure is the combined effect of five socioeconomic barriers (income, culture, education, insurance and housing). A score of 1.0 indicates a zip code with the fewest socioeconomic barriers, while a score of 5.0 represents a zip code with the most socioeconomic barriers. Residents of communities with the highest CNI scores were shown to be twice as likely to experience preventable hospitalizations for manageable conditions such as ear infections, pneumonia or congestive heart failure compared to communities with the lowest CNI scores. (*Ref*

(Roth R, Barsi E., Health Prog. 2005 Jul-Aug; 86(4):32-8.) The CNI is used to a draw attention to areas that need additional investigation so that health policy and planning experts can more strategically allocate resources.

For example, ZIPCODES: 92307, 92308, 92301, 92311, 92356, 92345, 92368 and 92394 on the CNI map (depicted below) is scored Highest Need (Red color) with a CNI Range Score of 4.2 – 5.0 making it a High Need community.

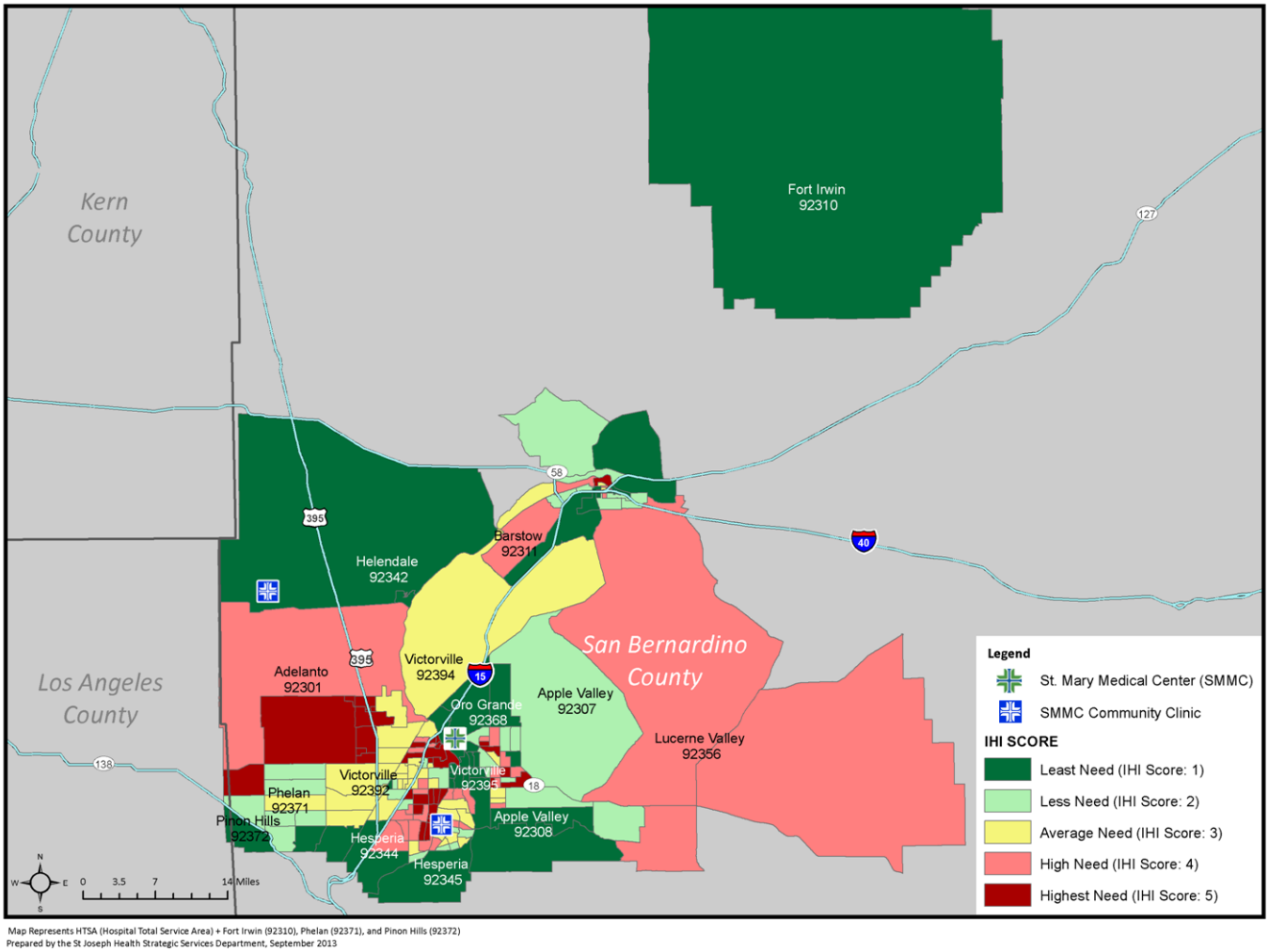
Figure 2 (below) depicts the Community Need Index for the ***hospital's geographic service area based on national need***. The map shows the location of the hospital in Apple Valley and three hospital-run community clinics located in Adelanto, Apple Valley and Hesperia. Additionally, the hospital operates a mobile medical clinic serving poorer neighborhoods in Apple Valley and old town Victorville. Finally, the hospital supports grant efforts of partners providing housing and food assistance to the area's poor. This includes Catholic Charities, The Lords Table, and Victor Homeless Program.

Figure 2. St. Joseph Health, St. Mary Community



Need Index (Zip Code Level) Figure 3 below depicts highest need communities at the block group levels identifying census tracks in Adelanto, Apple Valley, Hesperia and Victorville. These highest need block groups are identified in red and have been scored a 5 for highest need.

Figure 3. St. Joseph Health, St. Mary Community Need Index (Block Group Level)



COMMUNITY HEALTH NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

The hospital's FY15-FY17 CB Plan was developed in response to findings from the FY14 Community Health Needs Assessment (CHNA) and is guided by the following five core principles:

1. Disproportionate Unmet Health-Related Needs: Seek to accommodate the needs of communities with disproportionate unmet health-related needs.
2. Primary Prevention: Address the underlying causes of persistent health problems.

3. Seamless Continuum of Care: Emphasis evidence-based approaches by establishing operational linkages between clinical services and community health improvement activities.
4. Build Community Capacity: Target charitable resources to mobilize and build the capacity of existing community assets.
5. Collaborative Governance: Engage diverse community stakeholders in the selection, design, implementation, and evaluation of program activities.

The St. Mary Community Benefit Committee held special sessions to review, and prioritize results of the CHNA. Results of the CHNA for the service area were provided in addition to health results for the region. Committee members selected a key list of health issues that also discussed with community stakeholders including, but not limited to: public health and behavioral health, residents living in DUHN communities; leaders of local non-profit organizations and community benefit staff from other non-profit hospitals including Loma Linda Medical Center, St. Bernardines Hospital and Kaiser Permanente.

Community feedback was provided to the committee during its meeting to prioritize the seven health issues to four. To facilitate the committee reviewing and prioritizing health conditions, an 11 point matrix criteria was used which included but was not limited to: scope and seriousness of the problem, effectiveness of interventions, time commitment, implications for not proceeding and economic feasibility and likelihood of sustainability. Initial strategies were developed for each of the four initiatives. Clinical targets providing encounters to uninsured and underinsured were established. Each quarter the performance of each priority initiative (Access to Care, Diabetes, Mental Health and Obesity) was discussed at the hospital's Community Benefit meetings. These discussions included ways to innovate the programs to expand services, obtain new resources and develop new community partnerships.

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.

Identification and Selection of DUHN 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.

DUHN Group and Key Community Needs and Assets Summary Table

DUHN Population Group or Community	Key Community Needs	Key Community Assets
Undocumented residents	• Accessing and affording care for primary and specialty care needs • Access to health insurance • Access to bilingual service providers • Access to employment • Assistance helping children obtain college and career resources • Immigrant rights	• St. Joseph Health and community health clinics, • San Bernardino County community health clinics located in Adelanto and Hesperia • San Bernardino County Community Clinic Association • Community Health Action Network • Inland Empire Health Plan • Molina Health clinics in Adelanto and Victorville • The Diocese of San Bernardino, St. Joan of Arc, Holy Family, Christ the Good Shephard Church, Inland Congregations for Change and The Guatemala Consulate
Low income residents – no or inconsistent transportation	• Affordable and timely transportation to health and social appointments • Availability of public transportation in rural communities and weekends	• Victor Valley Transit Authority, (bus vouchers, TRIP, Travel training, bus donations) • Victor Community Services Council (senior, disabled transportation) • Lyft and Uber (pending)

Low income residents - (youth, adults and seniors) living with chronic disease and impacted by social issues (poor housing, poverty, mental health, food insecurity etc.	• Lack of affordable specialty care including laboratory, radiology, mental health, • Ability to pay for medicine and co-pays for dental and health services. • Availability of local providers offering affordable services including homecare	• St. Joseph Health clinics (fixed and mobile) • Arrowhead Regional Medical Center • San Bernardino County Public Health and Behavioral Health community clinics in Adelanto and Hesperia, • Mission City Mental clinics in old town Victorville • Molina clinics in Adelanto and old-town Victorville • San Bernardino County 24 hr. Crisis Walk-In Center • San Bernardino County/Arrowhead Breath mobile (asthma care at schools) • Molina Disability Collaborative
African American (AA) residents - (especially low income)	• Programs targeting their health needs and social norms; AA staff providing services	• Community Health Action Network • AA focused churches: (Burning Bush (old town VV), Kingdom Life (Adelanto), United in Christ Baptist Church (village of Apple Valley) Life Church (Victorville) • School based family resource centers • Foster Care agencies and Foster parents • Victor Community Services • Local NAACP chapter
Chronic homeless patients (living on streets of High Desert)	• Local expertise and programs engaging complex persons	• San Bernardino County Homeless Program • Victor Valley Rescue

	• Housing • Mental Health services	Mission • Victorville Homeless Services • San Bernardino County Sheriff HOPE program • City of Victorville • City of San Bernardino • Orenda Foundation
Residents of rural communities (portions of Adelanto, Lucerne Valley, portions of Phelan and Pinion Hills)	• Availability of services both health and other	• St. Mary Mobile clinic • San Bernardino County mobile clinic • Mission City mobile clinic • Borrego mobile clinic • Supervisor Lovingood's staff
Foster Youth	• Affordable Housing • Foster Parents	• County Transitional Assistance programs • FACCT churches • Family Assist • San Bernardino County Department of Behavioral Health

DUHN Population Group or Community	Key Community Needs	Key Community Assets
Adelanto 3 block groups 9,594 persons 82% poverty	• Economic Development • Employment • Redevelopment • College • Workforce development • Primary care • Specialty care • Dental care • Mental health care • Urgent care • Youth services • Park and Recreation • Crime	• St. Mary community clinic, • San Bernardino County public health clinic, • Molina Health clinic, • Woman, Infant and Child (WIC) office, • Adelanto School District, Healthy Adelanto, • residents of Communities of Excellence campaign, • City of Adelanto staff and code enforcement/public safety officer, • Victor Union High School District, • High Desert Outreach, • San Bernardino County Public Health Nutrition program, • Christ the Good Shepard Catholic Church, • Adelanto Senior Center, • Desert Garden Apartments, Adelanto pool, • Adelanto youth sports programs (baseball, football and soccer), First 5 of San Bernardino, • San Bernardino County Department of Behavioral Health • Another Level for Women • GRID Solar • County Workforce Development

DUHN Population Group or Community	Key Community Needs	Key Community Assets
Apple Valley 1 block group 1,093 persons 62% poverty	• Economic development • Employment • College education, • Specialty healthcare services • Job training	• Town of Apple Valley • St. Mary Medical Center • St. Mary High Desert Medical Group • Healthy Apple Valley campaign • Residents of the Apple Valley Communities of Excellence campaign • Apple Valley Unified School District • Paul Swick Family Resource Center and Phoenix Academy Family Center • Apple Valley Park and Recreation programs, • Ascension Lutheran Church • Church of the Valley • Broken Heart Ministries • United in Christ Baptist Church
Hesperia 1 block group 2,077 persons 54% poverty	• Economic development • Job training • College education • Employment • Access to health services • Specialty healthcare • Redevelopment	• City of Hesperia • Hesperia Unified School District • Hesperia Resource Center, • Cottonwood School • Healthy Hesperia Campaign • Happy-Healthy Kids • Residents of Hesperia Communities of Excellence campaign • San Bernardino County public health clinic • Hesperia Park and Recreation District • St. Mary Community Clinic • St. Mary High Desert Medical Group

DUHN Population Group or Community	Key Community Needs	Key Community Assets
Victorville (old-town) 3 block groups 3,730 persons 69% poverty	• Economic development • Employment • Access to health and dental services • Workforce • Chronic homelessness • Community revitalization • Poverty • College • Crime • Youth programs	• Azusa Pacific University nursing program • City of Victorville • old town residents (organized as ROOT) • Institute for Public Strategies • Victor Global Medical Center • Desert Valley Hospital • Victor School Districts • Victor Rotary • Victor Valley College • County Public Health County Government • Mission City Clinic • The Lords Table • Victor Rescue Mission • Healthy Victorville campaign • St. Mary Medical Center's mobile health program • Burning Bush Baptist Church • Mission City clinic • Molina clinic • St. Joan of Arc Catholic Church, • Friendly Temple Church • San Bernardino County Department of Behavioral Health • Valley Star Community Services – High Desert Walk-in Center • Family Assist Program • St. John of God Healthcare • High Desert Church

PRIORITY COMMUNITY HEALTH NEEDS

The 400,000 residents of the Victor valley are served by community benefit programs operated locally by SJH. St. Mary. Additionally, Kaiser Permanente awards grant funds to High Desert entities and San Bernardino County public health has been expanding health programs at two Federally Qualified Health Centers in Adelanto and Hesperia. Finally, St. Mary works regionally with community benefit staff at four Orange County hospitals. This regional work includes the sharing of resources and best practices including addressing disparities and programs including access to care and behavioral health. The table below lists the four health priorities selected by SJH, St. Mary. The Victor valley region is located in the secondary service area of Kaiser's Fontana CA hospital. A ranking of health need by that hospital has been provided.

Priority Issues in St. Joseph Health, St. Mary FY15-FY17 Community Benefit Plan

Significant Health Issue	2012% increase over 2007 baseline within Hospital's service area	Ranking by SJH, St. Mary CHNA	Ranking by Kaiser Fontana CHNA
Obesity	6.6% increase to 35%	1*	7
Diabetes	3.9% increase to 15.3%	2*	4
Mental Health	3.9% increase to 16.4%	3**	2
Access to Care	3.1% increase of self-report problems accessing care	4	3***

Notes:
*Addresses heart disease, hypertension and high cholesterol which also increased from 2007 levels
**Addresses depression and community requests for additional mental health providers
***Kaiser Permanente Fontana, CA CHNA ranked economic instability as 1 and Health Access 3.

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 the St. Joseph Health, St. Mary. In FY17 the hospital provided $1,001,000 in program funds providing services to the poor.

Furthermore, St. Joseph Health, 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, resources to meet the identified needs of underserved communities through St. Joseph Health communities.

The following community health needs identified in the ministry CHNA will not be addressed and an explanation is provided below:

- **Homelessness Services:** The hospital does not directly address homelessness; however it partners with local shelters and agencies providing this care. The hospital has staff on the boards of local programs operating the High Desert Homeless Shelter and a Better Way Domestic Violence shelter. When possible the hospital provides assistance with an emergency housing grant offered by the Partnership Fund.

- **Transportation**: The hospital does not provide the public free or discounted transportation with the exception of operating a mobile bus transporting patients to the hospital's community clinics on a case-by-case basis. Additionally, the hospital subsidizes transportation on a case-by-case basis for patients discharged to home or transferred for follow-on care. The hospital partners with local agencies including the Victor Valley Transportation Authority (VVTA) and Victor Community Services Council (VCSC). Both partners offer programs assisting poor seniors and the disabled to access health and social services. VCSC routinely transports patients to the hospital's Wound Care program.

COMMUNITY BENEFIT PLANNING PROCESS

Summary of Community Benefit Planning Process

The hospital's FY15-FY17 CB Plan was developed in response to findings from the FY14 Community Health Needs Assessment (CHNA) and is guided by the following five core principles:

• Disproportionate Unmet Health-Related Needs: Seek to accommodate the needs to communities with disproportionate unmet health-related needs.
• Primary Prevention: Address the underlying causes of persistent health problem.
• Seamless Continuum of Care: Emphasis evidence-based approaches by establishing operational between clinical services and community health improvement activities.
• Build Community Capacity: Target charitable resources to mobilize and build the capacity of existing community assets.
• Collaborative Governance: Engage diverse community stakeholders in the selection, design, implementation, and evaluation of program activities.

The St. Mary Community Benefit Committee held special sessions to review, and prioritize results of the CHNA. Results of the CHNA for the hospital's service area were provided in addition to health results for the region. Committee members selected a key list of health issues that were discussed with community stakeholders including, but not limited to: public health and behavioral health, residents living in DUHN communities; leaders of local non-profit organizations and community benefit staff from other non-profit hospitals.

Community feedback was provided to the committee during its meeting to prioritize the seven health issues to four. To facilitate the committee reviewing and prioritizing health conditions, an 11 point 25 criteria matrix was used. The matrix criteria included: scope and seriousness of the problem, effectiveness of interventions, time commitment, implications for not proceeding and economic feasibility and likelihood of sustainability. Initial strategies were developed for each of the four initiatives. A target of clinical encounters to uninsured and underinsured is established as a Tracker goal and reported quarterly to the region. This goal of caring for the poor is listed among other key goals including finance, quality and patient satisfaction.

St. Joseph Health, St. Mary
FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY17 Accomplishments

Initiative: Access to Care: FY14 CHNA reports 41.5% of residents report barriers accessing medical care
Goal (anticipated impact): Increase number of low income and uninsured patients receiving appropriate medical care

Outcome Measure	Baseline	FY17 Target	FY17 Result
Increase access to low income persons seeking medical care (data source: Clinical Tracker)	33,860 in FY15	32,453 in FY16	31,609 clinical encounters

Strategy(ies)	Strategy Measure	Baseline	FY17 Target	FY17 Result
Improve clinic efficiency caring for patients	Implement new Electronic Medical Record and Billing system in clinics	No electronic medical records in community clinics	Implement All Scripts electronic medical record (EMR) system in fixed clinics. This EMR allows referral of patients from St. Mary High Desert Medical group to community clinics needing specialized care (diabetes, and medical nutrition therapy)	All Scripts system implemented. Systems to install new billing systems underway
Conduct health enrollment campaigns at hospital, in community	# of persons provided enrollment assistance from hospital program	Enrolled 2,422 in FY15	Enroll 2,500 persons. Support enroll campaigns Participate in IE-CHI advocacy	1,878 persons enrolled IE-CHI Legislative Forum; taskforce assessing gaps of care in rural communities

Improve referral of patients to community clinics and physicians providing care	Establish referral relationships between hospital clinics and physician offices of St. Mary High Desert Medical group	No referrals	Physician Group and community clinics refer patients and use All Scripts as single EMR.	Patient referrals (especially for Diabetes care) take place using single EMR. Hospital's community clinic establishes referral relationship with SJH programs in Orange Representative of St. Mary High Desert Medical joins hospital's CB committee

Key Community Partners: *Covered California, San Bernardino County Community Clinic Association, Armstrong Insurance, Fath Insurance, Inland Empire Health Plan and Inland Empire Covered Health Initiative; St. Joseph Health, St. Mary High Desert Medical Group, St. Joan of Arc Catholic Church/Lords Table, James Woody Recreation Center, United Way High Desert office, Mission City Community Network.*

FY17 Accomplishments:

- Community clinic's mobile unit expands to 2nd site in Apple Valley; second mobile unit obtained; service to Lucerne Valley by Fall 17
- Community clinic initiates Faith-Health program providing clinical and educational services to churches in low income communities
- Community Clinic adds services to Family Resource programs
- Heart and stroke education provided to bilingual population (north Adelanto) AA populations (church) and rural (Phelan)
- Hospital campus urgent care to open Fall 2017 as strategy to direct eligible patients to appropriate place of care
- Hospital partner (FQHC clinic named Mission City) expands to second clinic serving old-town; dental care expected
- Hospital partner FQHC clinic named Borrego) opens Barstow clinic along with mobile medical unit

St. Joseph Health, St. Mary
FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY17 Accomplishments

Initiative: FY CHNA shows a marked increase in diabetes prevalence to a reported 15.3%.

Goal (anticipated impact): Improve clinical outcomes among patients with diabetes who receive ongoing care at hospital clinics and from physician offices

Outcome Measure	Baseline	FY17 Target	FY17 Result
Percentage of diabetic patients whose HA1c levels are less than 7%, less than 8, less than or equal to 9% or greater than 9%	90	90	75

Strategy(ies)	Strategy Measure	Baseline	FY17 Target	FY17 Result
Increase screening for diabetes with patients seeking care in the clinics	# of patients (encounters)	1,842 persons	1,800	1,414
Coordinate care securing a medical home for patients admitted to St. Mary with diabetes	# of patients	0	0	0
Develop options for improving access to low income patients to screening for retinopathy	# of partners	2	3	2

Key Community Partners: St. Mary High Desert Medical Group, Communities of Excellence campaigns in Adelanto and Apple Valley, St Jude and Hoag Medical Centers, American Diabetes Association

FY17 Accomplishments:

- Expansion of program education into community facilities including churches and senior centers
- Regional collaboration with diabetes programs operating at St. Jude and Hoag Medical Center
- Developing a Diabetes registry (to identify and target patients using ER for care) with SJH experts

St. Joseph Health, St. Mary
FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY17 Accomplishments

Initiative: FY14 CHNA reports increases in self-reported depression at 13.5% and self-reported fair to poor mental health at 18%

Goal (anticipated impact): Improve clinical outcomes for patients with mental health conditions at community clinics and physician offices

Outcome Measure	Baseline (FY15)	FY17 Target	FY17 Result
The number of system and program changes resulting in increased access to mental health services	0	1	2 (draft and proposed) Tele-psychiatry policy TEST MOU for hospital ER

Strategy(ies)	Strategy Measure	Baseline	FY17 Target	FY17 Result
Partner to providers to improve access to services and advocacy	# advocacy partners	5	5	HASC, NAMI, Stars Behavioral Health, Family Agency of San Bernardino, SB County DBH
Partner to improve services in regional effort with SJH hospitals	Advocacy plan as part of Institute for Mental Health & Wellness plan	0	2	HASC, Well Being Trust
Partner to improve services in regional effort	# of patients provided mental health services	132 patients (SJ of God) 486 counseling visits (community health – Bridges Family Resource Center)	0	255 patients (SJ of God) 568 counseling visits (community health- Bridges Family Resource Center

Key Community Partners: St. Joseph Health, San Bernardino County Department of Behavioral Health, Ascension Lutheran Church, Hospital Association of Southern California, High Desert Church, St. John of God Healthcare Services, Victor Counseling, Support Services, National Alliance on Mental Illness (NAMI) San Bernardino and Pomona offices, Diocese of San Bernardino, Life Church, Stars Behavioral Health, Victor Services, Family Service Agency of San Bernardino

FY17 Accomplishments:

- 255 unduplicated patients provided weekly counseling and Burns Assessments (St. John of God)
- 80 youth provided 813 counseling session hours in individual and family counseling (Family Assist)
- Regional grant to integrate mental health into primary care settings awarded (Well Being Trust)
- San Bernardino County nears completion of 16-bed residential treatment facility to be open February 2018
- Mental health practice opens in Adelanto serving Tier 3 patients (Family Service Agency of San Bernardino County)
- Homeless patients with mental health disorders admitted for care (Victor Valley Homeless Services)
- Three faith partners offer mental health training and support groups (Ascension, High Desert and Life)
- Hospital implements tele-psychiatry service for improved Emergency Room care (Providence Health)

St. Joseph Health, St. Mary
FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY17 Accomplishments

Initiative: FY14 CHNA reports an increase in the prevalence of adult overweight and obesity to 37% and 33% respectively

Goal (anticipated impact): Body mass index measures in adults and children

Outcome Measure	Baseline	FY17 Target	FY17 Result
Body Mass Index	# of persons losing weight (121)	150 (adults and children)	46 adults (Adelanto) (227 total pounds lost) 23 adults (old town Victorville) (247 total pounds lost) **69 adults total**

Strategy(ies)	Strategy Measure	Baseline	FY17 Target	FY17 Result
Partner with schools to identify at-risk children/families	# of school partners	13 schools (FY15) Healthy4Life	Pilot SQORD at Cottonwood School; Develop health curricula Recruit additional schools for Fall 17	Pilot of 286 students complete 6 schools recruited
Counseling sessions provided for nutrition	# of sessions	678 sessions	Not set	287 (Faith) 761 (Community) **1,048 total**
Community change that increases access to healthy foods and exercise in low income neighborhoods	# of physical improvements in environment	2 changes	2 changes	¼ mile walking path installed in Adelanto Twice a month donations of fresh produce (totaled 760,000 pounds)

Key Community Partners: Healthy Adelanto, Healthy Apple Valley, Healthy Hesperia and Healthy Victorville campaigns, Community Health Action Network, San Bernardino County Department of Public Health, Faith Communities, Happy-Healthy Kids, Cottonwood Elementary School, Community Action Partnership of San Bernardino County, Victor Rescue Mission, Food Forward, High Desert Second Chance, Supervisor Robert Lovingood's office, Kaiser Permanente, Adelanto School District

FY17 Accomplishments:

•Two residents earn fitness certification in P90X® and ZUMBA® and offering exercise classes at Adelanto Parks, Columbia Middle School and a mobile home park

• "Clean Up Adelanto" campaigns, (a local effort led by residents in partnership with City), collects 89 tons of trash in an effort to make walking more safe

• Adelanto Mayor continues community-wide Mayor Weight Loss Challenge with prizes for top finishers

• 90 unduplicated seniors participate in weekly Senior Strengthening Classes hosted by St. Mary High Desert Medical Group

FY17 Other Community Benefit Program Accomplishments

Initiative (community need being addressed):	Program	Description (insert Target for)	FY17 Accomplishments
Access To Care	Transportation of patients upon discharge or to attend appointments at community clinic	No Target	863 persons provided transportation
Health Education & Chronic Disease management	Cardiovascular and Stroke Support Groups	No Target	807 clinical encounters
Health Education & Chronic Disease management	Wound Care	No Target	19 persons educated
Health Education	Breast Cancer Support Group English and Spanish	No Target	194 encounters
Health Careers & Workforce Development	College and High School students provided with work shadowing experience	No Target	388 college students

FY17 Community Benefit Investment

In FY17 St. Joseph Health, St. Mary invested a total of $1,001,000 in Care for the Poor dollars serving the needs of the poor. In FY17, Medicaid shortfall was $25,535,421.

FY17 COMMUNITY BENEFIT INVESTMENT
ST JOSEPH HEALTH, ST. MARY
(ending June 30, 2017)

CA Senate Bill (SB) 697 Categories	Community Benefit Program & Services[2]	Net Benefit
Medical Care Services for Vulnerable[3] Populations	Financial Assistance Program (FAP) (Traditional Charity Care-at cost)	$1,869,217
	Unpaid cost of Medicaid[4]	$25,535,421
	Unpaid cost of other means-tested government programs	$0
Other benefits for Vulnerable Populations	Community Benefit Operations	$0
	Community Health Improvements Services	$208,054
	Cash and in-kind contributions for community benefit	$171,279
	Community Building	$3,032
	Subsidized Health Services	$4,414,121
	Total Community Benefit for the Vulnerable	***$32,201,124***
Other benefits for the Broader Community	Community Benefit Operations	$295,329
	Community Health Improvements Services	$217,864
	Cash and in-kind contributions for community benefit	$37,925
	Community Building	$62,216
	Subsidized Health Services	$0
Health Professions Education, Training and Health Research	Health Professions Education, Training & Health Research	$371,719
	Total Community Benefit for the Broader Community	***$985,053***
	TOTAL COMMUNITY BENEFIT *(excluding Medicare)*	$33,186,177
Medical Care Services for the Broader Community	Unpaid cost to Medicare[5] ***(not included in CB total)***	$16,218,715

[2] Catholic Health Association-USA Community Benefit Content Categories, including Community Building.
[3] 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 (referred to as Medi-Cal in California), Medicare, California Children's Services Program, or county indigent programs. For SJH, we exclude Medicare as part of Community Benefit total and only include it below the line for SB697 reporting purposes.
[4] 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.
[5] Unpaid cost of Medicare is calculated using our cost accounting system. In IRS Form 990, Schedule H, we use the Medicare cost report.

Telling Our Community Benefit Story: Non-Financial[6] Summary of Accomplishments

President and CEO sworn-in as Commissioner of First 5 San Bernardino

VP of Mission member of Women's Health Advocacy Committee

Hospital undertakes Sustainability Initiative to strengthen five (5) nonprofits

Hospital departments donate food and supplies to local pantries and schools

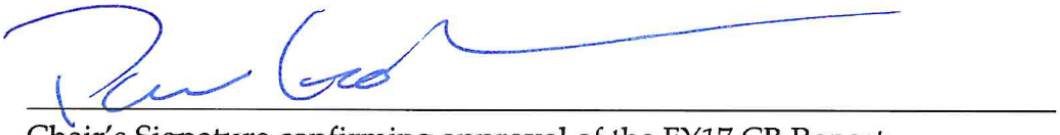
Hospital hosts annual fitness event with proceeds providing scholarships

Hospital staff participates in Christmas gift and coat and scarf donations

Hospital donates medical supplies in response to Blue Cut Fire

Governance Approval

This FY17 Community Benefit Report was approved at the meeting of the St. Joseph Health, St. Mary Community Benefit Committee of the Board of Trustees.



Chair's Signature confirming approval of the FY17 CB Report

9/19/2017

Date

[6] Non-financial summary of accomplishments are referred to in CA Senate Bill 697 as non-quantifiable benefits.