ST. JOSEPH HEALTH, ST. MARY

FY 12 – FY 14 Community Benefit Plan/Implementation Strategy Report

St. Joseph Health
St. Mary

TABLE OF CONTENTS

EXECUTIVE SUMMARY

St. Joseph Health, St. Mary (referred to in this document as St. Joseph Health, St. Mary and SMMC inter changeably) is a 210 bed not for profit acute care health ministry with St. Joseph Health (SJH) serving the greater high desert region of San Bernardino County. The primary and secondary service areas of the hospital encompass 350,000 residents in the communities of Adelanto, Apple Valley, Hesperia, and Victorville. Data from the 2010 US Census reports the population increased by 19.1% between 2000 and 2010- one of the fastest regions of growth in California. Census data also reports the continued ethnic diversification of residents. 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 has been impacted significantly in the economic downturn with one of the state's highest home foreclosure rates and a 50% increase in Food Stamp enrollment.

The hospital has operated in the region for 57 years and for the last 17 years provided extensive community clinic and healthy communities programs as part of SJH and the sponsoring orders of the Sisters of St. Joseph of Orange and the Brothers of St. John of God. SJH, St. Mary is the only hospital providing primary and chronic care services to the area's uninsured currently estimated to number 86,488 adults and children. The hospital completes tri-annual community health assessments in partnership with community organizations and residents. The hospital completed its most recent community needs assessment in June 2011. The assessment combines mapping using secondary socioeconomic data including poverty, unemployment and income to identify neighborhoods with the highest unmet social and health needs. The product of mapping enables SJH, St. Mary to focus community benefit programs in high need neighborhoods. Primary data collected on the community's health status and chronic disease burdens was obtained from households (n=400) participating in a professionally designed health questionnaire conducted by telephone. The survey is designed to identify and compare the general health status of residents as well as disease and modifiable health burdens compared to county, state and national Healthy People 2020 benchmarks. The product of this survey process highlights which health conditions and populations are most at-risk across the hospital's service area.

In 2008 (as a result of community feedback from the hospital's 2008 needs assessment) the hospital helped begin a regional health advocacy collaborative named Healthy High Desert (HHD). HHD members include SJH, St. Mary and three additional hospital systems, schools, health plans, county public health, community organizations, residents and representatives from city and county government. HHD meetings provide regular feedback on improving the health and quality of life of the community through advocacy, program development and policy change. Using community and HHD feedback from the 2011 assessment, the hospital developed three (3) priority initiatives for its FY12-FY14 Community Benefit Plan while continuing its efforts with breastfeeding as a key strategy of the hospital's recent Baby Friendly designation. The hospital's three new initiatives are: (1) Access to Care, (2) Diabetes and (3) Nutrition, Physical Activity and Weight Status. The hospital's selection of Access to Care is based on a county-wide initiative expanding the number of community clinics in San Bernardino County (as a strategy to implement federal health reform) and input from stakeholders of the local need for clinics serving low income and uninsured populations. Additionally, residents identified barriers to care as a significant issue in the hospital's health assessment survey. Therefore SJH, St. Mary will use its advocacy and local expertise and resources to assist in the opening of four (4) community clinics serving the poor. To the extent possible, these clinics will be located in neighborhoods identified by the hospital has having the highest barriers to accessing care.

The hospital's selection of Diabetes as a priority initiative is based on health survey data reporting that

15% of high desert adults have the chronic disease and its prevalence is higher than state and national diabetes rankings. Additionally, data on low income diabetics indicates they are increasing their utilization of hospital emergency rooms in efforts to manage their disease. Additionally, research conducted by Inland Empire Health Plan (San Bernardino County's major Medi-Cal insurance provider) identified little or no education was provided by primary care physicians to help high risk diabetic patients manage their disease.

The hospital's selection of Nutrition, Physical Activity and Weight Status is based on health data reporting higher than state rates for obesity, diabetes and heart disease and also the region's lower than state and national levels for adults and teens being physically active and eating five or more fruits and vegetables per day. Additionally, the hospital initiative supports a San Bernardino County Healthy Communities program aimed at improving public health through "healthier designed" communities. Health research by county public health has identified San Bernardino County as having one of the highest unhealthy food environments in the country. In 2009 the hospital helped start four Healthy City campaigns (Adelanto, Apple Valley, Hesperia and Victorville) in an effort to expand the public's access to recreation and healthier foods.

SJH, St. Mary anticipates the 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 the St. Joseph Health, St. Mary in the CB Plan/Implementation Strategy. With regard to the hospital access to care initiative, (which assists in the opening of four (4) community clinics serving the poor with primary care services) efforts may soon have to also address the large gap in specialty care of poor patients who are unable to travel to the community hospital 45 miles away or are unable to obtain an appointment for follow-up care for three to four months. Finally, California's implementation of federal health reform is beginning in the summer of 2014 including a state-wide Covered California health insurance campaign. By the fall of 2014 a local marketing campaign including education and outreach to the uninsured will be needed to assist the local uninsured to either purchase insurance through an exchange or enroll in an expanded Medi-Cal program. The strategy of increased health insurance enrollment activities will be ramped up as the health insurance campaign starts and local clinics are open.

MISSION, VISION AND VALUES

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

SJH, St. Mary is expanding its facilities to meet rising community need. Over the last three years the hospital has added 12 licensed hospital beds and expanded its emergency department (one of the busiest in San Bernardino County) at its Apple Valley hospital. In 2012 the hospital begins construction on a second hospital campus in the city of Victorville. Site planning and state and city approvals are in process and the new facility, when open in 2016, relieves the community's chronic shortage of hospital bed availability and overcrowding in emergency room care. The hospital's expansion of hospital beds and specialty care along with helping to increase community clinics addresses a key finding from the hospital's 2011 health assessment: barriers to health access are significantly higher locally (50.4%) than those reported at the national level (37.7%).

SJH, St. Mary is known throughout San Bernardino County for the strength and diversity of its community outreach programs. The hospital is the community's only provider of rural clinics and mobile medical vans serving uninsured communities. These clinics are located in low income neighborhoods where poverty and unemployment are typically twice the county average. The clinic programs also include transportation services and referrals for specialty care. The hospital also provides healthy community programs and by partnering with other organizations works to bring grant funds and programs to the region. Examples of programs include targeting low income communities to organize resources that improve public access to food, education, healthcare, recreation, safety and employment. Additionally, the hospital has been active on numerous county-wide public health initiatives including establishing Baby Friendly hospitals throughout the county, finding a medical home (or enrollment into low cost health insurance) for the county's 84,000 uninsured children and assisting San Bernardino County's public health department to better serve low income residents through its primary and specialty care programs.

SJH, St. Mary operates a Care For The Poor fund exclusive to providing care to persons in poverty. The program aligns with Catholic social teaching principles of advancing economic justice, the common good and an option for the poor. Funds are awarded to hospital programs and community partners providing a range of health and social services to persons in crisis. Many of the grants are targeted to meet community need issues that lie beyond the program expertise of the hospital. For example the fund provides grants to homeless and domestic violence shelters and to a local dental clinic serving the poor. Finally, SJH, St. Mary works with foundations, public health and grant making agencies to increase giving to the community. Examples include SMMC assisting community partners with grants awarded by the SJHS Foundation and the Sisters of St. Joseph of Orange Healthcare Foundation. These grant funds provide crucial support to help feed the hungry, house the homeless and assist families abused by domestic violence. Unemployment figures released in August 2011 report San Bernardino County's rate is 14.1% one of the highest percentages in California.

ORGANIZATIONAL COMMITMENT

Community Benefit Governance and Management Structure

A 16-member Board of Trustees meets monthly to review and discuss hospital operations. The Board of Trustee's Community Benefit Committee meets bimonthly and oversees and participates in development of the hospital's needs assessments and Community Benefit planning and has direct oversight of the hospital's Care for the Poor Fund. The administration of this fund is exclusively directed to programs providing direct service to low-income persons. Approximately 80% of funding helps subsidize some hospital community health programs and the remaining 20% is awarded to community partners in the form of annual grants.

A member of the hospital's Board of Trustees chairs the Community Benefit Committee. Each meeting is attended by community leaders, additional board of trustee members, and hospital executives including the CEO and Vice President of Mission Integration. Program updates on priority Community Benefit initiatives are presented by hospital staff and community partners.

SJH, St. Mary is transitioning to a health ministry recognized for its excellence in acute care and promotion of wellness as directed in the SJHS strategic plan. Included in this plan are three transformational goals: (1) Providing Perfect Care, (2) Providing Sacred Encounters and (3) Achieving Healthiest Communities which encompasses raising the community's general health status into the top decile. Currently 44% of households surveyed in the hospital's 2011 assessment reported their health status as "Excellent" or "Very Good". The hospital's strategic plan includes opening of a new 128 bed hospital and ambulatory care center by 2016. The new hospital site was selected to serve communities with no immediate access to acute care with plans to also achieve Trauma Center designation. Additionally, SMMC is expanding its newly formed St. Mary Medical Center Specialty Clinic in partnership with St. Joseph Heritage Healthcare. Expansion of specialty care will help reduce the 14,000 patients trips made out of the community because local specialists are lacking.

The hospital's Community Benefit Committee is a formal committee of the Board of Trustees and chaired by a board member. The committee has a regular meeting schedule enabling actions by the committee to be reviewed and approved by the Board of Trustees. Committee membership includes community leaders, residents from low income communities, hospital executives and representatives from the two sponsoring organizations: the Sisters of St. Joseph of Orange and the Brothers of St. John of God. The Community Benefit Committee develops and approves an annual Care For The Poor Budget. This budget is a required element of the SJH annual hospital operating budget process. A required 7.5% of hospital net income establishes an annual Care for The Poor Budget and the remaining 2.5% is directed to the SJH Foundation for grant making. In turn, annual grants are awarded by SJH Foundation in the areas of Wellness and Prevention, Community Clinics and Community Building. These grants enable the hospital and partners to pursue programs aligned with the Community Benefit Plan. Prior grant awards have provided recreation to low income children, the opening of food programs serving the hungry, expansion of community health programs and establishment of programs providing education and career development to youth.

The Community Benefit committee provides oversight of Care For The Poor expenditures through committee program reports and discussion. The Committee guides the hospital's development of Community Health Needs Assessments, discusses findings and development of priority Community Benefit initiatives and is updated on initiative progress by hospital staff and community partners. Priority community benefit initiatives are developed with goals, strategies and target measures to assist the committee to discern program success. Program goals have been selected for each of the hospital's four community benefit initiatives using Healthy People 2020 benchmarks where possible. The emphasis on developing programs

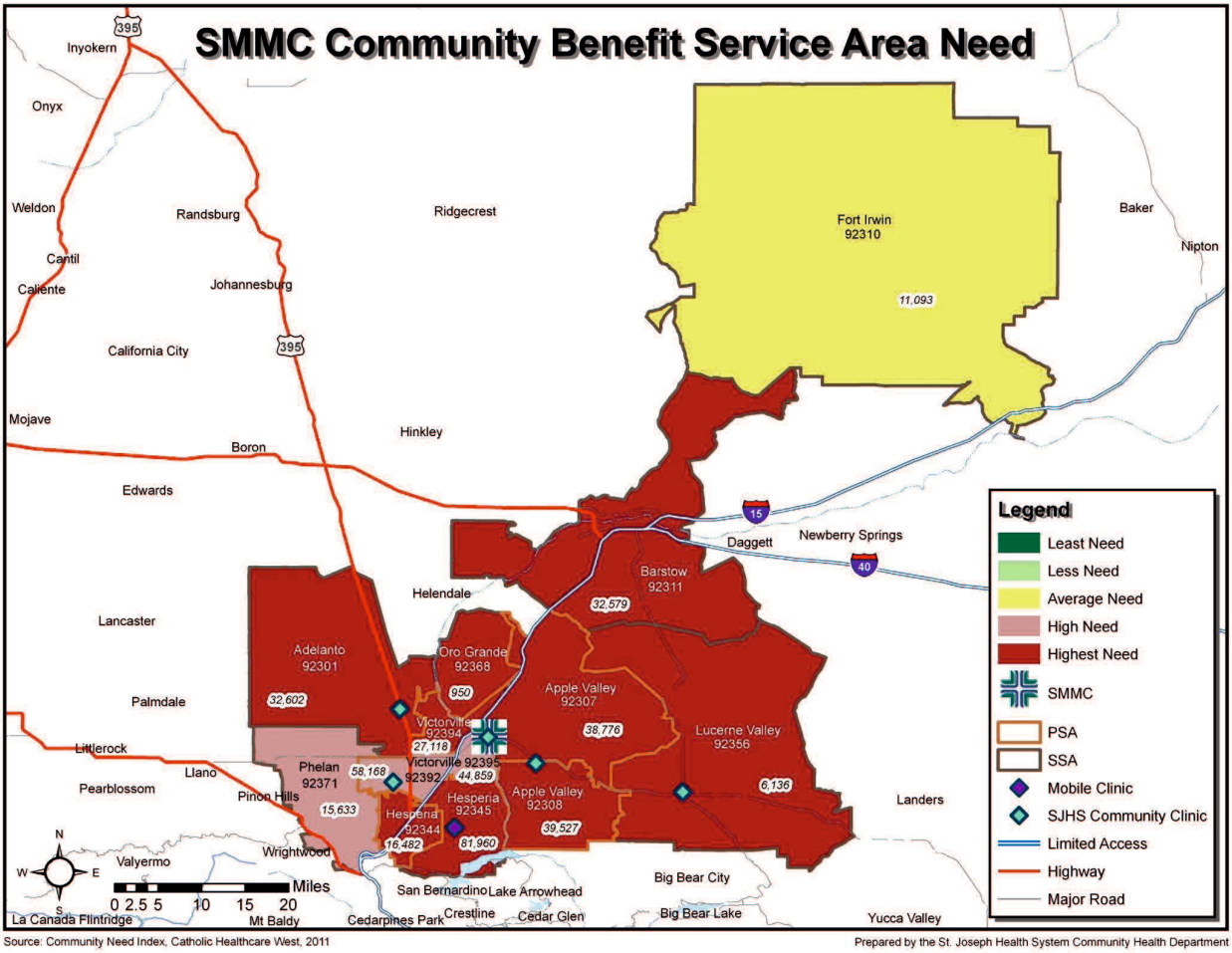
and targets for measurable health improvement enables the committee to more meaningfully discuss program success and shortcomings, expenditure of resources and building partnerships.

PLANNING FOR THE UNINSURED AND UNDERINSURED

SJH, St. Mary provides patients a financial assistance program in accordance with the California Hospital Free and Discount Payment Program and the Hospital Fair Pricing Act of 2006. As required by SJH, the hospital's policy exceeds California state requirements by offering financial assistance to patient's earning up to 500% of the Federal Poverty Level (FPL). The policy is designed with three discount payment options based on patient income. Free care is provided to patients with income up to 200% of the FPL; a sliding scale discount (using Medicare rates) is provided to patients earning 201% to 350% of the FPL and hospital charges not higher than Commercial PPO/HMO rates to patients earning from 351% to 500% of the FPL. Patient education on the policy begins at hospital admission. The hospital's Patient Services department is trained to educate patients on the policy in English and Spanish. The department also posts signage on the policy in English and Spanish. The hospital's lead Spanish language interpreter is trained to assist patients needing to use the program as this need surfaces during patient rounding. The hospital's business office and billing processes include information on the policy in English and Spanish during discussion of bills and payment. Community Health Department staff is trained to help their clinic patients qualify and use the hospital's program. The hospital's annual Report to the Community (mailed to households in the hospital's service area) reports the amount of financial assistance provided. The hospital also reimburses physicians for their care to uninsured patients whether patients are cared for in the Emergency Room or admitted to the hospital with acute care needs. The hospital also works with local physicians providing free or low cost primary and specialty care to low income and uninsured patients. The hospital is active on a county-wide initiative to successfully implement the Covered California health insurance enrollment campaign that is expected to take place in 2014.

COMMUNITY
DEFINITION OF THE COMMUNITY BENEFIT SERVICE AREA

The hospital's Community Benefit Service Area is roughly defined as serving the Victor Valley region of San Bernardino County an area (as depicted below) with a 2010 population of 350,000 residents. The communities of Apple Valley, Hesperia and Victorville comprise the hospital's primary service area



and the remaining surrounding communities of Adelanto, Oro Grande, Phelan, Oak Hills and Lucerne Valley comprise the hospital's secondary service area. 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 both indigent and uninsured populations when compared with both state and national levels. Additionally, residents suffer from heart disease and stroke at levels well above California and national benchmarks. As a result over 90% of the hospital's community benefit area has been identified as "High Need" from the SJH mapping and scoring of socioeconomic indicators contributing to health disparities. Over the past several years the hospital's community benefit expenditures have increased to over $15 million. As noted the hospital's service area is comprised of four major communities with some unique demographic, economic and health characteristics. The largest city is Victorville with a population of 130,145 residents. Demographic data indicates that 43.14% of residents are Latino and 28% of families prefer to speak Spanish, their primary language, at home. Socioeconomic data reports 16% of families are living in poverty and health assessment data indicates 24% of residents experience "Fair" or "Poor" physical health, the highest percentage among the four cities. The city of Hesperia has 98, 442 residents with 15.4% of families living below poverty and 22% of residents over age 25 with no High

School diploma. The hospital's home community of Apple Valley has 78,303 residents. Residents aged 65 years and older make up 14% of the population the highest concentration in the hospital's service area and 14.6% of families are living below poverty the lowest percentage of any city. The area's fourth city is Adelanto with a population of 32,602 residents. Adelanto is noted for being the region's most ethnically diverse as 63% of residents are Latino and another 10% African American. Socioeconomic data reports 26% of Adelanto families are living in poverty and 28% of households have no high school diploma the highest rankings in the region.

COMMUNITY NEEDS & ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs and Assets Assessment Process and Results

The hospital conducted a needs and assets assessment with consultation and assistance from the SJH and with numerous community partners including Kaiser Permanente, Loma Linda Medical Center, San Bernardino County's Public Health and Healthy Communities programs and representatives of Healthy High Desert. Mapping to determine need and community profiles was conducted by the SJH Strategic Planning department. This process of collecting and scoring socioeconomic indicators contributing to health disparities (or barriers) was developed by Catholic Healthcare West. The quantitative process involves aggregating five socioeconomic indicators: resident income, culture, education, insurance and housing to identify communities with high need. The hospital then targets these high need communities.

SJH, St. Mary partnered with Professional Research Consultants Inc. (PRC) to develop a community health needs assessment that was systematic and data driven in determining the health status, behaviors and needs of residents. Mapping of need was achieved by collection and analysis of secondary data for five socioeconomic indicators. This quantitative process aggregated data to report need by city zip code and by block group. Mapping community need by the hospital has been done for several years. Maps are discussed with community partners including residents, and with a local health partners including San Bernardino County public health. The hospital's familiarity with mapping prompted public health to move forward with an Environmental Scan (Scan) of the hospital's service area. This Scan (expected to be completed by the end of 2012) will produce maps of the area's built environment in area's impacting the health of residents. This quantitative process will identify transportation issues, an examination of the retail food environment, a profile of parks and recreation and environmental issues of air and water quality. Collection of primary and secondary data for the Scan will be completed as a HHD project with participation of local Healthy City representatives including city planners and park and recreation staff.

The assessment of health findings (conducted by PRC) incorporated data from primary research (a 146 community health survey) and secondary research from vital statistics and other existing health related data including, but not limited to the California Department of Public Health, the Centers For Disease Control and Prevention (CDC) and the National Center for Health Statistics. The hospital and PRC developed a questionnaire based largely on the CDC's Behavioral Risk Factor Surveillance System (BRFSS) as well as other public health surveys. The final survey instrument was developed with input from the hospital's Community Benefit Committee and with hospital leaders working on achieving Stroke Designation. A survey sampling strategy was developed for the hospital's service area where a stratified random sample of 400 individuals age 18 and older including 100 interviews each in the communities of Apple Valley, Hesperia and Victorville (n=300) and the remaining 100 interviews in the hospital's secondary service areas of Adelanto and other zip codes. All administration of the survey with data collection and analysis was conducted by PRC. For statistical purposes, the maximum rate of error associated with a sample size of 400 residents is ±4.9% at the 95 percent level of confidence. A completed survey and presentation of findings was provided to the hospital by PRC. Both SJH mapping

and the PRC health survey findings have been provided to San Bernardino County Public Health to assist in planning a San Bernardino County wide health assessment to be completed at a future date.

The hospital conducted a needs and assets survey following methodologies provided by SJH. Data mapping identified community need at the zip code and block group level of the hospital's service area. Mapping of the hospital's Community Service Area identified 90% of Victor Valley communities meeting the "Highest Need" ranking with portions of Phelan, Victorville as having "High Need". Additional mapping by SJH was completed using an Intercity Hardship Index (IHI) developed by the Urban & Metropolitan Studies Program at the Nelson A. Rockefeller Institute of Government. The IHI aggregates six socioeconomic indicators: Income Level, Crowded Housing, Unemployment, Education, Poverty and Dependency and assigns each Block Group a score from 1 (least need) to a 5 (highest need) to identify neighborhoods facing significant barriers to care. The process identified high need neighborhoods in each of the major communities the hospital serves. Currently the hospital serves all four high need communities with community clinics, mobile medical services and healthy community programs. The hospital hopes community clinics will be opened in these high need communities as part of its access to care initiative.

Findings from the PRC conducted health survey identified health priorities and recommended areas of intervention based on the information gathered through the health assessment and the guidelines set by Healthy People 2020. These findings are listed in the table below.

Areas of Opportunity Identified Through PRC Health Assessment
Access to Healthcare – Lack of insurance, Difficulty Accessing HealthCare Services, Emergency Room Utilization, Perceptions of local healthcare services
Cancer – Deaths (Lung, Prostate, Female Breast, Colorectal)
Diabetes – Deaths, Prevalence
Disability – Activity Limitations
Dementias – Alzheimer's Disease Deaths
Education – Attendance at Health Promotion Events
Family Planning – Birth to teens
Heart Disease & Stroke – Deaths, Hypertension
Injury & Violence – Motor Vehicle Crash Deaths, Firearm-related Deaths, Homicides, Violent Crime, including Domestic Violence
Maternal & Infant Health – Prenatal Care, Low Birth-weight, Infant Mortality
Nutrition & Overweight – Fruit & Vegetable Consumption, Overweight/Obesity
Oral Health – Dental Visits (Adults)
Respiratory Disease – Chronic Lower Respiratory Disease Deaths, Pneumonia/Influenza Deaths
Substance Abuse – Cirrhosis/Liver Disease Deaths
Vision – Blindness/Trouble Seeing, Routine Vision Care

Identification and Selection of Disadvantaged Unmet Health Needs (DUHN) Communities

The population residing in the Victor Valley has been identified through mapping processes to be in "high need". Access to care barriers are significant especially for residents of Hesperia where an estimated 14.9% of insured teens and adults went without coverage at some point in the past year a finding ten percentage points higher than national rankings. Of note, the city of Hesperia has 90,000 residents is and is without its own hospital. The construction of SJH, St. Mary's new Victorville campus will be built on the boarder of Victorville and Hesperia and when completed, will be the only hospital serving residents living on the west side of Interstate 15.

Residents in secondary service areas of SJH, St. Mary face significant access to care issues. Adelanto, a city of 32,000 residents has very few physicians and no urgent care. Low income residents of the community continue to be concerned about their access to basic health services and in community feedback sessions have asked for a hospital. The hospital has worked with health workforce experts at the state of California's Office of State-wide Health Planning and Development (OSHPD) in an effort to have the area designed a Medically Underserved Area (MUA). A MUA designation allows additional resources for recruiting physicians.

Survey findings identified that 62% of Apple Valley residents reported difficulties or delays of some kind in receiving needed healthcare in the past year. This community, which has the largest population of senior citizens, reports in feedback that the hospital's local emergency room is overcrowded, bed delays are too commonplace and the need for specialty care requires them to travel out of the area. In response, the hospital will continue efforts recruiting physician specialists especially in critical areas like orthopedics and behavioral health.

At least 63% of persons earning <200% of the FPL reported difficulties or delays receiving care. Low income and uninsured persons with specialty care needs also face access issues. Medical care for low income adults is largely provided under the county's Medically Indigent Adult (MIA) program. MIA services in the community are scarce and most patients must find transportation to travel to the county hospital over 40 miles away. The hospital is working with the Victor Valley Transit Authority with their intentions of piloting a daily bus service enabling patients to travel "down the hill and back" to access care in late 2012. Additionally, the hospital is active in a specialty care collaborative working to improve referrals of low income patients to the county hospital.

The hospital's health survey reports a population experiencing domestic violence at rates higher than national rankings. Thirty percent of residents living in the hospital's secondary service area report having been hit, slapped, pushed, kicked or hurt by an intimate partner a finding twice the national level. This finding aligns with the high rate of poverty and unemployment the area is struggling with and the reality that only two domestic violence shelters serve the region with both located in the city of Victorville. The hospital's Care For The Poor fund already provides grants to domestic violence shelters and will assist partners seeking grants addressing violence and bullying.

Low income and uninsured young mothers with young children are also a population at-risk. Health survey findings indicate higher than California rankings for low birth weight births, infant death rate; the percentage of mothers with low educational attainment and the percentage of mothers with late (3rd trimester) or no prenatal care. Closure of the county run Women Infant and Children's program has caused concern as private contractors are sought to operate the program. The hospital's community clinic programs are noted for their excellence in providing care to uninsured and low income mothers with young children

and the county's First Five Commission, although facing budget cuts, continues to fund the hospital to provide care to young low income families.

Residents suffering from respiratory conditions are also a population at-risk. Health survey findings indicate higher than California and national ratings for Chronic Lower Respiratory Disease. Additionally, children ages 2-17 are reported to have asthma at rates higher than national levels. The hospital works with local schools to schedule the county's new asthma mobile van visits to local schools. The service is operated by the county's Arrowhead Hospital with support from San Bernardino County's First Five program.

Residents with diseases of the heart are a population at high risk with death rates significantly higher than state and national rankings. As previously mentioned the hospital is working to receive stroke care designation. This follows the hospital designation as a Segment Elevation Myocardial Infarction (STEMI) receiving center. Additionally, a second local hospital (Desert Valley) is expanding its facility to include a Heart program and probable STEMI designation. SJH, St. Mary is working with the American Heart Association in a new partnership to bring a "Heart Healthy" campaign to the community. An initial event is planned for February 2012 with the assistance of partners in the Healthy Apple Valley campaign. The hospital may consider piloting a Congestive Heart Clinic.

Adults needing regular dental care have been identified as a population at-risk. The hospital's community health and healthy community department's are actively referring low income adults to the region's only low cost community dental clinic operated in Victorville. Hospital leaders serve as directors of the clinic. Grant-writing efforts will be started between the hospital and clinic in an effort to strengthen this only dental service serving the poor.

DUHN Group and Key Community Needs and Assets Summary Table

DUHN Population Group or Community	Key Community Needs	Key Community Assets
Low Income and uninsured residents of the Victor Valley	Access to care – primary and specialty care has been identified as a key need. Expansion of community clinics to ease ER overcrowding and provide community care	SMMC's fixed & mobile Clinics San Bernardino County Public Health Clinics Molina Healthcare Clinics Inland Empire Children's Health Initiative Community Clinic Association of San Bernardino County (Inland Behavioral) SMMC recruitment of physicians Physician partners providing low cost care to uninsured adults Successful operation of Victor Valley Community Hospital as a not for profit charity Inland Empire Health Plan's High Desert (IEHP) Health Navigator program Victor Valley Community Services Dental Program SMMC Specialty Clinic expansion

DUHN Population Group or Community	Key Community Needs	Key Community Assets
Low income families of children identified as overweight or obese	Rates of overweight and obesity have been identified and consumption of fruits and vegetables is significantly lower than state and national rankings.	Hospital's Healthy For Life Jr. program Four Healthy City campaigns Network of physicians referring at-risk children to hospital's Registered Dietitian San Bernardino County's Healthy Communities Program IEHP Loma Linda Medical Center
Uninsured and Low Income persons with uncontrolled Diabetes	A comprehensive low cost/free diabetes education program is not available and needed by population	SMMC's Community Health Clinics IEHP Physician partners San Bernardino County Public Health
Mothers with young infants	Accessing early maternal care including breastfeeding and lactation support.	SMMC's Community Health Clinics Hospital's Baby Friendly designation Physician partners Women Infant and Children program (WIC)

PRIORITY COMMUNITY HEALTH NEEDS

Figure 1 describes the community health needs identified through the SJH, St. Mary CHNA. Those needs that the hospital does not plan to address are noted[1].

Figure 1.

Health Needs Identified through CHNA	**Plan to Address**
Access to Healthcare	Recruit and assist opening of four (4) community clinics serving low income and uninsured persons and to the extent possible clinics located in high risk communities identified as having highest barriers to accessing care. Connect new clinics to county's Low Income Health Plan for billing and reimbursement. Assist clinics in developing marketing programs to reach uninsured persons needing care through community partners. Conduct health insurance enrollment services assisting uninsured families eligible for health insurance or needing referrals to community clinics for care. Assist San Bernardino County Public Health in developing a Federally Qualified Health Center program in the region to include primary care, dental services and behavioral health.

[1] A number of community health needs are already addressed by other organizations and will not be addressed in the implementation plan report.

Health Needs Identified through CHNA	**Plan to Address**
Diabetes	Provide education and self-care to uninsured diabetes who have uncontrolled diabetes and no access to care. The program will be the only diabetes program serving uninsured persons in the community. Program is designed to achieve Healthy People 2020 goals in: increasing access to care for annual diabetes screenings, increasing access to nutrition therapy, increasing patients' understanding of disease and self-care with support group. Goal of program is 10% of participants will control their HgA1C levels to less than 7.
Nutrition &Overweight	The hospital will implement at comprehensive child obesity program targeting low income families with children enrolled in local Head Start and state funded pre-school programs. The program will: work with schools to increase play and exercise time and educate parents on adopting healthier eating habits through nutritional counseling. The program will meet of exceed Healthy People 2020 goals in reducing the number of obese children by 10%.
Cancer	Offer cancer detection screening services for uninsured and low income women through community health department programs offered at fixed clinics and through a mobile medical van. The services will be provided to as many low income women as possible.
Disability	The hospital will fund a local partner providing services including home care and transportation to low income seniors.
Dementia	The hospital will establish relationship with Choice Medical Group as they offer community support groups for Dementia.
Education	The hospital will continue its free Healthy Eating Active Living series to the community. The program teaches families the benefits of healthy eating and exercise as preventative care. The hospital will recruit community partners who also will teach on diet, exercise and diabetes self-care. The hospital will extend its Senior Select program with local health fairs.
Family Planning	The region's first Planned Parenthood clinic will open in Victorville and provide services including, but not limited to: birth control, HIV testing, Pregnancy testing services, STD treatment, testing and vaccines, LGBT services and men's health services.
Heart Disease & Stroke	The hospital will continue building its expertise in Heart and Stroke care including the benefits of healthy eating and exercise as key behaviors preventing heart and stroke. The hospital will work with community partners and Cardiologists to educate residents on heart care. The hospital will continue its Senior Select program addressing the unique health and service needs of seniors.
Injury & Violence	The hospital will fund local partners addressing domestic violence and bullying and assist with grant support. The hospital will provide advocacy for city adoption of policies banning the sale of Bath Salts and Spice (synthetic marijuana) to the public.

Health Needs Identified through CHNA	Plan to Address
Maternal and Infant Health	Build on the hospital's Baby Friendly expertise by increasing breast feeding rates and community acceptance of breast feeding. The program will track breastfeeding mothers to six months and provide education and support while also providing professional education and peer support to nurses and physicians. The program will increase the percentage of mothers providing breast milk to their babies at six months to
Oral Health	The hospital will provide board member leadership and grant support to improve the region's only low cost provider of dental services to adults and children. The hospital will use its advocacy with San Bernardino County Public Health and establish a FQHC-Dental provider partnership in an effort to expand dental services to low income persons.
Substance Abuse	The hospital will provide board leadership, funds and grant support to the area's leading provider of drug and alcohol services in the region. The hospital will look to provide advocacy on local adoption of policies that limit additional alcohol licenses in neighborhoods identified with high needs.
Vision	The hospital will partner with the local Lions Club who offer free vision screening services.
Respiratory Disease	The hospital will adopt a smoke-free campus and continue offering a "Better Breathers" program to patients with respiratory disease. The hospital will sponsor local partners offering sports and fitness events as a way of preventing health disease. The hospital will work with local communities for expansion of walking paths, bicycle lanes and sidewalks to promote exercise and active living.

Needs Beyond the Hospital's Service Program

The following health needs will not be addressed directly through a St. Joseph Health, Mary initiative or program because they are already addressed by local non-profit organizations that have the resources and expertise.

Formation of Community Clinic Collaborative addressing shortages of clinics and physicians in San Bernardino County:

SJH, St. Mary will partner with Kaiser Permanente and San Bernardino County Public Health to more formerly organize community clinics to expand care across the county. The hospital will serve as a supporting member of the collaborative and provide advocacy that clinic expansion is needed in the High Desert. However, the hospital will not provide grant funding or technical expertise.

Formation of a Specialty Care Initiative to speed uninsured adults receiving specialty care

SJH, St. Mary will partner with San Bernardino County Public Health to lead a health collaborative focused on improving the specialty care of uninsured and low income persons needing care at the county hospital Arrowhead Regional Medical Center. The hospital will participate in meetings but not fund or lead the

initiative. The hospital will continue to recruit specialty care physicians to the High Desert and work with those offering services to the uninsured.

Implementation of a County-wide initiative conducting a Community Vital Signs Assessment to improve health status of residents

SJH, St. Mary will partner with San Bernardino County Public Health to lead the development of a public health improvement framework that creating actions that encompass policy, education, environment and systems change for the improvement of health outcomes. The hospital will play a supporting member of the campaign by sharing results of the hospital's Community Health Needs Assessment and advocate for county resources to fund local Healthy City campaigns. The hospital shall assist in establishing and building local Healthy City campaigns as part of its Community Benefit including support, where possible with funding and grants.

Regional Initiative assisting the uninsured

SJH, St. Mary will partner with Inland Empire Health Plan, tthe lead organizer of a regional effort to enroll the estimated 500,000 uninsured residents in both San Bernardino and Riverside Counties. The hospital will play a supporting role to directly assist uninsured persons locally, including enrolling them into health insurance and referring them for care.

Establish reducing Heart Disease as key health initiative across Healthy City campaigns

SJH, St. Mary looks to Loma Linda Medical Center and the Healthy Communities Department of San Bernardino County to lead an effort that all 13 Healthy City campaigns develop local strategies addressing heart disease. St. Mary will take local action to assist the four local Healthy City campaigns in developing heart disease interventions.

SJH, St. Mary will endorse local non-profit organizations partners to apply for funding through our St. Joseph Health Foundation. Organizations that receive funding provide specific services, resources and meet the needs of the underserved communities that St. Joseph, St. Mary is unable to serve due to limited resources or lack of expertise in those areas of health. Examples of this include a local dental provider who has successfully obtained SJHS grants to build the clinic's capacity and now bills dental insurance as a step in building sustainability, operation of food pantries and utility and housing shelter programs to assist the increasing numbers of homeless. SJHS grants have also been awarded to local partners to provide protection and housing to victims of domestic violence.

COMMUNITY BENEFIT PLANNING PROCESS

Summary of Community Benefit Planning Process

Findings from SJHS community mapping and the PRC health assessment findings were initially reviewed by SMMC's Director of Community Health and Healthy Communities Director. A subsequent meeting was held with the hospital's Vice President of Mission Integration to identify strategies to present the information to SMMC's Community Benefit Committee. Additionally, findings were discussed with the hospital's Vice President of Business Strategy to determine areas of alignment between proposed FY12-FY14 Community Benefit priorities and SMMC's FY12 strategic plan. In particular discussion focused on expanding access to care and improving heart care. Assessment findings were also provided to leaders at SJHS's Community Health department.

Mapping and findings from the health survey were presented to a number of community partners for feedback. SMMC is active in a regional collaborative of hospitals sharing needs assessment and community benefit programs in San Bernardino County. The meeting is lead by San Bernardino County public health and provides the opportunity for hospital's to compare and discuss strategies for addressing unmet community needs. SMMC's presentation of access barriers, diseases of the heart, obesity and weight status aligned with reports from other hospital's including Loma Linda, St. Bernadine's Medical Center and Kaiser Permanente's Fontana Medical Center. Additionally, SMMC's findings align with County Health data reported on its Healthy San Bernardino website www.healthysanbernardinocounty.org. As in the past the hospital presented data locally to obtain feedback. Residents of Adelanto (the community with the highest unmet needs) expressed concern that services to uninsured adults in their community would be hampered when county public health relocated its clinic serving uninsured adults from Adelanto to Hesperia beginning in late 2011. Additionally these residents are concerned that undocumented members in their community will not have access to care in 2014.

Members of HHD requested the hospital continue its efforts expanding access, continuing its Healthy City programs but considered high unemployment as a serious issue confronting the community. Feedback from Inland Empire Health Plan, (IEHP) the county's largest provider of managed Medi-Cal and low income health insurance urged expansion of community clinics and recruitment of physicians to address access issues as federal health reform takes full effect by 2014. IEHP also contacted SMMC to discuss joint efforts collaborating on diabetes as their efforts with contracted physicians identified unsatisfactory patient education by their offices. Finally, IEHP will start a Community Navigator program in an effort to teach families how to properly use the local health system.

Based on hospital and community stakeholder feedback and assessment of existing clinic and community lead programs, the Directors of Community health and Healthy Communities drafted three new FY12-FY14 priorities initiatives while maintaining the current Breastfeeding program the hospital began in 2009. These draft programs were presented to SJHS Community Health Department for technical feedback and presented to SMMC's Community Benefit Committee for discussion and approval at a June 2011 meeting.

A lack of resources was identified as preventing SJH, St. Mary from starting a Congestive Heart Clinic although the need is clearly identified. Members of the Community Benefit Committee agreed that Access to Care was a key need for the region and that the hospital's efforts at facility expansion, recruitment of physicians and expansion of community clinic for low income serving low income populations would be an effective initiative. The committee had been previously briefed by leaders of Public Health and an operator of Federally Qualified Health Centers of their intentions to expand clinic operations to the community starting in late 2011. As a result the Access to Care initiative was approved with the target of helping to open three community clinics in underserved communities by 2014.

The Committee also agreed with moving forward on priority initiatives addressing comprehensive Diabetes education and self care to uninsured and low income patients after learning of program success helping patients control their HgA1C to less than 7 after one year participating in the program. The program will be funded by SMMC's Care For The Poor fund and from outside grant sources that currently include IEHP.

The Committee agreed that a prevention focus of addressing healthy behaviors among young children of low income families and residents could "prevent the next generation of obesity" while also addressing the larger challenge of diseases of the heart which rate so high in the community. The committee approved the priority initiative as part of the hospital experience implementing the Healthy For Life childhood obesity programs in local schools and their understanding that unhealthy eating and activity habits are key modifiable lifestyle behaviors residents must adopt if the community's health status is to improve. Funding for this initiative is currently provided by the hospital and major grant funds from the county's First Five Commission. The target measure of success for the initiative is moving 10% of more of at-risk patients (i.e., those with Body Mass Index values of overweight or obese) downward one weight classification by year end.

Through oversight of the hospital's Care For The Poor budget the Committee can continue to support some of the key community needs identified from the 2011 health assessment. These include providing assistance to partners providing assistance to victims of domestic abuse and persons seeking low cost dental care. Both of these identified needs lie beyond the expertise and resources of SMMC to run directly. Additionally, the hospital's Care For The Poor fund provides critical grants assisting the unemployed needing food and housing assistance.

Addressing the Needs of the Community:
FY 12 – FY 14 Key Community Benefit Initiatives

As a result of the 2011 assessment, community feedback, hospital leader and committee member discussion of existing resources, the hospital has approved three priority initiatives in its FY12-FY14 Community Benefit Plan while continuing Breastfeeding as a fourth key program.

The hospital's continuation of Breastfeeding as a priority initiative builds upon the hospital's designation as Baby Friendly and the work of the community health department and hospital departments to fully implement the World Health Organization's 10 Steps program in the hospital and to successfully provide follow-up out-patient education to new mothers. Program effectiveness shall be measured by the number of mothers providing breast milk to their infants for at least 50% of feedings at six months. The target state for the initiative is that by FY14 29% of mothers will self-report this level of feedings.

The hospital's Access to Care initiative is made possible through community partnership with outside organizations looking to expand their programs to meet the high need of the community. Hospital assistance is needed to assist in locating clinic locations and engaging community stakeholders to successfully open and operation these clinics. These clinic partners need the hospital's advocacy and local networking expertise and not grant funds. And the hospital needs additional partners providing low cost care to low income and uninsured persons. The effectiveness of the program shall be measured by the number of new community clinics either (1) opening in DUHN communities and; (2) opening to serve uninsured and low income persons in the High Desert.

The Comprehensive Diabetes initiative builds upon the hospital's community clinic's expertise providing primary care, education and referral services to low income and uninsured patients. The program is the only one of its kind in the community where free diabetes education is provided along with follow-up care

and testing. Program effectiveness shall be measured by the programs clinical outcomes as compared with Healthy People 2020 goals including the percentage of patients with HgA1C levels less than 7 (target is 58.9% or a minimum a double digit improvement) and the percentage of patients with HgA1C greater than 9 (target is less than 14.6% or at a minimum a double digit improvement).

The hospital's initiative of Nutrition, Physical Activity and Weight Status builds upon SMMC success implementing a pediatric obesity program in local schools; the participation of physician partners recognizing the need for nutritional counseling of parents and the public health department's county-wide effort creating Healthy City campaigns. Program effectiveness shall be determined by the number of at-risk children (target is 10% of greater) that move downward one weight classification and the number of normal weight children who remain in a normal weight range at one year.

FY 12 – FY 14 Key Community Benefit Initiatives

Breastfeeding Alpha Project Initiative

Description: The initiative builds on an existing hospital strength providing maternal care to low income families. The community health department (staffed with Certified Nurse Midwives and Licensed Social Workers has successfully implemented programs exceeding Healthy People goals addressing low infant birth weight and the rates of uninsured women accessing pre-natal care) will work with hospital nurses and community partners to improve local breast feeding rates. This initiative builds on a county-wide effort to have local hospitals attain the World Health Organization's Baby Friendly designation. This initiative will focus on confirming that: (1) hospital staff continue performing specific Baby Friendly activities (2) implement a systematic method of conducting random surveys with mothers at one, three and six month intervals to report and track the percentage providing breast milk at feedings and (3) work with physicians and other partners to make the community more breast feeding friendly.

Goal: Increase the percentage of mothers' who provide breast milk at least 50% of feedings for 6 months.

Community Partners: San Bernardino County WIC offices, local physicians

Outcome Measure: Percentage of women who provide breast milk to their infants at least 50% of feedings for the first six months of life based on self report.

Scope: All women delivering liveborn infants at SMMC

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

Strategy 2: Provide Professional and Breastfeeding support for Breastfeeding Mothers
Strategy 2 Measure: Percentage of women providing breast milk to their infants at least 50% of feedings at one month after delivery

Strategy 3: Educate mothers prenatally about breastfeeding
Strategy 3 Measure: Percent of mothers who received breastfeeding education during the prenatal period

Strategy 4: Develop data collection and reporting infrastructure
Strategy 4 Measure: Percent of patient care staff educated regarding data outcomes

FY 12 – FY 14 Key Community Benefit Initiatives

Access to Care Initiative

Description: This initiative will increase by four (4) the number of community clinics providing primary care services to low income and uninsured persons. This initiative addresses the lack of health services available to uninsured persons including availability of physicians and affordability of seeing a physician and obtaining prescriptions. The hospital will recruit community clinic organizations to the region and assist them to locate clinics in communities identified as having high barriers to accessing care. The initiative will work with San Bernardino County Public Health to establish the area's first Federally Qualified Health Center and support recruitment of staff and partners enabling the clinic to provide primary, dental and behavioral health services. The initiative will assist community clinics to organize into a regional group as part of a newly created San Bernardino County Community Clinic Association. The initiative will also continue enrolling uninsured persons into safety net health insurance; refer persons to community clinics and partner with local physicians offering pro-bono health services to the poor. The program will be funded by the hospital with grant support provided (when possible) to support start-up costs.

Goal : Expand Access of primary care services to uninsured and underinsured individuals in the High Desert.

Community Partners: Molina Healthcare, San Bernardino County Public Health Dept, Inland Behavioral Health Services, local Healthy City campaigns

Outcome Measure (Evaluation Plan): Number of clinics open and providing services to uninsured and underinsured residents
Scope: Expand Primary Care services by opening of community clinics serving low income and uninsured residents of the High Desert

Strategy 1: Collaborate with hospital and to expand clinic services in High Desert
Strategy Measures: Number of partners opening or expanding clinic services in High Desert

Strategy 2: Mobilizing stakeholders to support clinic opening and expansion
Strategy 2 Measure: Number of stakeholders engaged

Strategy 3: Engagement of residents to better access health services offered by clinic and ARMC
Strategy 3 Measure: Number of resident groups engaged and patients educated on new clinic services

FY 12 – FY 14 Key Community Benefit Initiatives

Comprehensive Diabetes Care Initiative

Description: Create a diabetes program serving low income and uninsured patients by improving the clinical outcomes for these patients. Uninsured patients will be enrolled into the program from community clinics and mobile medical van and be referred by health providers and staff at the hospital's Emergency Room. Participants will be provided clinical care to include annual eye and foot exams and provided self-care education in English and Spanish. Physician partners will be recruited for periodic specialty care. This program addresses the increase in the prevalence of diabetes in the community and provides the area's only free service to uninsured and low income patients lacking a medical home. The program will be funded by the hospital and, when possible with grants.

Goal: Improve clinical outcomes among patients with diabetes who receive ongoing care at St. Mary Medical Center Community Clinics

Community Partners: IEHP, Physicians providing specialty care as needed

Outcome Measure: Percent of diabetic patients with HgA1C less than 7

Scope: Low income residents of the High Desert region of San Bernardino County who have been diagnosed with Diabetes

Strategy 1: Increase access to medical care
Strategy 1 Measure: Number of diabetic visits

Strategy 2: Provide Diabetes Self Management Education (DSME)
Strategy 2 Measure: Number of patients with minimum of 1 documented self management goal

Strategy 3: Provide Medical Nutrition Therapy
Strategy 3 Measure: Percent of patients who are compliant with therapy.

FY 12 – FY 14 Key Community Benefit Initiatives

Nutrition, Physical Activity and Weight Status Initiative

Description: A child obesity program will be implemented in local Head Starts assisting low income families. The program will build the capacity of local Head Start schools to expand play and exercise time and provide nutritional counseling to families whose children are identified as overweight or obese. The goal of the program will be to reduce by 10% to number of overweight and/or obese children while improving the school to promote health. The program will be the only free resource for low income families to receive nutritional counseling for their children. The program will partner with physicians and schools for support. The hospital will fund the program and, where possible, obtain grants to increase the program.

Goal: Reduce the prevalence of overweight and obese low income children

Community Partners: Public Schools and Physician Partners

Outcome Measure: Percentage of at-risk children moving downward in weight classification while maintaining the number of children maintaining a healthy weight.

Scope: Low income children enrolled in Healthy For Life program or referred by Physician partners requiring nutritional counseling to lower their weight status or maintain normal weight

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

Strategy 2: Recruit physician partners to refer at risk children for counseling
Strategy 2 Measure: Number of physician partners referring at-risk children

Strategy 3: Provide nutritional sessions to parents of at-risk children
Strategy 3 Measure: Percent of parental adherence to treatment plans and goals

Strategy 4: Provide periodic weight assessments of at-risk children
Strategy 4 Measure: Percent of at-risk children completing scheduled weight assessments

http://www.stjhs.org/

St. Joseph Health (SJH) is an integrated healthcare delivery system providing a broad range of medical services. The system is organized into three regions--Northern California, Southern California, and West Texas/Eastern New Mexico - and consists of 14 acute care hospitals, as well as home health agencies, hospice care, outpatient services, skilled nursing facilities, community clinics, and physician organizations. The ministries that comprise SJH offer a wide variety of services within each of the three regions. From well-established acute care hospitals to clinics in non-traditional settings like school rooms, SJH is establishing a "continuum of care," that is, a system that links and coordinates an entire spectrum of health services.