



## St. Mary Medical Center

# Community Benefit Report 2013 Community Benefit Implementation Plan 2014

*A message from Thomas Salerno, President, St. Mary Medical Center and  
Daniel O'Callaghan, Board Chair*

At St. Mary Medical Center, we share a commitment to optimize the health of the community we are privileged to serve. Vital to this effort is the collaboration we enjoy with our community partners. How we contribute to the quality of life and the environment in our communities has always been a key measure of our success, and it will continue to be so as we move forward.

During fiscal year 2013 we, like the nation, continued to be impacted by the economic climate and experienced both successes and challenges. Despite declining revenue from government sponsored patients, we provided \$48,946,838 in charity care, community benefits, and unreimbursed patient care.

At St. Mary Medical Center, we strive to manage our resources and advance our healing ministry in a manner that benefits the common good now and in the future. Despite today's challenges we see this as a time of great hope and opportunity for the future of health care. We want to acknowledge and thank the women and men who have worked together in a spirit of collaboration to address the health priorities of our community through health and wellness programs and services.

In accordance with policy, the St. Mary Medical Center Community Board has reviewed and approved the annual Community Benefit Report and Implementation Plan at their meeting on October 24, 2013.



Thomas Salerno  
President, St. Mary Medical Center



Daniel O'Callaghan  
Chair, St. Mary Medical Center Community Board

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## EXECUTIVE SUMMARY

St. Mary Medical Center (SMMC), founded in 1923 by the Sisters of Charity of the Incarnate Word and a member of the Dignity Health system, is the only Catholic hospital in the greater Long Beach area. St. Mary Medical Center is a non-profit medical center with 389 licensed beds and has 1428 employees and 504 active medical staff members offering award-winning, quality medical services. It continues to be funded as a Disproportionate Share Hospital (DSH) with a significant level of indigent care. St. Mary Medical Center's Emergency Department features a life-saving trauma center, which is also the Base Station for the area. The Emergency Department had 56,657 visits in Fiscal Year 2013 with nearly 21% of these visits for patients who are uninsured.

St. Mary Medical Center is a tertiary center that provides care throughout the spectrum of life, from prenatal and childbirth services to palliative care and cancer services. St. Mary is a level II trauma center, has a 24-bed intensive care unit, and a level IIIB NICU with 25 beds. In April St. Mary Medical Center received Healthgrades' 2013 Patient Safety Excellence Award and Maternity Care Excellence Award. The Joint Commission gave its certification to SMMC's Advanced Primary Stroke Center, and a report from the Centers for Medicare & Medicaid (CMS) showed that the medical center had the shortest Emergency Department wait times of area hospitals, and patients spent less time in the ED before being discharged.

St. Mary Medical Center is committed to improving the quality of life in the community. In response to identified unmet health-related needs as reflected in the community needs assessment, St. Mary Medical Center provides active inpatient as well as community outreach programs targeting the poor and underserved. For FY 2013, St. Mary Community Benefit activities focused on increasing access to care and management of chronic diseases with a concentration on Disproportionate Unmet Health Needs (DUHN) communities. Outreach to vulnerable communities is accomplished through the Senior Health Center, Low Vision Center, the C.A.R.E. Program (Comprehensive AIDS Resources and Education,) Families in Good Health (FIGH,) the Faith Health Resource Ambassadors, and other initiatives. In response to identified community needs of greater access to care, St. Mary opened the Pediatric Clinic in October 2011 at the Mary Hilton Family Health Center and launched the Breathe Easy Mobile Clinic with a generous grant from the Port of Long Beach on March 1, 2012. The Mobile Clinic provides screenings to various vulnerable communities by bringing a team consisting of a health educator, respiratory assistant, and nurse practitioner, to provide screenings and care for such conditions as asthma and chronic obstructive pulmonary disease. These programs are St. Mary's commitment to the health and improved quality of life in our community. The total value of Community Benefit in FY 2013 was \$48,946,838 which includes the unreimbursed costs of Medicare of \$9,790,487; without this cost the total value of Community Benefits for FY 2013 would be \$39,156,351.

St. Mary Medical Center actively addresses the issue of health care worker shortages through several means, including a highly respected and competitive internal medicine residency program. St. Mary provides nursing clinical sites to colleges including California State University Long Beach, Long Beach City College, Cypress College, and Harbor College. Many other disciplines encourage students at St. Mary to utilize staff expertise, while providing a nurturing environment for the students. Through the COPE Program (Community Outreach Prevention and Education,) St. Mary was able to offer an RN scholarship program through Long Beach City College. The Clinical Care Extender Program offers college and high school students an opportunity to learn about health care careers while providing volunteer service to St. Mary.

Some examples of our commitment to living our mission include:

- The **Low Vision Center** provides free vision screening to more than 34 public and parochial schools in the greater Long Beach community as well as providing visionary aids at low cost to those with vision impairment.
- The **C.A.R.E. Program** provides education on HIV Prevention and provides programs and services to those affected or infected with HIV and AIDS. Dental services comprise one of the key services provided, with St. Mary being the only provider of HIV Dental Services in south Los Angeles County.
- The **Faith Health Resource Ambassadors Program** works with health ministries and parish nurses at the area church congregational level in providing education, bulletin information, health speakers, and health fairs/displays/screenings to more than 40 faith congregations in the greater Long Beach area.
- St. Mary "**Life Begins Here**" Childbirth Services provide the following services to more than 4600 expecting mothers: baby showers, tours of the maternal child unit education on what to expect when delivering, delivery suites, postpartum, and NICU, breastfeeding classes, childbirth education, car seats for low income clients, and specialized perinatology services to high risk pregnant mothers through the Antenatal Center. The Mary Hilton Family Health Center services more than 25,000 visits annually.

# MISSION STATEMENT

## I. St. Mary Medical Center Mission Statement

As members of Dignity Health, St. Mary Medical Center shares a common mission statement:

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

- delivering compassionate, high-quality, affordable health services;
- serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- partnering with others in the community to improve the quality of life.

# ORGANIZATIONAL COMMITMENT

## II. St. Mary Medical Center Organizational Commitment

A. The St. Mary Medical Center Community Benefit Program reflects our commitment to improve the quality of life in the community. We seek to promote a healthier community by supporting partnerships with others. In keeping with our tradition of Catholic health care, we do this with special concern for the poor and disenfranchised. St. Mary Medical Center realizes that the needs of the community's underserved are much greater than the resources St. Mary has to meet them. St. Mary strives to maximize the benefits of limited resources.

1. St. Mary Medical Center Administrative Leadership reviews all the community benefit programs, decides on continuation or termination, and makes the budget decisions with Community Board input. Administrative Leadership ensures that St. Mary Medical Center's strategic plan is aligned with the mission of St. Mary Medical Center and linked with the strategic plan to the community benefit process and priorities. Administrative Leadership reports the Community Benefit activities, programs, and focus on a monthly basis to the Community Board of St. Mary Medical Center. Their feedback molds the final budget decisions and consideration of the community benefit programs.

This Community Benefit Report and Plan is reviewed by and approved by Administrative Leadership, the Community Benefit Advisory Committee, and then submitted for approval to the Community Board of St. Mary Medical Center.

While deeply committed to the community's health, St. Mary recognizes that the organization cannot provide all necessary programming to provide change. St. Mary ensures the continuum of care to those most vulnerable by other not-for-profit organizations through collaborations and through the Dignity Health community grants program. In FY2013 the program awarded \$118,000 to the following organizations:

- 1) Alliance for Housing and Healing
- 2) Lutheran Social Services
- 3) Long Beach NAACP
- 4) Alzheimer's Association, California Southland Chapter
- 5) The Center
- 6) YMCA of Greater Long Beach
- 7) Beacon House Association of San Pedro
- 8) New Hope Grief Support Community
- 9) Pathways Volunteer Hospice

2. The Community Benefit Advisory Committee (CBAC) of the Community Board has been an ongoing driver of community benefit priorities and helps to determine program targeting and design which are shaped by our Mission and Core Values, which emphasize collaboration, justice, stewardship, dignity, and excellence. These areas are reassessed and will continue to be reviewed based upon information available on a quarterly basis. The committee is composed of community members representing the diversity of Long Beach including leaders from the following: Khmer Parent Association, Long Beach Health and Human Services, Catholic Charities, and the Greater Long Beach Interfaith Community Organization. Members of the committee also include the Vice President of Mission Integration, the President of the St. Mary Foundation, and the Community Benefit Coordinator. The directors of the major community benefit programs attend as requested. (Please see Addendum D for Roster.)

## B. Non-Quantifiable Benefits

There are countless ways in which St. Mary Medical Center makes difficult-to-measure contributions to improve the health status of our community. St. Mary continues to provide leadership and assistance with community-wide health planning in collaboration with other area hospitals and non-profit agencies including the Hospital Association of Southern California. Many examples of non-quantifiable benefits relate to contribution of St. Mary's organizational capacity and consulting resources in the community. Working collaboratively with community partners, St. Mary provided leadership and advocacy, assisted with local capacity building, and participated in community-wide health planning. An example of this includes our active participation in the Long Beach Chamber of Commerce. St. Mary Medical Center, in the role of community partner, provides meeting space for other not-for-profit and community organizations such as: American Diabetes Association, American Cancer Society, Khmer Parents Association, Leadership Long Beach, Long Beach Unified School District, and Long Beach Police Department's Quality of Life Committee, among others.

St. Mary Medical Center collaborates with many community-based organizations to improve capacity and enhance the health of the greater community. The C.A.R.E. Program collaborates with many regional and local boards to educate and encourage awareness of preventing HIV/AIDS as well as to make patient-centered treatment available to everyone affected or infected. Many of the St. Mary leadership and staff represent St. Mary throughout the community providing expertise as speakers, board members, mentors, and resources to the community that we serve.

St. Mary Medical Center works to ensure the carbon footprint is minimal. Administrative Leadership established the "Green Team" to promote awareness and initiate efforts at recycling and being responsible stewards. St. Mary collaborates with the Beacon House Association, a nonprofit, to recycle cardboard, glass, plastic, newspapers, and ink cartridges. In collaboration with Food Finders and the American Red Cross, St. Mary recycles cell phones.

The mission of St. Mary Medical Center is one that is embraced by staff. Community requests by SMMC in FY2013 include sponsoring, in collaboration with Catholic Charities, more than 200 families at the annual Helping Hands program which provides toys and gift certificates for food at Christmas-time to families who would otherwise be unable to have a celebration. Clothes for babies and children are provided by SMMC staff to the Mary Hilton Family Health Center Clinic to provide for families who are in need. Food drives occur several times a year to provide food for the clients of the C.A.R.E. (Comprehensive AIDS Resources and Education) Program through which hundreds of pound of food have been donated by staff and volunteers in support of their food bank.

# COMMUNITY

## III. Community

### A. Definition of Community

#### 1. Key Factors

St. Mary Medical Center is located in Long Beach, CA, the second largest city in Los Angeles County. St. Mary Medical Center also serves the surrounding communities of Wilmington, Carson, San Pedro, Seal Beach, Signal Hill, Lakewood, and Bellflower. St. Mary Medical Center's service area encompasses a population of nearly 840,000 with 460,000 from Long Beach. While a few of the zip code communities enjoy a higher standard of living, the majority of the communities served have greater needs.

#### 2. Description of Community Setting

Overall, the St. Mary's Service Area has regions that are economically challenged, have a great deal of homelessness, and have an influx of transitory populations; many of these neighborhoods and communities are below the poverty level and are considered underserved. Access to care and services, perceived barriers to existing services, lack of insurance, mental health services, diabetes, asthma, drug and alcohol abuse, and childhood obesity are some of the major health concerns (LBHNA, 2012). From a health perspective, these low income and underserved areas are growing and are of major concern to St. Mary Medical Center.

#### 3. Demographics

- Population: 838,818
- Diversity: Caucasian 21.4%, Hispanic 51.6%, African American 11.7%, Asian and Pacific Islander-primarily Filipino, Khmer(Cambodian), Vietnamese, Tongan, and Samoan 12.6%, Other 2.7%
- Average Income: median household income of \$47,974; Persons Living Below Federal Poverty levels 19.3%
- Uninsured: 43%
- Unemployment: 14.2%
- No HS Diploma: 26.1%
- Renters: 58.4%
- CNI Score: 4.8% (Please see Appendix B for the CNI map of St. Mary Medical Center's Service Area.)
- Medicaid Patients: 72.2%
- Other Area Hospitals: Other health care facilities and resources within the community that are able to respond to the health needs of the community are Los Angeles County Harbor General, Los Angeles County Rancho Los Amigos Hospital, Veterans Administration Long Beach System, Pacific Hospital of Long Beach, Lakewood Regional Medical Center and Los Alamitos Medical Center, Long Beach Memorial Medical Center, Miller's Children's Hospital, and Community Hospital of Long Beach. The greater Long Beach area also has the Los Angeles County Long Beach Comprehensive Health Center, "free" clinics including, The Children and Family Clinics, North East Community Clinics, Wilmington Community Clinics, and Westside Neighborhood Clinic. Health and Human Services Department.

#### 4. Medically Underserved Area/Population

St. Mary Medical Center Service Area is situated among areas that are mostly medically underserved, including North Long Beach, Central Long Beach, West Long Beach, the Port (including Wilmington,) and Compton.

# COMMUNITY BENEFIT PLANNING PROCESS

## IV. Planning Process

### A. Community Health Needs Assessment Process

1. Needs Assessment Process: St. Mary Medical Center partnered with Community Hospital of Long Beach and Long Beach Memorial Medical Center/Miller's Children's Hospital to conduct the tri-annual Community Needs Assessment. The collaboration contracted with California State University Long Beach's Professors Tony Sinay, Ph.D. of the Health Care Administration Department and Veronica Acosta-Deprez, Ph.D. of the Public Health Department. This 2013 Community Benefit Report and 2014 Plan were developed based on the 2012 Long Beach Community Health Needs Assessment. The role of the partners was to fund the project and provide information as requested. The partners also assisted in conducting the Key Informant Survey and the Long Beach Health Needs Assessment Survey, which were completed by more than 433 key informants.

2. The Long Beach Health Needs Assessment (LBHNA) included the Key Informant Survey Data, Long Beach Health Needs Assessment Data, California Health Interview Survey (CHIS)-2003 Data, and many other secondary data collected from partners and stakeholders with the overall purpose of determining the health issues, the accessibility to services, strengths and weaknesses of services and the gaps that exist. The LBHNA provided information on the entire demographic area served by the partners. The information was synthesized in an executive summary, highlighting the areas of greatest need. The 2012 survey instrument was developed through an iterative process and covered topics such as population demographics, health concerns affecting adults, teens, and children, and access to services and providers.

3. The survey instrument was provided both in English and Spanish languages and was self-administered through a convenience sample at community forums, events, and health fairs within the city of Long Beach from September, 2011, until March, 2012. The total number of surveys collected was 1,309. Only 1,066, however, were completed accurately and used for analysis..

4. Findings of the LBHNA indicate that while the greater Long Beach area contains excellent healthcare resources, unmet health-related needs exist. The diversity of the population creates inconsistent healthcare needs that are difficult for any one hospital or healthcare organization to meet. Although the study clearly defines the diversity of the population, there are repeating health needs for multiple subgroups that can be addressed in a global manner. The greatest unmet needs included: lack of insurance and financial access including access to health resources; pregnancy—including not meeting Healthy People 2010 goals of early prenatal care, teen pregnancy reduction, and low birth weight infants for the greater Long Beach area. Diabetes, cancer, HIV/AIDS rates, and asthma along with other chronic diseases are increasing. Another need was lack of information about exercise and nutrition to live healthier. Obesity was rated among the top five health issues for children.

5. St. Mary Medical Center in collaboration with Long Beach Memorial Medical Center, Miller's Children's Hospital, and Community Hospital of Long Beach provided the Long Beach Health Needs Assessment to the community through community partners, elected officials and leaders. The LBHNA was provided electronically in the form of a PDF through email, on a DVD, and hard copies were provided to leaders throughout the community.

### B. Assets Assessment

1. Information on community assets is regularly shared by members of the Community Benefit Advisory Committee and the Community Board who are key stakeholders in the community. These members engage with a variety of community agencies and are keenly aware of both the programs offered and challenges faced. St. Mary also partners with California State University Nursing and Social Work Programs, California State University Dominguez Hills Nursing Program, and American University of Health Science Nursing School to continually do asset mapping of the community.

2. St. Mary participated with COPE (formerly Community Outreach Prevention and Education), Health Solutions Long Beach Regional Assessment, whose purpose was to gain a better understanding of systematic barriers to care for patients within the Long Beach area and identify opportunities for collaborative solutions. The recommendations were to build increased access to outpatient care (*The right care, at the right place, at the right time*).

### **C. Developing the Hospital's Implementation Plan (Community Benefit Report and Plan)**

**1. Process:** The process that was utilized for prioritization of needs for the Community Benefit program was to identify needs that could possibly be addressed by St. Mary Medical Center and its partners. The Community Benefit Advisory Committee spent several sessions determining, with the existing resources, which of the multitude of issues could be effectively addressed with at least some success within the next year.

**2. Factors Considered:** The factors that were considered in this process of identifying priorities included the size and severity of the problems. Several communities within the greater Long Beach area have been identified to have Disproportionate Unmet Health Needs (DUHN). Communities with DUHN are defined as either having a high prevalence or severity for a particular health concern to be addressed by a program activity or as community residents who face multiple health problems and who have limited access to timely, high quality health care. These communities include older Khmer, pregnant and parenting teenagers especially in the 90813 zip code, the gay/lesbian/bi-sexual/transgender communities, and those that live at or below 200% of the poverty level.

**3. Addressing Health Issues:** St. Mary Medical Center has determined that the health priorities that will be focused on are as follows: Access to care and Chronic Disease including HIV. St. Mary Medical Center currently has existing resources and expertise to create access to care for these issues. These identified health issues will be addressed by advocating in the community and linking clients to these and other programs through education at health fairs, partnering with faith communities, and partnering with other community based organizations. These existing Community Benefit programs and services include C.A.R.E. (Comprehensive AIDS Resources & Education) Program, Imaging Center, the Low Vision Center, St. Mary Senior Center, Faith Resource Health Ambassadors, the EMPOWER Initiative, and Families in Good Health (FiGH.) These programs have been enhanced as a result of the Community Needs Index (CNI) which assisted SMMC in identifying the areas that should be targeted for outreach with the limited resources available.

**4. Addressing the Vulnerable Population:** The vulnerable populations being focused on are those with limited English proficiency, including new immigrants, uninsured, underinsured, and communities of color. For St. Mary's Service Area, the DUHN Communities include Seniors, African American, Latinos (particularly monolingual Spanish speaking), and Asian American (particularly Khmer, Vietnamese, and Filipino), which have a high incidence of diabetes, heart disease, and other chronic diseases along with barriers/lack of access to care. The lesbian, gay, bi-sexual, transgender (LGBT) community has a high rate of HIV and tobacco use. This information

was obtained from the LBHNA, Long Beach Health and Human Services, the Long Beach Senior Center, and the Center Long Beach also known as the Gay and Lesbian Center of Greater Long Beach

**5. Containing Health Costs:** By offering screening and linkages to existing services, St. Mary Medical Center is helping contain costs by the reduction of the need for emergency room services and by helping promote a generally healthier community.

**6. Needs that were not addressed:** St. Mary is not able to address the identified need of mental health counselors throughout the community in multiple languages. While St. Mary has funded some programs through our Dignity Health grants, St. Mary does not have the capacity or resources to provide before and after school programs. St. Mary does partner with other groups by providing space for such programs like Khmer Parents Association Khmer Youth Reaching Out that works with high-risk youth through after school tutoring and leadership classes.

#### **D. Planning for the Uninsured/Underinsured Patient Population**

**1. St Mary's Financial Assistance/ Charity Care Policy:** St. Mary Medical Center adheres to Dignity Health's Patient Financial Assistance Policy. Dignity Health is committed to providing financial assistance to persons who have health care needs and are uninsured, under-insured, ineligible for a government program, and are otherwise unable to pay for medically necessary care based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable health care services, and to advocate for those who are poor and disenfranchised, Dignity Health strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Financial assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with Dignity Health's procedures for obtaining financial assistance and to contribute to the cost of their care based on individual ability to pay. Individuals with financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services. (Please see Addendum C.)

**2. Process Implemented:** St. Mary offers Payment Assistance to all uninsured patients who seek treatment through the Registration and Admitting Department. St Mary has information in English and Spanish posted in public areas, all registration waiting rooms, the cafeteria, emergency department, and admitting. Each patient receives a pamphlet describing the program regardless of their coverage. On each billing statement sent to the patient's home, there is documentation about the financial assistance program and how to apply.

**3. Process to Inform Public:** Assistance is offered for applying for public health coverage programs, discounts, and payment plans are offered for uninsured patients. St. Mary has worked to inform the public of the Financial Assistance/Charity Care policy through its work with the Ambassadors/Health Ministries of the faith communities, our St. Mary Clinics, and community partners by providing information and discussion regarding the policy and how to access the assistance.

# PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

## IV. Summary of Key Programs and Initiatives – FY 2013

Below are the major initiatives and key community based programs operated or substantially supported by St. Mary Medical Center in Fiscal Year 2013. Programs were developed in response to the current Community Health Needs Assessment and are guided by the following five core principles that Dignity Health adopted recommended by the "Advancing the State of the Art in Community Benefit" project that guide the selection and prioritization of Community Benefit program activities. These core principles are:

- Disproportionate Unmet Health-Related Needs: Seek to accommodate the needs of communities with disproportionate unmet health-related needs.
- Primary Prevention: Address the underlying causes of persistent health problems.
- Seamless Continuum of Care: Emphasis on evidence-based approaches by establishing operational linkages (i.e., coordination and re-design of care modalities) 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.

### Initiative I: Access to Care

- Charity Care for uninsured/underinsured and low income residents
- C.A.R.E. Program (HIV/AIDS)
- Psychiatric Care through College Hospital for Indigent Patients
- Clinical experience for medical professional students including physician, nursing, social work, physical therapy, pharmacy, respiratory, and radiology
- Emergency Department Physician Services for Indigent Patients
- Mary Hilton Family Health Center: OB Clinic, Pediatric Clinic
- St. Mary Family Clinic
- St. Mary Breathe Easy Mobile Clinic
- Faith Health Resource Ambassadors (Faith Congregation Health Ministry Support)
- "Life Begins Here" Childbirth Services
- Senior Center Education and Screenings: Health Promotion/Disease Prevention including Flu Shots
- Low Vision Center
- Imaging Center: Every Woman Counts and Komen Fund Mammography for Low Income and Indigent Patients
- St. Mary Medical Center Transportation Program
- EMPOWER Initiative

## Initiative II: Preventing and/or Managing Chronic Health Conditions

- Well Check Program Community Health Fairs
- C.A.R.E. Program (HIV/AIDS)
- Quality of Life Cancer Support Group
- Dignity Health Community Grant Program-Lutheran Social Services
- Dignity Health Community Grant Program-Alzheimer's Association, California Southland Chapter
- Dignity Health Community Grant Program-The Center
- Senior Center Education and Screenings: Health Promotion/Disease Prevention including the Chronic Disease Self Management Program
- Health Resource Ambassadors (Faith Congregation Health Ministry Support)
- Families In Good Health (FIGH)
- St. Mary Outpatient Diabetes Program

These key programs are continuously monitored for performance and quality with ongoing improvements to facilitate their success. The Community Benefit Committee, Executive Leadership, the Community Board, and Dignity Health receive quarterly updates on program performance and news.

This implementation strategy specifies community health needs that the Hospital has determined to meet in whole or in part and that are consistent with its mission. The Hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During the three years ending December 31, 2015, other organizations in the community may decide to address certain needs, indicating that the Hospital then should refocus its limited resources to best serve the community.

The following pages include Program Digests for key programs that address one or more of the Initiatives listed above.

## PROGRAM DIGESTS

Comprehensive AIDS Resource and Education (CARE)	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>X Access to care and the delivery system working with disproportionate unmet health needs (DUHN) communities including but not limited to dental care</li> <li>X Promotion of mental wellness and health including identifying those who need care and prevention activities.</li> </ul>
<b>Program Emphasis</b>	<ul style="list-style-type: none"> <li>X Disproportionate Unmet Health-Related Needs</li> <li>X Primary Prevention</li> <li>X Seamless Continuum of Care</li> </ul>
<b>Link to Community Needs Assessment</b>	Access to care
<b>Program Description</b>	Comprehensive AIDS Resource and Education (CARE) Program at St. Mary Medical Center was founded in 1986. Since its inception, CARE has grown into a nationally recognized HIV medical and psychosocial service program that now provides comprehensive HIV medical, dental, and psychosocial services to over 1,700 low-income residents of Southern Los Angeles County who are infected and affected by HIV disease regardless of their ability to pay. CARE is a non-profit, hospital-based HIV program that is directly funded by federal, state and county grants (see <a href="http://www.careprogram.org">www.careprogram.org</a> ).

	<p>As an HIV-specific health and social service organization staffed exclusively by HIV specialist, nurses, social workers, allied health professionals, and psychosocial service providers, CARE has insight into the needs of its largely low-income, multi-ethnic population, and has the capacity to deliver client-centered services that meet patient needs in an effective and culturally competent manner. CARE provides a comprehensive range of on-site HIV services that allows clients to access high-quality care in the context of a one-stop, patient-centered medical home (PCMH) framework. The ability to access multiple services at a single location significantly enhances clients' ability to utilize health and wellness support. Among CARE's services are the following:</p> <ul style="list-style-type: none"> <li>▪ <b>On-site HIV counseling, testing, referral, partner notification, and linkage to care</b>, including HIV testing provided in the only setting in Long Beach that is not clearly identified to outsiders as being an STD facility.</li> <li>▪ <b>Extensive community outreach services</b> that utilize community-based campaigns, linkages with existing agencies and planning bodies, and active collaborations with health providers and social service organizations to identify new or out of care HIV patients.</li> <li>▪ A comprehensive, on-site, JCAHO-accredited <b>HIV specialist medical clinic</b> that provides a full spectrum of culturally competent medical and health services to nearly <b>1,350</b> persons living with HIV regardless of income, ranging from comprehensive diagnostic testing, to on-site laboratory services, to on-site pharmaceutical services, to pro-active clinical trials referrals.</li> <li>▪ <b>Oral health services</b> providing care to over <b>650</b> clients through the CARE Dental Center, one of only a handful of HIV-specific dental clinics in the United States, employing two full-time dentists who provide procedures such as fillings, extractions, complete and partial dentures, and root canals as well as a full-time dental hygienist.</li> <li>▪ <b>Comprehensive medical and non-medical case management services</b> which coordinate client care for over <b>250</b> clients and support access to medication adherence, including nurse case management services for clients with multiple diagnoses or severe needs.</li> <li>▪ <b>Outpatient mental health and substance abuse treatment services</b>, including on-site Psychiatric consultation by a 50% time Psychiatrist, individual and group counseling services, and clinic-based substance abuse treatment and counseling, augmented by referrals to outside providers and agencies.</li> <li>▪ <b>Nutritional services</b> provided by an on-site Registered Dietitian, provided as part of each client's regular HIV medical management. CARE also makes food available to the client and family through a weekly food bank.</li> <li>▪ <b>Housing assistance services</b> provided through a contract to the City of Long Beach, which bases <b>two</b> full-time City-funded Housing Coordinators directly within CARE's offices to provide client housing placement and referral services.</li> </ul>
<b>FY 2013</b>	
<b>Goal 2013</b>	Reduce HIV morbidity and mortality through continuing current services to HIV/AIDS-at risk or infected populations who are not receiving care or who are underserved.
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>➤ Of those that test positive for HIV, 100% of them will be offered linkages to care and offered assistance in navigation through the system.</li> <li>➤ CARE will track all patients who are eligible for service and all related service deliveries through the County-mandated CaseWatch system.</li> <li>➤ CARE will track both the number of submitted grants and the results and have them available to meet the goal and to report financial progress.</li> <li>➤ Review of CQI results will be available on a quarterly basis.</li> </ul>
<b>Baseline</b>	The number of individuals seeking services at CARE has continued to grow at approximately 20% in the past year. CARE will use the number of new cases, as it does every year, to demonstrate need in the greater Long Beach community.
<b>Intervention Strategy for Achieving Goal</b>	Improve partnerships with referral sources including HIV testing centers, Shelters, Jails/Prisons, and providers of substance abuse and mental health services. CARE also continues its expansion of the electronic medical record.
<b>Result FY 2013</b>	100% of those HIV positive clients were offered linkages to care. During this fiscal year CARE saw over 350 new clients.
<b>Hospital's Contribution / Program Expense</b>	Hospital contributed additional support to the program by assigning an administrative director to the CARE program to facilitate expanded access to care while providing guidance during changes to the program's funding sources. Additionally a Clinical Director was assigned to the program to assist with process improvement as new quality standards must be implemented to support changes for standards of care.

FY 2014	
<b>Goal 2014</b>	Support expanded access to clients as new affordable care act initiatives may create challenges to clients ability to navigate the benefits process, transition from county low income health plans to Medi-Cal, dual eligible (Medi-Medi) patients will be required to select plans that will manage their benefits, and Denti-Cal is slated to return for adults during 2014. The expanded access to clients intends to support a reduction of HIV morbidity and mortality through continuing current services to HIV/AIDS-at risk or infected populations who are not receiving care or who are underserved.
<b>2014 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>➤ Of those that test positive for HIV, 100% of them will be offered linkages to care and offered assistance in navigation through the benefits system.</li> <li>➤ CARE will track patients that are at-risk for loss of continuity of care due to their insurance status or lack of application for Medi-Cal benefits.</li> <li>➤ CARE will track all patients who are eligible for service and all related service deliveries through the County-mandated CaseWatch system.</li> <li>➤ CARE will track both the number of submitted grants and the results and have them available to meet the goal and to report financial progress.</li> <li>➤ Review of CQI results will be available on a quarterly basis.</li> </ul>
<b>Baseline</b>	Currently over 750 clients are at risk for a disruption in benefits if they do not initiate enrollment into a managed care plan, CARE will track the at risk clients to ensure that they are supported through the benefits transition. The number of individuals seeking services at CARE has continued to grow at approximately 10% in the past year. CARE will use the number of new cases to demonstrate need in the greater Long Beach community.
<b>Intervention Strategy for Achieving Goal</b>	Partner with insurance plans, content experts, the county HIV commission, and local community organizations to educate clients on the upcoming changes resulting from the affordable care act. Pursue approval of personnel as Certified Enrollment Counselors as part of the community clinic's pursuit of approval as a Certified Enrollment Entity. Create Taskforce consisting of social workers, benefits personnel, public health workers, and managers to address: <ul style="list-style-type: none"> <li>➤ A communication plan for the upcoming open enrollment period.</li> <li>➤ Resources available at CARE and throughout the community for benefits education and assistance</li> <li>➤ Benefits of various insurance plans relative the client health needs.</li> <li>➤ Planning of a client lead forum to assist clients with benefits issues.</li> <li>➤ Dissemination of pertinent benefits information to CARE providers and staff members to ensure that medical and dental treatments are not adversely impacted by changes to health plans.</li> </ul>
<b>Community Benefit Category</b>	Disproportionate Unmet Health-Related Needs & Seamless Continuum of Care

Mary Hilton Family Health Center	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>X Prevention and treatment of obesity and related chronic disorders such as promotion of nutrition, identification and treatment of diabetes and high blood pressure</li> <li>x Access to care and the delivery system working with disproportionate unmet health needs (DUHN) communities including but not limited to dental care</li> </ul>
<b>Program Emphasis</b>	<ul style="list-style-type: none"> <li>X Disproportionate Unmet Health-Related Needs</li> <li>X Primary Prevention</li> <li>X Seamless Continuum of Care</li> </ul>
<b>Link to Community Needs Assessment</b>	Obesity prevention and access to care
<b>Program Description</b>	Mary Hilton Family Health Center has OB, perinatal, and pediatric services: St. Mary OB Clinic's Mission Statement reflects the clinic's service overview. In the spirit of God's love, <b>St. Mary Medical Center OB, Perinatal Center, and Pediatric Clinic</b> will provide the highest quality obstetric care in a friendly, safe and comfortable environment. Our multidisciplinary team will strive to meet the physical, emotional, nutritional, and educational needs of all those who seek our services with the expectation that such empowerment will assist them in making informed decisions about the health-care and life-long wellness of both mother and child.

	<p>St. Mary Medical Center Clinic's vision is to be the leading obstetric, perinatal, and pediatric clinic in Long Beach. Over 1,200 babies are delivered through the clinic each year. The clinics provide comprehensive services to serve mothers and children from pregnancy through young adulthood. Services include:</p> <ul style="list-style-type: none"> <li>• <b>Testing</b>, Free pregnancy and STD testing is offered at the OB Clinic.</li> <li>• <b>Benefits Assistance</b>, Clients can obtain Medi-Cal coverage through an on-site enrollment coordinator.</li> <li>• <b>Education</b> in English, Spanish, and Khmer on nutrition, child safety, child development, and breast-feeding.</li> <li>• <b>Comprehensive Perinatal Services Program (CPSP)</b>. Through our commitment to the Comprehensive Perinatal Services Program, our goals are: <ol style="list-style-type: none"> <li>1. To decrease the incidence of low birth weight in infants</li> <li>2. To improve the outcome of every pregnancy</li> <li>3. To give every baby a healthy start in life</li> <li>4. To lower health care costs by preventing catastrophic and chronic illness in infants and children</li> </ol> </li> <li>• <b>High-risk care</b> from a multi-disciplinary team of healthcare professionals such as a dietician, health educator, social worker associate and perinatal specialists.</li> <li>• <b>Perinatal testing, counseling, and risk assessments</b> for high-risk pregnancy are offered through our perinatal center. Screening services include serum integrated screening, amniocentesis, non-stress test, and ultrasound.</li> <li>• <b>California Diabetes and Pregnancy Program</b>, known as Sweet Success to provide extra medical care for expecting mothers that have diabetes. Workshops, consultation, referrals, classes, and counseling are offered through this program.</li> <li>• <b>Pediatric care</b>. The pediatric clinic serves the comprehensive needs of mothers and children by providing continued quality care. The clinic provides diagnosis, treatment, and/or follow-up of children with general health problems in addition to immunizations, physical examinations, newborn screens, and routine child health maintenance. Specialty services include onsite Asthma Clinic services provided by a pediatric specialist monthly.</li> <li>• <b>Vaccines For Children program</b> to provide free vaccines to children in low income households.</li> </ul>
<b>FY 2013</b>	
<b>Goal 2013</b>	To increase and provide prenatal care and education to 2000 women. To increase and provide pregnancy testing to 3000 women. To provide pediatric care to over 1000 children.
<b>2013 Objective Measure/Indicator of Success</b>	Achieve targets for services provided to women and children. At least 90% of the clients will verbalize that their knowledge of health increased as a result of their care in the clinics through the pregnancy testing and patient visits that are documented through the clinics
<b>Baseline</b>	The community has many women who fall into the high-risk category when becoming pregnant. The majority of the women are Hispanic, and the clinic is a culturally sensitive facility that can provide a multi-disciplinary team of healthcare professionals to insure a safe outcome for the mother and child. The area we service is also an uninsured and underserved community, and we have many resources to facilitate these patients to a healthier way of life
<b>Intervention Strategy for Achieving Goal</b>	Health Fairs, Marketing. Established / Refresh program objectives. Monitor and report measurable outcomes. Community outreach with education and information about our services
<b>Result FY 2013</b>	The clinics delivered over 21,000 individual services to women and children during FY2013 to support the increased service delivery of women's and children's services to the community.
<b>Hospital's Contribution / Program Expense</b>	The hospital has provided capital for installation of a clinic AEMR, the project will exceed \$500,000 to improve quality outcomes, coordinate patient care, and track effectiveness of clinic services.

FY 2014	
<b>Goal 2014</b>	<p>To support access to care for clients that may experience challenges with implementation of the Affordable Care Act</p> <p>To support increased access to in home and post-partum and pediatric services through implementation of the Welcome Baby Program.</p> <p>To support obesity prevention by partnering with California State University of Long Beach to facilitate Sanos y Fuertes childhood obesity prevention program.</p> <p>To increase and provide prenatal care and education to 2200 women.</p> <p>To increase and provide pregnancy testing to 3200 women.</p> <p>To provide pediatric care to over 1200 children.</p>
<b>2014 Objective Measure/Indicator of Success</b>	<p>Enrollment of clients including mothers and their children into the Welcome Baby Program. Benefits support for mothers and children to prevent disruption or delays in care.</p> <p>Access to prenatal care for over 2200 women. Access to pregnancy testing for over 3200 women. Access to pediatric care to over 1200 children.</p> <p>Enrollment in the Sanos y Fuertes program in collaboration with California State University of Long Beach provide education for childhood obesity prevention.</p>
<b>Baseline</b>	<p>The area we service is an uninsured and underserved community, over 40 pregnant mothers and 20 infants and children per month seek temporary Medi-Cal benefits at the Mary Hilton clinic.</p>
<b>Intervention Strategy for Achieving Goal</b>	<p>Partner with other St. Mary Clinics and their social workers, benefits staff, and health workers to assist clients of the Mary Hilton Clinic and other clinics throughout the Long Beach area with benefits counseling and Medi-Cal enrollment.</p> <p>Additionally, the Mary Hilton clinic will initiate outreach on the clinic services and Medi-Cal expansion through Health Fairs and Marketing. Community outreach personnel will provide education and information about our services</p> <p>Pediatric providers and staff will assist with promotion of the Sanos y Fuertes childhood obesity prevention program to identified clients of the pediatric clinic.</p>
<b>Community Benefit Category</b>	<p>Disproportionate Unmet Health-Related Needs, Primary Prevention, and Seamless Continuum of Care</p>

Mobile Care Clinic (Formerly Breathe Easy Mobile Outreach Program)	
<b>Hospital CB Priority Areas</b>	<p><input checked="" type="checkbox"/> Prevention and treatment of respiratory disorders related to air pollution which would include but not limited to asthma and chronic obstructive pulmonary disorder (COPD), and advocating on ways to make the air cleaner especially for vulnerable communities</p> <p><input checked="" type="checkbox"/> Access to care and the delivery system working with disproportionate unmet health needs (DUHN) communities including but not limited to dental care</p>
<b>Program Emphasis</b>	<p>Please select the emphasis of this program from the options below:</p> <p><input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs</p> <p><input checked="" type="checkbox"/> Primary Prevention</p> <p><input checked="" type="checkbox"/> Seamless Continuum of Care</p>
<b>Link to Community Needs Assessment</b>	<ul style="list-style-type: none"> <li>- Access to care for respiratory health an emphasis on targeting vulnerable communities (e.g., children, seniors)</li> <li>- Underserved and the uninsured</li> <li>- Broader community of the poor, homeless adults, women and children, cultural diversity</li> </ul>
<b>Program Description</b>	<p>For the 2012-2013 fiscal year, the St. Mary Breathe Easy Mobile Outreach Program aimed to decrease the burden of asthma and pollution-related respiratory illness on residents of Long Beach (particularly among seniors and children).</p>
FY 2013	
<b>Goal FY 2013</b>	<p>The objectives of the Breathe Easy Mobile Outreach Program were as follows:</p> <p>(1) Forge partnerships with senior residential facilities, schools and community centers in target areas</p>

	<ul style="list-style-type: none"> <li>(2) Provide 22,750 units of service <ul style="list-style-type: none"> <li>o Respiratory testing and screenings</li> <li>o One-on-one respiratory health education</li> <li>o Respiratory care provided at St. Mary's Emergency Department</li> <li>o Pediatric Asthma Clinic at St. Mary Pediatric Clinic</li> <li>o In-home assessments for asthma triggers</li> </ul> </li> <li>(3) Conduct an outreach campaign to advise residents of the Mobile Care Clinic's services and to provide respiratory health prevention and management education.</li> </ul>
<b>2013 Objective Measure/Indicator of Success</b>	<p>For the objectives previously outlined, the Program Manager tracked relevant outputs and outcomes on an ongoing basis through appropriate documentation</p> <ul style="list-style-type: none"> <li>- Maintenance of electronic database to track the units of service delivered</li> <li>- Archival of information pertinent to services provided at identified sites (including collection of sign-in sheets at outreach events, etc.)</li> </ul>
<b>Baseline</b>	<p>The prevalence of asthma among children ages 0 to 17 years in the Long Beach Health district is 14.2%, which is higher than that of Los Angeles County overall (12.6%), and 8.0% of adults in SPA 8 are currently diagnosed with asthma (Los Angeles County Health Survey of 1999). Also, Chronic Obstructive Pulmonary Disease (COPD) represents the fifth leading cause of death in Los Angeles County; individuals with COPD are among those with an increased sensitivity to air pollution particles.</p> <p>There is a clear need in the area surrounding the Port of Long Beach and the 710 freeway for education, outreach, testing/screening and diagnosis of pollution-related respiratory ailments, and increased access to care for the underserved, especially as over 60% of St. Mary's patients are un- or under-insured</p>
<b>Intervention Strategy for Achieving Goal</b>	<p>Implementation of the Breathe Easy Mobile Outreach Program involved the following activities:</p> <ul style="list-style-type: none"> <li>(1) Objective 1: Forge partnerships in target areas <ul style="list-style-type: none"> <li>o Provide mobile clinic services to patients from at least 20 senior housing facilities, schools, or community centers in the target areas</li> </ul> </li> <li>(2) Objective 2: Provide 22,750 units of service <ul style="list-style-type: none"> <li>o Respiratory testing and screenings</li> <li>o One-on-one respiratory health education</li> <li>o Respiratory care provided at St. Mary's Emergency Department</li> <li>o Pediatric Asthma Clinic at St. Mary Pediatric Clinic</li> <li>o In-home assessments for asthma triggers</li> </ul> </li> <li>(3) Objective 3: Conduct an outreach campaign <ul style="list-style-type: none"> <li>o Achieve a total of 280,000 impressions through outreach efforts as well as media and public relations coverage</li> </ul> </li> </ul>
<b>Result FY 2013</b>	<p>The following outcomes were achieved (as organized by Objective):</p> <ul style="list-style-type: none"> <li>(1) Objective 1: Forge partnerships in target areas <ul style="list-style-type: none"> <li>o St. Mary facilitated services to patients from at least 30 sites in the target areas (nine of which are senior residential facilities)</li> </ul> </li> <li>(2) Objective 2: Provide 22,750 units of service <ul style="list-style-type: none"> <li>o In aggregate, a cumulative total of 25,450 units of service were provided over the grant period <ul style="list-style-type: none"> <li>▪ Respiratory screenings</li> <li>▪ Home visitations (to provide respiratory health education as well facilitate in-home assessments)</li> <li>▪ Follow-up phone calls with patients seen by the Mobile Care Clinic</li> </ul> </li> </ul> </li> <li>(3) Objective 3: Conduct an outreach campaign <ul style="list-style-type: none"> <li>o In aggregate, a cumulative total of 1,296,099 impressions were achieved <ul style="list-style-type: none"> <li>▪ Distribution of outreach flyer at various community events</li> <li>▪ Coverage of mobile clinic services in local media outlets</li> </ul> </li> </ul> </li> </ul>
<b>Hospital's Contribution / Program Expense</b>	<p>While the Breathe Easy Mobile Outreach Program was funded through a grant award furnished by the Port of Long Beach (\$824,791 total), St. Mary leveraged matching funds.</p>
<b>FY 2014</b>	
<b>Goal 2014</b>	<p>The objectives of the Breathe Easy Mobile Outreach Program are as follows:</p> <ul style="list-style-type: none"> <li>(4) Forge partnerships with parks and recreation facilities, low-income housing, senior residential facilities, schools and community centers in target areas</li> <li>(5) Provide 7,500 units of service <ul style="list-style-type: none"> <li>o Assistance with Medi-Cal and low-income health plan enrollment to support community need for benefits resources as part of Covered California and Medicaid expansion.</li> <li>o Respiratory testing and screenings</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>○ One-on-one respiratory health education</li> <li>○ Respiratory care provided at St. Mary's Emergency Department</li> <li>○ Expand screenings to the Family Clinic and OB Clinic to reach additional clients in the community.</li> </ul> <p>Coordinate with the Department of Health, Parks and Recreation Departments, and leaders of community organizations in long beach to promote an outreach campaign to advise residents of the Mobile Care Clinic's services and to provide Medi-Cal enrollment resources, and respiratory health prevention and management education.</p>
<p><b>2014 Objective Measure/Indicator of Success</b></p>	<p>1. Provide 7,500 units of service during the 12-month period via the St. Mary Medical Center (St. Mary) mobile clinic to the residents in the Long Beach Area. Types of services include:</p> <ul style="list-style-type: none"> <li>• Assessment and diagnosis by the Nurse Practitioner</li> <li>• Screenings and exams e.g. spirometry, PFT, EKG, and other diagnostic exams by the Respiratory Therapist</li> <li>• Benefits assessment, patient education, in-home visits, follow-up phone calls by Health Coach &amp; Case Manager</li> <li>• Follow-up visits with health care providers at St. Mary</li> </ul> <p>2. Provide units of services to at least 300 unique individuals during the 12-month period. Patient population will include:</p> <ul style="list-style-type: none"> <li>• Men</li> <li>• Women (including pregnant women)</li> <li>• Children</li> <li>• Elderly</li> </ul> <p>3. Provide screenings for respiratory and cardiopulmonary ailments at 4 community events.</p> <p>4. Track the following data points for reporting and evaluation of program efficacy:</p> <ul style="list-style-type: none"> <li>• Name of facilities/locations of new agreements</li> <li>• Weekly hours of operation and location of Mobile Clinic</li> <li>• Number of clients served divided into age groups of 0-18, 18-64, and 65+</li> <li>• Number and type of clinical (screenings/exams), case management and educational services</li> <li>• Ethnic breakdown of clients served</li> <li>• Number of clients served through large community outreach activities</li> <li>• Number of pregnant clients receiving spirometry screening at OB Clinic</li> <li>• Track patient hospital admissions after their first visit to the Mobile Clinic</li> <li>• Track patient re-admissions for discharged patients referred to Program because of respiratory or cardiopulmonary diagnosis</li> </ul>
<p><b>Baseline</b></p>	<p>The prevalence of asthma among children ages 0 to 17 years in the Long Beach Health district is 14.2%, which is higher than that of Los Angeles County overall (12.6%), and 8.0% of adults in SPA 8 are currently diagnosed with asthma (Los Angeles County Health Survey of 1999). Also, Chronic Obstructive Pulmonary Disease (COPD) represents the fifth leading cause of death in Los Angeles County; individuals with COPD are among those with an increased sensitivity to air pollution particles.</p> <p>There is a clear need in the area surrounding the Port of Long Beach and the 710 freeway for education, outreach, testing/screening and diagnosis of pollution-related respiratory ailments, and increased access to care for the underserved, especially as over 60% of St. Mary's patients are un- or under-insured</p> <p>There is also a clear need for Medi-Cal benefits guidance throughout the Long Beach community due to the evolving details that are emerging with the Affordable Care Act.</p>
<p><b>Intervention Strategy for Achieving Goal</b></p>	<p>Implementation of the Breathe Easy Mobile Outreach Program will require that the mobile clinic complete an application designating it as a Certified Enrollment Entity, so that staff on the unit can pursue designation as Certified Enrollment Counselors. Additional interventions will involve the following activities:</p> <p>(4) Objective 1: Forge partnerships</p> <ul style="list-style-type: none"> <li>○ Provide mobile clinic services to patients at rotating sites in the long beach area including parks, churches, senior housing facilities, schools, or community centers in the target areas</li> </ul>

	<p>(5) Objective 2: Provide 7,500 units of service</p> <ul style="list-style-type: none"> <li>o Benefits counseling and Medi-Cal enrollment</li> <li>o Respiratory testing and screenings</li> <li>o One-on-one respiratory health education</li> <li>o Respiratory care provided at St. Mary's Emergency Department</li> <li>o Pediatric Asthma Clinic at St. Mary Pediatric Clinic</li> <li>o In-home assessments for asthma triggers</li> </ul> <p>(6) Objective 3: Conduct an outreach campaign Achieve a total of 280,000 impressions through outreach efforts as well as media and public relations coverage</p>
<b>Community Benefit Category</b>	Primary prevention

<b>Imaging Center</b>	
<b>Hospital CB Priority Areas</b>	<input type="checkbox"/> Prevention and treatment of respiratory disorders related to air pollution which would include but not limited to asthma and chronic obstructive pulmonary disorder (COPD), and advocating on ways to make the air cleaner especially for vulnerable communities <input type="checkbox"/> Prevention and treatment of obesity and related chronic disorders such as promotion of nutrition, identification and treatment of diabetes and high blood pressure <input checked="" type="checkbox"/> Access to care and the delivery system working with disproportionate unmet health needs (DUHN) communities including but not limited to dental care <input type="checkbox"/> Promotion of mental wellness and health including identifying those who need care and prevention activities.
<b>Program Emphasis</b>	Please select the emphasis of this program from the options below: <input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input type="checkbox"/> Primary Prevention <input type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
<b>Link to Community Needs Assessment</b>	Long Beach Health Needs Assessment identified our service area as culturally diverse with a large uninsured population. We will be providing access to care for a culturally diverse population by offering mammography.
<b>Program Description</b>	Please describe the program. The program offers mammography services for women of low/no income over the age of 40 through the Cancer Detection Program: Every Woman Counts funded by the State of California's Tobacco tax. Breast care services are also offered through the Susan G. Komen Grant and the St. Mary Foundation for women under the age of 40 who otherwise have no other recourse and have been diagnosed with a breast lump/mass.
<b>FY 2013</b>	
<b>Goal FY 2013</b>	Describe the goal for FY 2013. Our goal for FY 2013 is to increase awareness of the importance of breast health care. We will educate women on the importance of routine screenings as well as advise the Long Beach and surrounding communities of the free program available to them and their families.
<b>2013 Objective Measure/Indicator of Success</b>	How did you measure the success of this program and the achievement of your goal? Surveys and attendance for health screenings will give an accurate picture of the results of our outreach with the community.
<b>Baseline</b>	Describe the current situation in the community. Why are you doing this program? The need exists not only in this community but also in the surrounding communities. Many women do not bother to take care of themselves because they are busy taking care of their loved ones. We want to enforce the fact that their health care is just as important.
<b>Intervention Strategy for Achieving Goal</b>	Which actions did you do to achieve your 2013 goal? Health fairs held throughout the year helped spread the word regarding the programs available. Lectures and luncheons with primary care physicians were also held to inform doctors of services available to their patients.
<b>Result FY 2013</b>	Please describe the result this project achieved in the community. 4840 services were performed to women under the Cancer Detection Program: Every Woman Counts. 189 women were evaluated for breast masses under the Susan G. Komen Grant (April – March 2013).
<b>Hospital's Contribution / Program Expense</b>	Please describe what kind of contribution your hospital provided for the success of this program. St. Mary Medical Center provides for the coordination of care for this program. A registered nurse follows the patient from the moment she walks in until the end of her treatment. \$56.18/Hour (\$93,737/Annual)
<b>FY 2014</b>	
<b>Goal 2014</b>	What will you achieve through this program? Please clearly define your goal for this program for the next fiscal year. Our goal for FY2014 is to increase awareness of the importance of breast health. We will educate women about the importance of routine screenings as well as create awareness in Long Beach and surrounding communities of the free programs available to them and their families.

<b>2014 Objective Measure/Indicator of Success</b>	How will you measure the success of this program and the achievement of your goal? Surveys and attendance for health screenings will give an accurate picture of the results of our outreach with the community.
<b>Baseline</b>	Describe the current situation in the community. Why will you continue doing this program? The need exists not only in this community but also in the surrounding communities. We want to enforce the fact that their health care is important.
<b>Intervention Strategy for Achieving Goal</b>	What type of actions have you planned to achieve your goal in FY 2014? Health fairs held throughout the year will help spread the word regarding the programs available. Lectures and luncheons with primary care physicians will also be held to inform doctors of the services available to their patients
<b>Community Benefit Category</b>	

<b>Bazzeni Wellness Center</b>	
<b>Hospital CB Priority Areas</b>	<p>X Prevention and treatment of obesity and related chronic disorders such as promotion of nutrition, identification and treatment of diabetes and high blood pressure</p> <p>X Access to care and the delivery system working with disproportionate unmet health needs (DUHN) communities including but not limited to dental care</p>
<b>Program Emphasis</b>	<p>Please select the emphasis of this program from the options below:</p> <p>X Disproportionate Unmet Health-Related Needs</p> <p>Primary Prevention</p>
<b>Link to Community Needs Assessment</b>	The Community Needs Assessment identified Seniors as a vulnerable community and access to services as being a major barrier to health.
<b>Program Description</b>	<p>The Bazzeni Wellness Center promotes health lifestyles to those 50 years of age or older. Ongoing services include: free health education classes and workshops, free health screenings, free transportation, low cost exercise classes, and a free resource center. Annual membership to The Wellness Center is available for \$25 which includes discounts: on exercise programs offered by the Center, 10% discount at the hospital gift shop and cafeteria and free parking in the hospital's parking structure and at the MOB. For Fiscal Year 2013, there were approximately 2,800 members.</p> <p><b>Services include:</b></p> <ul style="list-style-type: none"> <li>• <b>Insurance counseling</b>—assisting seniors to clarify insurance needs, issues, and concerns.</li> <li>• <b>Hospital and community referral service</b> – assist with access to hospital and community services and programs in the greater Long Beach area.</li> <li>• <b>Free Health Resource library</b> – health and health care resources are available.</li> <li>• <b>Fitness program</b>, taught by SMMC Physical Therapy department, includes: Fall Prevention class, two days per week – a one-on-one balance class; SeniorFit exercise class, three days per week – 35-to-one. Tai Chi classes are offered in sessions of 10 weeks each.</li> <li>• <b>Free monthly health screenings</b> include: fall risk assessment, foot check, blood pressure, cholesterol and blood sugar and hearing evaluations.</li> <li>• <b>Health and Wellness education</b>— offered monthly which focuses on different diseases, such as breast, prostate, heart, etc., with an emphasis on wellness and home safety and disaster preparedness and nutrition. Screenings are also offered at some of the lectures.</li> <li>• <b>Estate Planning and Financial Counseling</b> assisted seniors with financial issues and retirement planning.</li> <li>• <b>Advanced directives assistance</b>—assisting seniors with filling out necessary paperwork for health care directives before the need for hospitalization.</li> <li>• <b>Transportation service</b>—free van service for seniors, which transports them to and from hospital and medical appointments.</li> <li>• <b>Monthly low cost excursions</b> – build camaraderie among the seniors, and promote companionship, as well as opportunities to make new acquaintances.</li> <li>• <b>Annual flu vaccines</b> - Provided annually to uninsured adults 50 and older.</li> <li>• <b>AARP Safe Driver Classes</b> – provided quarterly.</li> <li>• <b>AARP CarFit</b> – provided annually.</li> </ul>

FY 2013	
<b>Goal FY 2013</b>	<ul style="list-style-type: none"> <li>• Increase participation in educational classes, screenings and exercise classes by 300 new members.</li> <li>• Develop new partnerships to support ongoing and new programming.</li> <li>• Develop a system to coordinate efforts to provide continuity and quality of services to the senior population at SMMC and in the community.</li> <li>• Begin using evidence based programming.</li> <li>• Have one community health fair off campus.</li> <li>• Have one community health fair on campus.</li> </ul>
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• Developed a tracking system for new and renewal memberships.</li> <li>• Redesigned newsletter that contains health related information as well as list of current events.</li> <li>• Program evaluations were developed that included suggestions on programs, services and screenings.</li> <li>• Assessed current partnerships and exploring new partnerships and new programming to advance the quality of services provided.</li> <li>• Develop a tracking system that measures the success of each service offered.</li> <li>• Increased utilization of current data base and call center information.</li> <li>• Provide referral and short term case management to adults 65+.</li> </ul>
<b>Baseline</b>	Seniors continue to be at risk of poor health outcomes due to lack of access and resources. The Senior Center helps to bridge this gap
<b>Intervention Strategy for Achieving Goal</b>	Increase knowledge of preventative health care services through health education seminars, baseline screenings and interactive workshops held on campus as well as in the community. Partnering with the community strengthens awareness and ability to provide services.
<b>Result FY 2013</b>	<ul style="list-style-type: none"> <li>• Membership increased by 255 members.</li> <li>• New relationships with community based organizations were developed.</li> <li>• Existing partnerships were evaluated for effectiveness and adjusted where necessary.</li> <li>• Started monthly meetings with all ancillary departments of the hospital to determine if programs were being duplicated, to adjust current programs to meet patient needs and determine where the gaps are and to ensure that lines of communication stay open.</li> <li>• Began researching evidence based programs that will be beneficial to target population.</li> <li>• Held the 2<sup>nd</sup> Annual Safety Summit for stroke awareness and general safety in the home and outside. Vendors displayed home safety equipment, HCP provided screenings and SMMC physicians and staff provided health education lectures to over 150 older adults.</li> <li>• Held the 1<sup>st</sup> Annual Patriots Day Remembrance and Health Summit at American Gold Star Manor. Vendors provided information that is important to seniors, SMMC provided health screenings and health and safety lectures.</li> <li>• Overall outreach: <ul style="list-style-type: none"> <li>○ 1,600 seniors attended community education events.</li> <li>○ 325 seniors attended community health screenings.</li> </ul> </li> </ul>
<b>Hospital's Contribution / Program Expense</b>	St. Mary Medical Center contributed \$125,500 to the program.
FY 2014	
<b>Goal 2014</b>	<ul style="list-style-type: none"> <li>• Become the Wellness Navigator of choice for the 50+ population.</li> <li>• Provide high quality and where appropriate evidence based wellness programs and services.</li> <li>• Develop community partnerships to provide and promote services to the older adult community.</li> </ul>
<b>2014 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• Provide community resources, referrals and education to keep older adults living independently, safely and with dignity in their own homes.</li> <li>• Customer satisfaction surveys and program evaluations to be done annually.</li> <li>• Measure participant outcomes through evidence based programs.</li> </ul>
<b>Baseline</b>	The senior population is still one of the most vulnerable populations, especially in the zip codes that we serve. As healthcare changes, we must keep our seniors informed and

	engaged. Preventative healthcare is a major issue and continually needs to be addressed and met.
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Develop high end resource and information center and partner with community organizations that provide services that our center does not.</li> <li>• Provide educational workshops and seminars on campus monthly</li> <li>• Provide exercise programs on campus monthly.</li> <li>• Research and incorporate STEADI and/or EnhanceFit evidence-based physical activity programs for older adults to measure outcomes and reduce the risk of falls and fall episodes and help control weight management.</li> <li>• Hold one major safety summit on fall prevention on campus</li> <li>• Provide education lectures on heart disease, diabetes and fall prevention to a minimum of 6 residential or community settings in catchment area.</li> <li>• Research companies or a university that could assist with developing robust consumer satisfaction and program evaluation survey that will guide the center moving forward.</li> </ul>
<b>Community Benefit Category</b>	

<b>Chronic Disease Self-Management Program</b>	
<b>Hospital CB Priority Areas</b>	<p>X Prevention and treatment of obesity and related chronic disorders such as promotion of nutrition, identification and treatment of diabetes and high blood pressure</p> <p>X Access to care and the delivery system working with disproportionate unmet health needs (DUHN) communities including but not limited to dental care</p>
	<p>Please select the emphasis of this program from the options below:</p> <p>X Disproportionate Unmet Health-Related Needs</p>
<b>Link to Community Needs Assessment</b>	The Community Needs Assessment identified seniors as a vulnerable community and access to services as being a major barrier to health care.
<b>Program Description</b>	<b>Chronic Disease Self Management Program (CDSMP)</b> —Based on the Stanford Model, this proven 6 week self help program is offered to the community in English, Spanish, and Khmer. The goal of the program is to teach participants the skills they need to know in manage their chronic condition(s) on a daily basis to achieve the maximum quality of physical, mental and emotional well being.
<b>FY 2013</b>	
<b>Goal FY 2013</b>	<ul style="list-style-type: none"> <li>• Train two staff members as Master Trainers</li> <li>• Provide three CDSMP workshops to the community</li> <li>• Recertify current Lay Leaders</li> </ul>
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• Two staff members will successfully complete the program as Master Trainers</li> <li>• Participation in the program on campus and in the community.</li> <li>• Lay Leaders will be trained and recertified on the program updates</li> </ul>
<b>Baseline</b>	There are many older adults that live with one or more chronic conditions that take a toll on the quality of their life on a daily basis. Providing this program gives suffers of chronic conditions many tools to be able to manage their condition(s) on a daily basis to achieve the maximum quality of physical, mental and emotional well being.
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Two staff members will attend the Stanford Education Program</li> <li>• Educate the community of the successful outcomes of the works</li> <li>• Lay Leaders were trained and recertified</li> </ul>
<b>Result FY 2013</b>	<p>Participants learned practical ways to deal with effects of their chronic conditions such as pain, fatigue and stress; they also learned better nutrition and exercise choices. By giving participants the support they needed, they were happier, healthier and more independent.</p> <ul style="list-style-type: none"> <li>• Three workshop s were completed <ul style="list-style-type: none"> <li>○ One on campus in Khmer</li> <li>○ Two at residential facilities in English</li> </ul> </li> <li>• Two staff are certified as Master Trainers</li> <li>• Lay Leaders have been recertified</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	St. Mary Medical Center contributed \$5,000

FY 2014	
<b>Goal 2014</b>	<ul style="list-style-type: none"> <li>• Train 10 Community Lay Leaders for the Chronic Disease Self Management Program.</li> <li>• Provide Chronic Disease Self Management classes at 5 community settings, residential facilities or on campus.               <ul style="list-style-type: none"> <li>○ One in workshop in Spanish – off campus</li> <li>○ One workshop in Khmer</li> <li>○ Three workshops in English                   <ul style="list-style-type: none"> <li>▪ Two off campus</li> <li>▪ One on campus</li> </ul> </li> </ul> </li> </ul>
<b>2014 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• 10 Community Lay Leaders will be trained</li> <li>• 5 workshops will be held either in the community or on campus</li> </ul>
<b>Baseline</b>	There are many older adults that live with one or more chronic conditions that take a toll on the quality of their life on a daily basis. Providing this program gives suffers of chronic conditions many tools to be able to manage their condition(s) on a daily basis to achieve the maximum quality of physical, mental and emotional well being.
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Outreach to religious organizations and retiree groups to recruit volunteers to be trained a Community Lay Leaders</li> <li>• Community outreach and education regarding the success and positive outcomes achieved through the Chronic Disease Self Management Program</li> </ul>
<b>Community Benefit Category</b>	

Senior Connections	
<b>Hospital CB Priority Areas</b>	<p>X Access to care and the delivery system working with disproportionate unmet health needs (DUHN) communities</p> <p><input type="checkbox"/> Promotion of mental wellness and health including identifying those who need care and prevention activities.</p>
<b>Program Emphasis</b>	<p>Please select the emphasis of this program from the options below:</p> <p>X Disproportionate Unmet Health-Related Needs</p> <p><input type="checkbox"/> Primary Prevention</p> <p><input type="checkbox"/> Seamless Continuum of Care</p> <p><input type="checkbox"/> Build Community Capacity</p> <p><input type="checkbox"/> Collaborative Governance</p>
<b>Link to Community Needs Assessment</b>	The Senior Connections Program seeks to provide short term case management services to the following populations who have financial barriers to access, language barriers to access, lack of transportation, physical disabilities, mental disabilities and seniors who are living alone.
<b>Program Description</b>	The Senior Connections Program is a support/referral program that is designed with the older adult in mind. Individuals who are 55 and older may be eligible for linkage and referral services for, but not limited to, recreational activities, health related services and social services.
FY 2013	
<b>Goal FY 2013</b>	The goal of the program is to better utilize, better coordinate and expand existing services to provide increased benefit to seniors in Long Beach, so they can maintain healthy independent and long lives.
<b>2013 Objective Measure/Indicator of Success</b>	<p>The program measured its achievements within the program by implementing and completing the following objectives.</p> <ul style="list-style-type: none"> <li>• The City of Long Beach Senior Links' Social Worker will case manage at least 30 seniors, by conducting home visitations, follow-up calls, and managing their navigation to resources.</li> <li>• Administer health screenings to at least 4,000 seniors, at community outreach events and health fairs.</li> <li>• Provide low-cost Fall Prevention classes to 20 seniors</li> <li>• Provide 75 seniors free in-home evaluations of living space and limitations, education on the use of assistive devices and proper body mechanics, and installation of assistive devices, through the Fall Prevention Program.</li> <li>• Provide low-cost exercise classes to at least 400 seniors: Balance, Beginning and Advanced SeniorFit, T'ai Chi Chih, and dance.</li> </ul>

	<ul style="list-style-type: none"> <li>• Coordinate at least 12 low-cost travel excursions, attended by at least 500 seniors.</li> <li>• Provide low-cost Mature Drivers Education classes to 150 seniors.</li> <li>• Provide 30 Health and Wellness education classes for 3,000 seniors.</li> <li>• Provide approximately 120 eye exams and/or eye glasses at a reduced rate to seniors demonstrating financial need, at the St. Mary Low Vision Center.</li> </ul>
<b>Baseline</b>	The need for St. Mary and the city of Long Beach to provide access to adequate care for seniors remains crucial as the number of persons over the age of 65 continues to rise. With a growing and significantly impoverished population of seniors in Long Beach, it is important that larger institutions, especially those already working with seniors such as St. Mary, continue to enhance community outreach efforts, provision and access to care, and patient navigation to these at-risk seniors.
<b>Intervention Strategy for Achieving Goal</b>	Through establishment of client intake at a single location, the Coordinator was able to provide patient navigation to services and assist senior clients to locate and direct clients to appropriate resources.
<b>Result FY 2013</b>	The Senior Connections Coordinator in collaboration with the City of Long Beach Senior Links Social Worker were able to accomplish the objectives set for 2013
<b>Hospital's Contribution / Program Expense</b>	The hospital's foundation helped secure monies to fund this program through an Archstone grant for \$75,000.
<b>FY 2014</b>	
<b>Goal 2014</b>	<ul style="list-style-type: none"> <li>• Complete at least 700 calls to and from seniors recently discharged from hospital, through the Senior Patient Assistance Line (Senior PAL).</li> <li>• Provide 80 seniors with free or low-cost dental screening and subsequent referral to a low-cost clinic .</li> <li>• Provide at least 20 seniors with technology education in computers and smart phones.</li> <li>• Build inter-referral relationship with at least 1 Latino-serving Community-Based Organization in the local area. <ul style="list-style-type: none"> <li>◦ Anticipating success from increased outreach modalities, enroll 40 new Spanish-speaking clients into the Senior Connections Program, a 60% increase from last year.</li> </ul> </li> <li>• The City of Long Beach Senior Links' Social Worker will case manage at least 25 seniors, by conducting home visitations, follow-up calls, and managing their navigation to resources.</li> <li>• Administer health screenings to at least 2,500 seniors, at community outreach events and health fairs.</li> <li>• Provide low-cost Fall Prevention classes to 20 seniors.</li> <li>• Provide 40 seniors free in-home evaluations of living space and limitations, education on the use of assistive devices and proper body mechanics, and installation of assistive devices, through the Fall Prevention Program.</li> <li>• Provide low-cost exercise classes to at least 400 seniors: Balance, Beginning and Advanced SeniorFit, T'ai Chi Chih, and dance.</li> <li>• Coordinate at least 11 low-cost travel excursions, attended by at least 500 seniors.</li> <li>• Provide low-cost Mature Drivers Education classes to 150 seniors.</li> <li>• Provide 30 Health and Wellness education classes for 3,000 seniors.</li> <li>• Provide approximately 100 eye exams and/or eye glasses at a reduced rate to seniors demonstrating financial need, at the St. Mary Low Vision Center.</li> </ul>
<b>2014 Objective Measure/Indicator of Success</b>	The measure of success will be recorded by the number of individuals who participate in the services that are offered.
<b>Baseline</b>	Even though a great number of individuals were assisted through the Senior Connections Program, there is still a great need for its services. The need for St. Mary and the city of Long Beach to provide access to adequate care for seniors remains crucial as the number of persons over the age of 65 continues to rise. With a growing and significantly impoverished population of seniors in Long Beach, it is important that larger institutions, especially those already working with seniors such as St. Mary, continue to enhance community outreach efforts, provision and access to care, and patient navigation to these at-risk seniors.

<b>Intervention Strategy for Achieving Goal</b>	Through establishment of client intake at a single location, the Coordinator will continue to be able to provide patient navigation to services and assist senior clients to locate and direct clients to appropriate resources.
<b>Community Benefit Category</b>	

<b>Diabetes Education</b>	
<b>Hospital CB Priority Areas</b>	<input type="checkbox"/> Prevention and treatment of obesity and related chronic disorders such as promotion of nutrition, identification and treatment of diabetes and high blood pressure
<b>Program Emphasis</b>	Please select the emphasis of this program from the options below: <input type="checkbox"/> Disproportionate Unmet Health-Related Needs <input type="checkbox"/> Primary Prevention <input type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity
<b>Link to Community Needs Assessment</b>	Insured, uninsured, Medi-Cal and Medicare
<b>Program Description</b>	Outpatient Self-Management Education and Support Program
<b>FY 2013</b>	
<b>Goal FY 2013</b>	To provide effective and appropriate education to meet the medical and psychological, social and spiritual needs of the person with diabetes.  To prevent or minimize the acute or chronic complications associated with diabetes.  To reduce inpatient hospitalization stay as appropriate.  To develop partnerships with referring physicians.
<b>2013 Objective Measure/Indicator of Success</b>	By Goal setting, Foot assessment, Nutrition by verbalizing understanding of meal planning, glucose monitoring, and A1C results.
<b>Baseline</b>	Obesity leads to higher incidence of Diabetes Type 2. The Diabetes Self-Management Education and Support program provide knowledge and skills needed to successfully self-manage the disease.
<b>Intervention Strategy for Achieving Goal</b>	3 month, 6 month, and 1 year follow up from time of initial visit with A1C results.
<b>Result FY 2013</b>	An average of 80% of patients show improvement with lifestyle changes.
<b>Hospital's Contribution / Program Expense</b>	The hospital provides a yearly "Walk for Diabetes", quarterly support group and an annual November fair for Diabetes to provide funds for uninsured patients.
<b>FY 2014</b>	
<b>Goal 2014</b>	To provide effective and appropriate education to meet the medical and psychological, social and spiritual needs of the person with diabetes.  To prevent or minimize the acute or chronic complications associated with diabetes.  To reduce inpatient hospitalization stay as appropriate.  To develop partnerships with referring physicians.  To develop partnership with Outreach Mobile Clinic to identify newly diagnosed patient with diabetes and refer for diabetes education.  To develop a relationship with staff of Stanford Chronic Care Model for continued education for people with diabetes.
<b>2014 Objective Measure/Indicator of Success</b>	By Goal setting, Foot assessment, Nutrition, by verbalizing understanding of meal planning, glucose monitoring, and A1C results and also Body Mass Index (BMI) by initial visit, 3 month, 6 month and 1 year follow up.
<b>Baseline</b>	Obesity leads to higher incidence of Diabetes Type 2. The Diabetes Self-Management Education and Support program provide knowledge and skills needed to successfully self-manage the disease.

<b>Intervention Strategy for Achieving Goal</b>	The patient will follow the AADE 7 Self Care Behaviors: Healthy Eating, Being Active, Monitoring, Taking Medications, Problem Solving, Healthy Coping, and Reducing Risks. Reassessment of patient's lifestyle changes will be done: 3 months, 6 months and 1 year after Education.
<b>Community Benefit Category</b>	

Low Vision Center	
<b>Hospital CB Priority Areas</b>	Access to health care specifically for the underserved and culturally diverse populations. Focus on prevention of vision impairments in all age groups 5 through 105 years of age.
<b>Program Emphasis</b>	<ul style="list-style-type: none"> <li>X Disproportionate Unmet Health-Related Needs</li> <li>X Primary Prevention</li> <li>X Seamless Continuum of Care</li> </ul>
<b>Link to Community Needs Assessment</b>	Visually impaired, underinsured, uninsured, local private schools, senior centers and local businesses.
<b>Program Description</b>	<p>The St. Mary Low Vision Center provides the following services:</p> <ul style="list-style-type: none"> <li>• Near and distance acuity testing performed</li> <li>• Assistance in the selection of appropriate aids</li> <li>• Training in the use of optical aids</li> <li>• Training in the use of electronic video equipment (CCTV's)</li> <li>• Education through Independent Living Skills Classes</li> <li>• Lectures for public &amp; private organizations</li> <li>• Vision screenings at public &amp; private health fairs, senior centers &amp; businesses</li> <li>• Free vision screenings to 40+ area schools</li> <li>• In-home visits</li> <li>• Minor eyeglass repairs</li> <li>• Instruction given to maximize remaining eyesight to regain useful and productive lives.</li> </ul>
FY 2013	
<b>Goal FY 2013</b>	<ul style="list-style-type: none"> <li>• Continue to maintain successful LVC School Screening Program</li> <li>• Continue to maintain educational awareness of eye care through seminars, health fairs and educational classes</li> <li>• Continue community awareness of services offered to public and low income through aggressive marketing strategies</li> <li>• Continue to host educational tours for resident physicians and students from surrounding medical centers and rehabilitation centers</li> </ul>
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• Attendance of patients at the Low Vision Center</li> <li>• Increase in schools served</li> <li>• Increase in Community screening sites</li> <li>• Increase in number of seminars, health fairs and educational classes</li> <li>• Awareness of services to the public through advertisement within St. Mary Medical Center and local advertising agencies</li> <li>• Referrals from physicians who have attended a personal tour of the Center.</li> </ul>
<b>Baseline</b>	The current situation in the community is such that once the ophthalmologist can no longer assist a patient with eye care management, the patient finds him/herself searching for other avenues of assistance with their visual impairment. Through the provision of consultations, Independent Living Skills Classes, and optical aids and free community programs, children, teens, adults and seniors have the ability to manage their lives and continue to live independently.

<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>1. Increase in schools, seminars, Independent living Skills classes</li> <li>2. Promotion of Low Vision Center at health fairs, through newsletters and marketing</li> <li>3. Scheduled vision screenings to be performed at Harbour Area Halfway House, WSLB (Women's shelters), The Village, CSULB – SEE US SUCCEED (Homeless children's camp)</li> <li>4. Promotion of Low Vision Center within St. Mary Medical Center to visitors, physicians and free screenings within the hospital grounds.</li> <li>5. Collaboration with SMMC departments, (e.g. CARE Program) for free vision evaluations.</li> </ol>
<b>Result FY 2013</b>	The Low Vision Center has shown steady, continued growth since 2004. Attendance numbers have increased and visitors regularly drop in to be screened due to awareness through advertising, and free vision screenings. A closer relationship has been established interdepartmentally, and with surrounding hospitals, schools, businesses and the surrounding community.
<b>Hospital's Contribution / Program Expense</b>	Support is provided by grants obtained through the SMMC Foundation. The hospital also provides rooms for lectures and health fairs. St. Mary transportation is also provided to local residents to access health care.
<b>FY 2014</b>	
<b>Goal 2014</b>	<ol style="list-style-type: none"> <li>1. Community awareness and prevention of eye diseases.</li> <li>2. Continued education to clients and the public through Independent Living Skills classes, health fairs, lectures.</li> <li>3. Continued free assistance to the visually impaired that are homeless, uninsured or facing financial burdens.</li> <li>4. Continued maintenance of marketing, lectures, physician contacts and referrals for populations of low income that have already been established.</li> <li>5. The acquisition of future grants to sustain programs that are successful and continuing to grow.</li> </ol>
<b>2014 Objective Measure/Indicator of Success</b>	Measurement of success is obtained through computer data, feedback from LVC patients, the public, businesses, physicians and the parents of children served.
<b>Baseline</b>	<p>The current situation in the community remains the same as in previous years. Individuals continue to seek assistance with eye care management once they can no longer be helped by their ophthalmologist.</p> <p>The Low Vision Center is a unique and much needed program. Although our consultations are free of charge to all who visit, it is those Individuals of low income status who are especially grateful to be able to access free services such as consultation and counseling, educational classes, lectures and health fairs. The value of services offered and the array of inventory offered cannot be underestimated. The Center is centrally located between Los Angeles and Orange County. Patients come from as far away as Oregon and New York City.</p> <p>The free school screening program has helped thousands of children annually and created a renewed sense of importance, awareness and understanding with the parents, teachers, children and most importantly the community.</p>
<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>1. Continue to build community awareness through health fairs, marketing, lectures, advertising</li> <li>2. Continued contact with physicians to promote the Low Vision Centers' services.</li> <li>3. Continued promotion of LVC services to senior centers, schools, businesses, health fairs</li> <li>4. Acquisition of grants through SMMC Grant Writing Department for the acquisition of new and innovative technology for redistribution to the visually impaired.</li> <li>5. Continued maintenance of successfully established programs</li> <li>6. Acquisition of grants to maintain all free services</li> </ol>
<b>Community Benefit Category</b>	Community Based Clinical Services-Ancillary

Families in Good Health: Best Babies Collaborative (BBC)	
Hospital CB Priority Areas	<input checked="" type="checkbox"/> Access to care and the delivery system working with disproportionate unmet health needs (DUHN) communities including but not limited to dental care
Program Emphasis	Please select the emphasis of this program from the options below: <input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care
Link to Community Needs Assessment	– Underserved and the uninsured – Broader community of the poor, homeless adults, women and children, cultural diversity
Program Description	Best Babies Collaborative (BBC) is funded through a subcontract from the Long Beach Department of Health and Human Services to provide in-home care management services to pregnant and parenting teens as part of the construct of interception care.
FY 2013	
Goal FY 2013	To improve maternal and infant mortality rates in targeted high risk communities in the greater Long Beach area.
2013 Objective Measure/Indicator of Success	– Outreach to a minimum of 75 pregnant or childbearing age women in the target areas regarding the BBC and the importance of prenatal and interconception care – Disseminate BBC health education and messaging materials to the community in the target areas at community events and other identified venues – Provide intensive, home-based health, nutrition, and infant/child development education, utilizing Parents and Children Together curriculum, to a minimum of 10 or a maximum of 15 high-risk mothers in the target areas as part of case management services
Baseline	– High teen pregnancy rate – High infant mortality rate – Incidence of low birth weight
Intervention Strategy for Achieving Goal	Implementation of home visitation modules account for, but are not limited to, prenatal health and nutrition, infant development, maternal health, and bonding and attachment
Result FY 2013	– Conducted outreach and education to 1,471 individuals via one-on-one and at various community events – Case load would total 12-16 clients at any given moment
Hospital's Contribution / Program Expense	\$35,310 grant award
FY 2014	
Goal 2014	To improve maternal and infant mortality rates in targeted high risk communities in the greater Long Beach area.
2014 Objective Measure/Indicator of Success	– Provide home visitation services to 10-15 high-risk pregnant and parenting teens at a time – Healthy second births to be measured over time
Baseline	– High teen pregnancy rate – High infant mortality rate – Incidence of low birth weight
Intervention Strategy for Achieving Goal	Implementation of home visitation modules account for, but are not limited to, prenatal health and nutrition, infant development, maternal health, and bonding and attachment
Community Benefit Category	

Families in Good Health: Educated Men with Meaningful Messages (EM3)	
Hospital CB Priority Areas	<input type="checkbox"/> Prevention and treatment of respiratory disorders related to air pollution which would include but not limited to asthma and chronic obstructive pulmonary disorder (COPD), and advocating on ways to make the air cleaner especially for vulnerable communities <input checked="" type="checkbox"/> Prevention and treatment of obesity and related chronic disorders such as promotion of nutrition, identification and treatment of diabetes and high blood pressure <input checked="" type="checkbox"/> Access to care and the delivery system working with disproportionate unmet health needs (DUHN) communities including but not limited to dental care <input checked="" type="checkbox"/> Promotion of mental wellness and health including identifying those who need care and prevention activities.

<b>Program Emphasis</b>	Please select the emphasis of this program from the options below: <input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
<b>Link to Community Needs Assessment</b>	<ul style="list-style-type: none"> <li>- Underserved and the uninsured</li> <li>- Broader community of the poor, homeless adults, women and children, cultural diversity</li> </ul>
<b>Program Description</b>	Educated Men with Meaningful Messages (EM3) was initially funded in 1996 by the State of California Office of Family Planning. EM3 is now funded by the Asian Pacific Partners for Empowerment And Leadership (APPEAL) and The California Endowment to conduct community education and mobilization efforts within Long Beach multiethnic male youth regarding the built environment physical activity, nutrition, tobacco control and health advocacy. These male youth serve as Peer Leaders and Educators to conduct training, outreach, and advocacy to their peers and within the community as well as to encourage fellow peers to become responsible individuals and leaders. Participant ages range from 14-18 years old.
<b>FY 2013</b>	
<b>Goal FY 2013</b>	To improve the quality of life of at-risk youth residing in the greater Long Beach area by increasing community involvement, facilitating youth leadership development and advocacy, and increasing graduation rates.
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>- Increase the capacity of male youth of color to participate in and advocate for health promoting policies and activities as well as to understand how race, culture and place matters to health. Train 20-25 youth as youth leaders per year with youth attending a total of 6-8 community meetings advocating for health promoting policies.</li> <li>- Increase youth understanding of how school policies can affect male youth of color and engage them in advocating for reform of school discipline policies. Support two youth as participants in the Long Beach Building Healthy Communities Youth Committee as well as attendance monthly Long Beach Building Healthy Communities Youth Work Group Meetings (and other events).</li> <li>- Maintain strong collaborative relationships with community partners, including continued participation in the Long Beach Cambodian Coalition.</li> </ul>
<b>Baseline</b>	High-risk, vulnerable participant population
<b>Intervention Strategy for Achieving Goal</b>	Activities include, but are not limited to, recruitment of male youth for development of Peer Leaders and Educators, collaboration with other youth programs in Los Angeles County, and ongoing participation in the Long Beach Building Healthy Communities place-based initiative.
<b>Result FY 2013</b>	<ul style="list-style-type: none"> <li>- Recruitment and engagement of ~25 multiethnic male youth for active participation in EM3, with some youth actively involved in community meetings that advocate for health promoting policies</li> <li>- Active participation in the launch and implementation of the Every Student Matters campaign, especially as this effort relates to the reform of school discipline policies</li> <li>- Continued maintenance of collaborative relationships with community partners such as Centro CHA, Khmer Girls in Action, Long Beach Cambodian Coalition</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	~\$85,000 grant award (From The California Endowment for Youth Promoting Good Health project)
<b>FY 2014</b>	
<b>Goal 2014</b>	To improve the quality of life of at-risk youth residing in the greater Long Beach area by increasing community involvement, facilitating youth leadership development and advocacy, and increasing graduation rates.
<b>2014 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>- Increase the capacity of male youth of color to participate in and advocate for health promoting policies and activities as well as to understand how race, culture and place matters to health. Train 20-25 youth as youth leaders per year with youth attending a total of 6-8 community meetings advocating for health promoting policies.</li> <li>- Increase youth understanding of how school policies can affect male youth of color and engage them in advocating for reform of school discipline policies. Support two youth as participants in the Long Beach Building Healthy Communities Youth Committee as well as attendance monthly Long Beach Building Healthy Communities Youth Work Group Meetings (and other events).</li> <li>- Maintain strong collaborative relationships with community partners, including continued participation in the Long Beach Cambodian Coalition.</li> </ul>
<b>Baseline</b>	High-risk, vulnerable participant population

<b>Intervention Strategy for Achieving Goal</b>	Activities include, but are not limited to, recruitment of male youth for development of Peer Leaders and Educators, collaboration with other youth programs in Los Angeles County, and ongoing participation in the Long Beach Building Healthy Communities place-based initiative.
<b>Community Benefit Category</b>	

**Families in Good Health: Educating Providers, Supporting Children Project (EPSC)**

<b>Hospital CB Priority Areas</b>	<input checked="" type="checkbox"/> Access to care and the delivery system working with disproportionate unmet health needs (DUHN) communities including but not limited to dental care
<b>Program Emphasis</b>	Please select the emphasis of this program from the options below: <input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care
<b>Link to Community Needs Assessment</b>	<ul style="list-style-type: none"> <li>- Underserved and the uninsured</li> <li>- Broader community of the poor, homeless adults, women and children, cultural diversity</li> </ul>
<b>Program Description</b>	Educating Providers, Supporting Children (EPSC) is funded by First 5 LA to deliver a 19 module curriculum to informal, license exempt child care providers in order to improve the quality of child care, improve child-adult relationships, provide activities that improve child brain development and function, and improve access to resources.

**FY 2013**

<b>Goal FY 2013</b>	To improve the safety of at-risk children 5 years old and under through improved child care provider education. The intermediate program goal reflects school readiness among those children in child care, while the long-term goal would reflect decreased gang involvement and increased school success.
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>- Provide comprehensive training, education and mentoring to a minimum of 32-35 informal child care providers who care for children 5 years old and under</li> <li>- Measures for short-term objectives include pre- and post-test assessments for educational workshops, provider satisfaction surveys</li> </ul>
<b>Baseline</b>	Not enough preschools or child care centers exist in Long Beach. Too many children are cared for by family and friends without significant consideration for their overall development.
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>- Delivery of 19-module training curriculum to African American, Latino and Southeast Asian informal child care providers (including training on PlayTangle, Jr. and administration of Ages and Stages Questionnaires)</li> <li>- Facilitation of opportunities, avenues for social connectedness</li> <li>- Facilitation of field trip opportunities as well as access to relevant community resources</li> <li>-</li> </ul>
<b>Result FY 2013</b>	<ul style="list-style-type: none"> <li>- A total of 35 child care providers participated in the 19-module training curriculum (i.e., 9 African American, 14 Latino and 12 Southeast Asian)</li> <li>- Child care providers participated in various social connectedness activities: Alumni Event, Holiday Social, Graduation</li> <li>- Child care providers participated in field trip opportunities, such as the local library, to increase access to relevant resources</li> <li>-</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	\$200,000 grant award

**FY 2014**

<b>Goal 2014</b>	To improve the safety of at-risk children 5 years old and under through improved child care provider education. The intermediate program goal reflects school readiness among those children in child care, while the long-term goal would reflect decreased gang involvement and increased school success.
<b>2014 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>- Provide comprehensive training, education and mentoring to 34 informal child care providers who care for children 5 years old and under</li> <li>- Measures for short-term objectives include pre- and post-test assessments for educational workshops, provider satisfaction surveys</li> </ul>
<b>Baseline</b>	Not enough preschools or child care centers exist in Long Beach. Too many children are

	cared for by family and friends without significant consideration for their overall development.
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>- Delivery of 19-module training curriculum to African American, Latino and Southeast Asian informal child care providers (including training on PlayTangle, Jr. and administration of Ages and Stages Questionnaires)</li> <li>- Facilitation of opportunities, avenues for social connectedness</li> <li>- Facilitation of field trip opportunities as well as access to relevant community resources</li> </ul>
<b>Community Benefit Category</b>	

<b>Families in Good Health: Health Access for Pacific Asian Seniors (HAPAS)</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Prevention and treatment of obesity and related chronic disorders such as promotion of nutrition, identification and treatment of diabetes and high blood pressure</li> <li><input checked="" type="checkbox"/> Access to care and the delivery system working with disproportionate unmet health needs (DUHN) communities including but not limited to dental care</li> </ul>
<b>Program Emphasis</b>	<p>Please select the emphasis of this program from the options below:</p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs</li> <li><input checked="" type="checkbox"/> Primary Prevention</li> <li><input checked="" type="checkbox"/> Seamless Continuum of Care</li> <li><input checked="" type="checkbox"/> Build Community Capacity</li> </ul>
<b>Link to Community Needs Assessment</b>	<ul style="list-style-type: none"> <li>- Underserved and the uninsured</li> <li>- Broader community of the poor, homeless adults, women and children, cultural diversity</li> </ul>
<b>Program Description</b>	Health Access for Pacific Asian Seniors (HAPAS) is part of a collaborative project funded by the REACH initiative of the Centers for Disease Control and Prevention to develop. HAPAS aimed to improve the quality of life for vulnerable seniors, particularly the Filipino and Lao communities in the greater Long Beach area.
<b>FY 2013</b>	
<b>Goal FY 2013</b>	To reduce racial and ethnic health disparities related to adult immunizations, diabetes, and cardiovascular diseases that affect Southeast Asian, Samoan, and Filipino communities of Los Angeles and Orange Counties of California (with an emphasis on the Filipino and Lao communities in the greater Long Beach area).
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>- Conduct outreach to target communities through community- and ethnic-specific venues</li> <li>- Facilitate community report back events to review findings gleaned from needs assessment efforts with target communities (focusing on the built environment, nutrition and physical activity)</li> <li>- Promote approaches to healthy living through the facilitation of a walking group as well as maintenance of community garden plots</li> </ul>
<b>Baseline</b>	Needs assessments conducted within the Filipino and Lao senior communities revealed culturally-specific views on the built environment, healthy nutrition and physical activity. Emergent issues from these needs assessments included the issue of community safety.
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>- Outreach and recruitment (including outreach at ethnic-specific venues as well as home-based recruitment)</li> <li>- Debriefed Filipino and Lao communities on needs assessments conducted with their respective communities through community report back events (Facilitated discussion on needs assessment findings so as to inform possible future interventions)</li> <li>- Promoted healthy living among seniors through the facilitation of a walking group with Lao seniors. Also maintained community garden plots for both the Filipino and Lao senior communities (through the Growing Experience in North Long Beach).</li> </ul>
<b>Result FY 2013</b>	<ul style="list-style-type: none"> <li>- Documented facilitation of community report back events within the Filipino and Lao senior communities</li> <li>- Produced with collaborative partners a Community Needs Assessment Report publication that details findings from needs assessment efforts conducted with Southeast Asian, Samoan and Filipino communities of Los Angeles and Orange Counties</li> <li>- Documented efforts in facilitation of a walking group for Lao seniors</li> <li>- Participated in a groundbreaking event for the establishment of the respective</li> </ul>

	community garden plots
<b>Hospital's Contribution / Program Expense</b>	\$60,000 grant award
<b>FY 2014 (Not applicable as grant funding ended in December 2012)</b>	
<b>Goal 2014</b>	
<b>2014 Objective Measure/Indicator of Success</b>	
<b>Baseline</b>	
<b>Intervention Strategy for Achieving Goal</b>	
<b>Community Benefit Category</b>	

<b>Families in Good Health: Promoting Access to Health for Women (PATH for Women)</b>	
<b>Hospital CB Priority Areas</b>	<input checked="" type="checkbox"/> Access to care and the delivery system working with disproportionate unmet health needs (DUHN) communities including but not limited to dental care
<b>Program Emphasis</b>	Please select the emphasis of this program from the options below: <input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity
<b>Link to Community Needs Assessment</b>	<ul style="list-style-type: none"> <li>- Underserved and the uninsured</li> <li>- Broader community of the poor, homeless adults, women and children, cultural diversity</li> </ul>
<b>Program Description</b>	Promoting Access to Health for Women (PATH for Women) was funded as part of the Centers of Excellence Initiative of the Centers for Disease Control and Prevention through a subcontract from the Orange County Asian Pacific Islander Community Alliance. The following program components focused on promoting breast and cervical health among Southeast Asian women in the greater Long Beach community: outreach, health promotion, patient navigation and policy advocacy.
<b>FY 2013</b>	
<b>Goal FY 2013</b>	To decrease the incidence of breast and cervical cancer in the Khmer and Lao communities in the greater Long Beach area.
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>- Conduct outreach and education to 800+ community members on breast and cervical health</li> <li>- Conduct outreach and education to community leaders and health care providers</li> <li>- Provide patient navigation to 70+ women to enable them access to early screenings</li> <li>- Present program successes to local legislators as well as identified community and professional venues.</li> </ul>
<b>Baseline</b>	Breast cancer represents the leading cause of death for Asian American women in Los Angeles County.
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>- Outreach and recruitment (including home-based recruitment)</li> <li>- Health promotion through one-on-one education, at ethnic venues and via community events</li> <li>- Patient navigation for breast and cervical health screenings</li> <li>- Leadership and advocacy training with an emphasis on breast and cervical health promotion</li> </ul>
<b>Result FY 2013</b>	<ul style="list-style-type: none"> <li>- Conducted outreach and education services to 1,724 community members on breast and cervical health</li> <li>- Conducted outreach and education to 17 community leaders and health care providers</li> <li>- Provide patient navigation to 379 women to enable them access to screenings</li> <li>- Provided education on Asian Pacific Islander health disparities and health policy system changes at various policy-oriented venues (e.g., with local elected officials, etc.)</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	\$70,000 grant award
<b>FY 2014 (Not applicable as grant funding ended in September 2012)</b>	
<b>Goal 2014</b>	
<b>2014 Objective</b>	

<b>Measure/Indicator of Success</b>	
<b>Baseline</b>	
<b>Intervention Strategy for Achieving Goal</b>	
<b>Community Benefit Category</b>	

<b>Families in Good Health: United in Health</b>	
<b>Hospital CB Priority Areas</b>	<input type="checkbox"/> Prevention and treatment of respiratory disorders related to air pollution which would include but not limited to asthma and chronic obstructive pulmonary disorder (COPD), and advocating on ways to make the air cleaner especially for vulnerable communities <input checked="" type="checkbox"/> Prevention and treatment of obesity and related chronic disorders such as promotion of nutrition, identification and treatment of diabetes and high blood pressure <input checked="" type="checkbox"/> Access to care and the delivery system working with disproportionate unmet health needs (DUHN) communities including but not limited to dental care <input type="checkbox"/> Promotion of mental wellness and health including identifying those who need care and prevention activities.
<b>Program Emphasis</b>	Please select the emphasis of this program from the options below: <input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
<b>Link to Community Needs Assessment</b>	<ul style="list-style-type: none"> <li>- Underserved and the uninsured</li> <li>- Broader community of the poor, homeless adults, women and children, cultural diversity</li> </ul>
<b>Program Description</b>	United for Health is part of a collaborative project funded through a Centers for Disease Control and Prevention Community Transformation Grant (Small Communities Program). This two-year project aims to increase health-promoting resources, programs, and policies in neighborhoods and communities of Pacoima, Boyle Heights, Central Los Angeles, Southeast Los Angeles, and Wilmington. The lead organization, Community Health Councils, is working with 12 organizations to improve health in these areas, in which Families in Good Health is one of the organizations working in the Wilmington area.
<b>FY 2013</b>	
<b>Goal FY 2013</b>	To empower individuals, families, and/or community members within Wilmington with the knowledge and skills to make appropriate choices in advocating for, and improving, their health and well being
<b>2013 Objective Measure/Indicator of Success</b>	Program objectives are as follows: <ul style="list-style-type: none"> <li>- Establish two of new collaborations between community-based organizations and community health center providers in Wilmington</li> <li>- Establish eight new age-appropriate physical activity programs for low-income families and residents in Wilmington to increase physical activity levels in the intervention population</li> <li>- Establish an additional 50 Farmer Market Days as expanded access points for fruits and vegetables within Wilmington to increase the consumption of fresh produce by the intervention population</li> </ul>
<b>Baseline</b>	With the lack of a formal medical center in Wilmington, there is a demonstrated need to address the health concerns of the Wilmington community needs (including the implementation of critical health prevention and promotion measures).
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>- Collaborate with Wilmington child care centers and organizations to provide appropriate physical activity programming for children age 0-5 (i.e., promote the nationwide effort Let's Move Childcare along with PlayTangle, Jr.)</li> <li>- Collaborate with Wilmington Clinics and organizations to provide health education on chronic disease self-management</li> <li>- Collaborate with the Wilmington community to expand access to fruits and vegetables through the creation of an accessible and community-driven farmers market</li> </ul>
<b>Result FY 2013</b>	- Outreach and engagement of various community partners in Wilmington integral to the completion of the identified program objectives (i.e., for training on PlayTangle,

	Jr., involvement in Let's Move Wilmington Childcare, implementation of the evidence-based Chronic Disease Self Management Program)
<b>Hospital's Contribution / Program Expense</b>	\$150,000 grant award
<b>FY 2014</b>	
<b>Goal 2014</b>	To empower individuals, families, and/or community members within Wilmington with the knowledge and skills to make appropriate choices in advocating for, and improving, their health and well being
<b>2014 Objective Measure/Indicator of Success</b>	Program objectives are as follows: <ul style="list-style-type: none"> <li>- Establish two of new collaborations between community-based organizations and community health center providers in Wilmington</li> <li>- Establish eight new age-appropriate physical activity programs for low-income families and residents in Wilmington to increase physical activity levels in the intervention population</li> <li>- Establish an additional 50 Farmer Market Days as expanded access points for fruits and vegetables within Wilmington to increase the consumption of fresh produce by the intervention population</li> </ul>
<b>Baseline</b>	With the lack of a formal medical center in Wilmington, there is a demonstrated need to address the health concerns of the Wilmington community needs (including the implementation of critical health prevention and promotion measures).
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>- Collaborate with Wilmington child care centers and organizations to provide appropriate physical activity programming for children age 0-5 (i.e., promote the nationwide effort Let's Move Childcare along with PlayTangle, Jr.)</li> <li>- Collaborate with Wilmington Clinics and organizations to provide health education on chronic disease self-management</li> <li>- Collaborate with the Wilmington community to expand access to fruits and vegetables through the creation of an accessible and community-driven farmers market</li> </ul>
<b>Community Benefit Category</b>	

<b>Families in Good Health: Welcome Baby</b>	
<b>Hospital CB Priority Areas</b>	<input type="checkbox"/> Prevention and treatment of respiratory disorders related to air pollution which would include but not limited to asthma and chronic obstructive pulmonary disorder (COPD), and advocating on ways to make the air cleaner especially for vulnerable communities <input type="checkbox"/> Prevention and treatment of obesity and related chronic disorders such as promotion of nutrition, identification and treatment of diabetes and high blood pressure <input checked="" type="checkbox"/> Access to care and the delivery system working with disproportionate unmet health needs (DUHN) communities including but not limited to dental care <input type="checkbox"/> Promotion of mental wellness and health including identifying those who need care and prevention activities.
<b>Program Emphasis</b>	Please select the emphasis of this program from the options below: <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs</li> <li><input checked="" type="checkbox"/> Primary Prevention</li> <li><input checked="" type="checkbox"/> Seamless Continuum of Care <ul style="list-style-type: none"> <li><input type="checkbox"/> Build Community Capacity</li> <li><input type="checkbox"/> Collaborative Governance</li> </ul> </li> </ul>
<b>Link to Community Needs Assessment</b>	<ul style="list-style-type: none"> <li>- Underserved and the uninsured</li> <li>- Broader community of the poor, homeless adults, women and children, cultural diversity</li> </ul>
<b>Program Description</b>	The Welcome Baby program is a voluntary, universally provided hospital and home-based intervention for pregnant and postpartum women. The program includes up to nine engagement points for families residing within the Best Start community: three prenatal, one hospital visit, and five postpartum. Families outside the Best Start community are eligible for the hospital visit and three postpartum engagements. A universal risk screening is conducted at the Welcome Baby hospital visit with all participating families to help identify those needing additional support. Families receive information and support during each visit on topics such as breastfeeding, home safety, the importance of establishing a medical home, well-child visits and immunizations, smoking cessation, crying patterns, parent-to-child temperament, and postpartum depression. Welcome Baby aims to achieve the following: (1) Increase breastfeeding; (2) Ensure families receive appropriate health and developmental care; and (3) Improve connections between families and needed resources and support.

FY 2013	
<b>Goal FY 2013</b>	<p>Welcome Baby aims to achieve the following goals:</p> <ul style="list-style-type: none"> <li>- Goal 1: Support pregnant women to receive needed mental health, dental services, and other needed resources</li> <li>- Goal 2: Achieve as safe and healthy of a home environment as possible</li> <li>- Goal 3: Increase breastfeeding initiation, exclusivity and duration rates</li> <li>- Goal 4: Provide education and support services for families at postpartum engagement points</li> <li>- Goal 5: Promote healthy physical and emotional development in 100% of infants visited</li> <li>- Goal 6: Obtain feedback from clients on their satisfaction with the program upon completion of visits</li> <li>- Goal 7: Create or enhance existing linkages with social service, educational and healthcare agencies to obtain needed services</li> </ul>
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>- Acceptance rate of 40% of women approached in hospital for participation</li> <li>- 80% of all program participants will receive home safety and security information by the 9-month home visit</li> <li>- 30% of program participants will initiate exclusive breastfeeding at time of hospital visit</li> <li>- 80% of all program participants receiving a nurse home visit will schedule a pediatric well-baby visit appointment within 2 weeks</li> <li>- 80% of program participants visited postpartum will be assessed for parent-infant attachment</li> <li>- 75% of families who complete satisfaction survey to be pleased with services received</li> <li>- 80% of postpartum women to receive at least one referral at or before the 9-month visit</li> </ul>
<b>Baseline</b>	<p>Welcome Baby represents a program of Best Start, a place-based initiative supported by First 5 LA to transform 14 identified Los Angeles County communities into places where children can grow up safe, healthy and happy. Both the Best Start Central Long Beach and Wilmington communities have been identified as sites where there is an apparent need to deliver such services.</p>
<b>Intervention Strategy for Achieving Goal</b>	<p>Utilizing a client-centered as well as strength-based approach, delivery of engagement points (i.e., prenatally, at the hospital, postpartum) occurs via home visitation, phone call or at the hospital.</p>
<b>Result FY 2013</b>	<p>Prior to the launch of the Welcome Baby program, the following ramp-up activities occurred during the 2012-2013 fiscal year:</p> <ul style="list-style-type: none"> <li>- Hiring of requisite Welcome Baby staff</li> <li>- Training of hired Welcome Baby staff by the Oversight Entity</li> <li>- Soft outreach efforts by the home visitation team</li> </ul> <p>(Adaptation and approval of the Welcome Baby protocols occurred in the succeeding fiscal year.)</p>
<b>Hospital's Contribution / Program Expense</b>	<p>\$336,441 grant award</p>
FY 2014	
<b>Goal 2014</b>	<p>Welcome Baby aims to achieve the following goals:</p> <ul style="list-style-type: none"> <li>- Goal 1: Support pregnant women to receive needed mental health, dental services, and other needed resources</li> <li>- Goal 2: Achieve as safe and healthy of a home environment as possible</li> <li>- Goal 3: Increase breastfeeding initiation, exclusivity and duration rates</li> <li>- Goal 4: Provide education and support services for families at postpartum engagement points</li> <li>- Goal 5: Promote healthy physical and emotional development in 100% of infants visited</li> <li>- Goal 6: Obtain feedback from clients on their satisfaction with the program upon completion of visits</li> <li>- Goal 7: Create or enhance existing linkages with social service, educational and healthcare agencies to obtain needed services</li> </ul>
<b>2014 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>- Acceptance rate of 30% of women approached in hospital for participation</li> <li>- 60% of all program participants will receive home safety and security information by the 9-month home visit</li> </ul>

	<ul style="list-style-type: none"> <li>- 30% of program participants will initiate exclusive breastfeeding at time of hospital visit</li> <li>- 50% of all program participants receiving a nurse home visit will schedule a pediatric well-baby visit appointment within 2 weeks</li> <li>- 60% of program participants visited postpartum will be assessed for parent-infant attachment</li> <li>- 75% of families who complete satisfaction survey to be pleased with services received</li> <li>- 60% of postpartum women to receive at least one referral at or before the 9-month visit</li> </ul>
<b>Baseline</b>	Welcome Baby represents a program of Best Start, a place-based initiative supported by First 5 LA to transform 14 identified Los Angeles County communities into places where children can grow up safe, healthy and happy. Both the Best Start Central Long Beach and Wilmington communities have been identified as sites where there is an apparent need to deliver such services.
<b>Intervention Strategy for Achieving Goal</b>	Utilizing a client-centered as well as strength-based approach, delivery of engagement points (i.e., prenatally, at the hospital, postpartum) occurs via home visitation, phone call or at the hospital.
<b>Community Benefit Category</b>	

St. Mary Medical Center Disaster Resource Center	
<b>Program Emphasis</b>	Please select the emphasis of this program from the options below: <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
<b>Link to Community Needs Assessment</b>	Prevention activities for disaster preparedness in the community
<b>Program Description</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> St. Mary Medical Center Disaster Resource Center (SMMC DRC) coordinates plans and implements effective regional hospital disaster response for the Long Beach community. The SMMC DRC stockpiles disaster supplies, purchases surge capacity equipment for the medical center, stockpiles and houses pharmaceuticals, houses portions of the CDC Strategic National Stockpile (CHEMPACK for hospital as well as Long Beach police department and Long Beach fire department) and provides education for health care workers and neighboring community partners on hospital incident command systems (HICS), mass casualty triage, hospital disaster coordination, injury prevention health education and disaster management.</li> <li><input type="checkbox"/> St. Mary Medical Center DRC utilizes grant funding to purchase equipment for the hospital annually to increase capabilities for surge capacity such as gurneys, burn equipment, pharmaceuticals, airway and intubation equipment, respirators, defibrillators and other equipment able to be utilized for a disaster surge.</li> <li><input type="checkbox"/> St. Mary Medical Center, as the lead disaster hospital in Long Beach California collaborates, meets and drills with its neighboring umbrella hospitals and agencies with bimonthly meetings. The Long Beach Hospitals/Agencies are:               <ul style="list-style-type: none"> <li>• Long Beach Memorial Medical Center/Miller Children's Hospital</li> <li>• The Veteran's Administration Hospital, Long Beach</li> <li>• Tri City Regional Medical Center</li> <li>• Catalina Island Medical Center (in Avalon on the island of Catalina)</li> <li>• Bellflower Medical Center</li> <li>• Community Hospital of Long Beach</li> <li>• Kaiser Foundation, Downey</li> <li>• Lakewood Regional Medical Center</li> <li>• Pacific Hospital of Long Beach</li> <li>• The Children's Clinic – Long Beach</li> </ul> </li> </ul> <p><b>City Involvement:</b> The SMMC DRC holds a seat on our City of Long Beach Emergency Operation Command Center and attends monthly disaster meetings with City representatives</p> <p><b>LA COUNTY EMS AGENCY:</b> The SMMC DRC attends trauma, burn, surge, DRC and</p>

	<p>pre-hospital meetings bimonthly at the LA County EMS agency with all of the other 13 DRCs in Los Angeles County.</p> <p><b>HAZMAT First Receiver trainings:</b> Hazardous materials training for health care providers is a key function of the SMMC DRC. Mass decontamination awareness and operational training is offered on the campus of the SMMC DRC as well as Pacific Hospital of Long Beach and the Island of Catalina. State of the art decontamination equipment and a trailer capable of decontaminating fifty ambulatory and non-ambulatory victims is maintained in a ready state at St. Mary Medical Center. Training is done at the SMMC DRC for all health care workers and hospital employees of Long Beach to address immediate needs of disaster victims</p> <p><b>INJURY PREVENTION AND COMMUNITY EDUCATION:</b> SMMC DRC is a driving force in community awareness programs and injury prevention as a trauma center and disaster hospital. Drug abuse awareness seminars are held at local high schools as well as CSULB by Kathy Dollarhide the Injury prevention coordinator and DRC Director. Senior citizen seminars are hosted biannually on injury prevention, fall and balance and fire safety.</p> <p>SMMC DRC lectures at the CERT Team trainings for the Long Beach Fire Department as well as the CSULB Student Health Center and Annual Health Fairs and Long Beach Police Department Staff meetings, patrol meetings, and academies.</p> <p><b>DISASTER DRILLS:</b> St. Mary Medical Center coordinates large multi agency mass casualty drills every 6months in the community. Since 2002 SMMC has coordinated over 23 mass casualty drills in Long Beach California including the Triennial Disaster Drills for the FAA at the Long Beach Airport</p>
<b>FY 2014</b>	
<b>Goal FY 2014</b>	The goal for 2014 for the Disaster Resource Center is to continue working in the community and hospitals to provide disaster education, training and drills
<b>2013 Objective Measure/Indicator of Success</b>	We coordinated two disaster drills in 2013 and performed mass evacuation drills for the entire medical center focused on active shooter. We coordinated a large mass casualty drill at CSULB focused on active shooter
<b>Baseline</b>	Emergency management needs for the community and hospital
<b>Intervention Strategy for Achieving Goal</b>	Maintaining program for disaster management at St. Mary Medical Center
<b>Result FY 2013</b>	In 2013-1014 St. Mary Medical Center continues to be an emergency management force for our community
<b>Hospital's Contribution / Program Expense</b>	No additional funding from St. Mary Medical Center is expended for equipment or training in DRC as all is ASPER HPP HRSA Grant funding for salary, equipment, pharmaceutical caches and disaster purchases required by HPP to maintain Disaster Program at St. Mary Medical Center
<b>Intervention Strategy for Achieving Goal</b>	Continue maintaining disaster program to meet goals of HPP Grant funding
<b>Community Benefit Category</b>	

## VI. COMMUNITY BENEFIT AND ECONOMIC VALUE

### A. Classified Summary of Un-sponsored Community Benefit Expense

332 St. Mary Medical Center Long Beach

- Financial data on following page -

8/1/2013  
 332 St. Mary Medical Center Long  
 Complete Summary - Classified Including Non Community Benefit  
 For period from 7/1/2012 through 6/30/2013

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses	Revenues
<b><u>Benefits for Living in Poverty</u></b>						
Financial Assistance	6,277	13,871,456	0	13,871,456	5.8	6.0
Medicaid	65,456	105,107,485	103,236,067	1,871,418	0.8	0.8
Means-Tested Programs	237,442	9,410,869	1,996,554	7,414,315	3.1	3.2
<b>Community Services</b>						
Community Benefit Operations	0	783,557	0	783,557	0.3	0.3
Community Health Improvement Service	47,825	4,189,651	106,472	4,083,179	1.7	1.8
Financial and In-Kind Contributions	2,577	2,624,452	0	2,624,452	1.1	1.1
Subsidized Health Services	97	226,650	0	226,650	0.1	0.1
<b>Totals for Community Services</b>	<b>50,499</b>	<b>7,824,310</b>	<b>106,472</b>	<b>7,717,838</b>	<b>3.3</b>	<b>3.4</b>
<b>Totals for Living in Poverty</b>	<b>359,674</b>	<b>136,214,120</b>	<b>105,339,093</b>	<b>30,875,027</b>	<b>13.0</b>	<b>13.4</b>
<b><u>Benefits for Broader Community</u></b>						
<b>Community Services</b>						
Community Building Activities	395	233,048	0	233,048	0.1	0.1
Community Health Improvement Service	627	485,169	0	485,169	0.2	0.2
Financial and In-Kind Contributions	4	1,482	0	1,482	0.0	0.0
Health Professions Education	1,087	8,920,402	1,445,809	7,474,593	3.1	3.3
Research	31	87,032	0	87,032	0.0	0.0
<b>Totals for Community Services</b>	<b>2,144</b>	<b>9,727,133</b>	<b>1,445,809</b>	<b>8,281,324</b>	<b>3.5</b>	<b>3.6</b>
<b>Totals for Broader Community</b>	<b>2,144</b>	<b>9,727,133</b>	<b>1,445,809</b>	<b>8,281,324</b>	<b>3.5</b>	<b>3.6</b>
<b>Totals - Community Benefit</b>	<b>361,818</b>	<b>145,941,253</b>	<b>106,784,902</b>	<b>39,156,351</b>	<b>16.5</b>	<b>17.0</b>
<b>Unpaid Cost of Medicare</b>	<b>18,298</b>	<b>55,097,770</b>	<b>45,307,283</b>	<b>9,790,487</b>	<b>4.1</b>	<b>4.3</b>
<b>Totals with Medicare</b>	<b>380,116</b>	<b>201,039,023</b>	<b>152,092,185</b>	<b>48,946,838</b>	<b>20.6</b>	<b>21.3</b>
<b>Grand Totals</b>	<b>380,116</b>	<b>201,039,023</b>	<b>152,092,185</b>	<b>48,946,838</b>	<b>20.6</b>	<b>21.3</b>

 09/19/2013  
 Harold Way, VP Chief Financial Officer

## *Telling the Story*

The final version of the 2013 Community Benefit Report and 2014 Plan will be made available to our Community Board members and hospital leadership. Information will also be shared to St. Mary employees through the St. Mary "E-Weekly." In addition, the report and plan will be sent to elected officials. St. Mary Medical Center is proud of its mission and of the work it does as an organization in the greater Long Beach community. Highlights from the Community Benefit Report and Plan are also available on the St. Mary Medical Center website, [www.stmarymedicalcenter.com](http://www.stmarymedicalcenter.com) and will be sent out in a press release to local and regional media.

The report will also be shared with collaborative partners in such venues as the Greater Long Beach Substance Abuse Prevention Council, and with the NAACP - Long Beach Branch. Progress is reported at these and other meetings throughout the year. Information is provided on success and challenges, and the community is encouraged to partner with St. Mary to make the community a healthier place.

**Addendum A**  
**St. Mary Medical Center Programs and Awards**

**St. Mary Medical Center Specialties, Programs, and Services:**

<p>4<sup>th</sup> Street St. Mary Medical Center Clinic          Blackwell/Spencer Cancer Center          Commission on Cancer approved              Community Hospital              Comprehensive Cancer Program              with a 3-year accreditation with              commendations including a              Cancer Registry          C.A.R.E. (Comprehensive AIDS              Resources and Education)              Program: CARE Clinic, CARE              Dental Clinic, CARE Family              Services Program          Cardiac Rehabilitation Clinic          Cardiac Cath Lab          Cardiac Care          Center for Surgical Treatment of Obesity          Charity Care Assessment: Financial              Assistance Applications          Chemotherapy          Childbirth Services "Life Begins Here"          Community Education          American Diabetes Association Certified              Outpatient Diabetes Program          Disaster Resource Center          Echography Lab          Emergency Medical Services          Emergency Department Approved for              Pediatrics (EDAP)          Emergency Department—Base Station              for the City of Long Beach          Emergency Department "Rapid Triage"              for non-emergent cases          Endoscopy          Every Woman Counts --Breast Center-              Breast Cancer Early Detection          Program              (BCEDP) participant          Faith Resource Ambassadors/Health              Ministry and Parish Nurse Support              Program          Families in Good Health (FiGH) including              the Best Babies Collaborative</p>	<p>(BBC), Educated Men with          Meaningful Messages (EM3),          Educating Providers-Supporting          Children(EPSC), Love Your Heart,          Healthy Aging for Pacific Asian          Seniors(HAPAS), Taking Control,          and Women Get Healthy-Stay          Healthy Project          Graduate Medical Education          Heaven Eleven—Convenience Store and              Thrift Shop          Intensive Care Unit—24 beds          John E. Parr Health Enhancement Center          Long Beach Emergency Medical Care              System (LBEMCS)          Low Vision Center          Mary Hilton Family Center: St. Mary OB              Clinic and the St. Mary Antenatal              Clinic (Perinatology—High Risk              Obstetrics)          Medi-Cal Assistance          Medical Library          Neurodiagnostics          Neonatal Intensive Care Unit (NICU)              American Academy of Pediatric              (AAP) Level IIIB-25 beds          Newborn Nursery          Orthopedics          Palliative Care          Passages: Geropsych Outpatient          Pediatrics, California Children's Services              approved Community level          Perinatal Center (Antenatal Clinic)          Physician Referral Services          Professional Education for nurses and              other allied health professionals          Radiation Oncology          Radiology including ultrasound          Rehabilitation Services including              Physical &amp; Occupational Therapies          Respiratory Care and Pulmonary Lab              including Bronchoscopy Lab          Speech Pathology</p>
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Spiritual Care Services  
Senior Health Center including the Senior  
Center at St. Mary and Senior  
Connections  
STEMI (ST-Elevation Myocardial  
Infarction) Center  
Stroke Center, certified by Joint  
Commission (new as of April 2011)  
Surgicenter-Outpatient Surgery

St. Mary Medical Center Foundation  
including the Clinical Care  
Extender Program providing  
internships students and the Nurse  
Scholar Program.  
Trauma Center-Level II  
Travel Clinic  
Women's Healthy Heart Resource Center  
Wound Care Service

St. Mary Medical Center is proud of the following distinctions and awards:

- A teaching hospital affiliated with UCLA School of Medicine
- Accredited by The Joint Commission, formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- Bariatric Surgery Center of Excellence as approved by the American Society for Metabolic and Bariatric Surgery (ASMBS) and Surgical Review Corporation
- One of the Los Angeles and Orange Counties Region's Best Hospitals, according to a list published by US News and World Report, April 5, 2011
- Hermes Award for Excellence in the nonprofit Annual Report category for the St. Mary Foundation's Annual Report. The Hermes Creative Awards from Arlington, TX is administered and judged by the Association of Marketing and Communication Professionals
- St. Mary was the only community hospital to receive grant funding from Health and Resources Service Administration (HRSA) of the U.S. Department of Health and Human Services for the expansion of Primary Care Medical Education, its grant of \$1.9 million one of the largest awarded by HRSA.
- St. Mary received a Port of Long Beach grant in the amount of \$834,000—as part of its Respiratory Disease Mitigation Program.
- Approved Stroke Center (ASC) by Emergency Medical Services Agency and a Certificate of Distinction for Advanced Certification as a Primary Stroke Center by the Joint Commission
- Received the Reducing Mercury in Healthcare Award from Practice Green Health, Reston, VA
- Received Medals of Honor from the US Department of Health & Human Services for Organ Donation
- Received Proclamations from the Los Angeles County Board of Supervisors and from Long Beach Mayor Foster and the City Council celebrating St. Mary Medical Center CARE Program's 25<sup>th</sup> year of service to our community.

## Addendum B

### Community Need Index, Map of the St. Mary Medical Center Service Area.

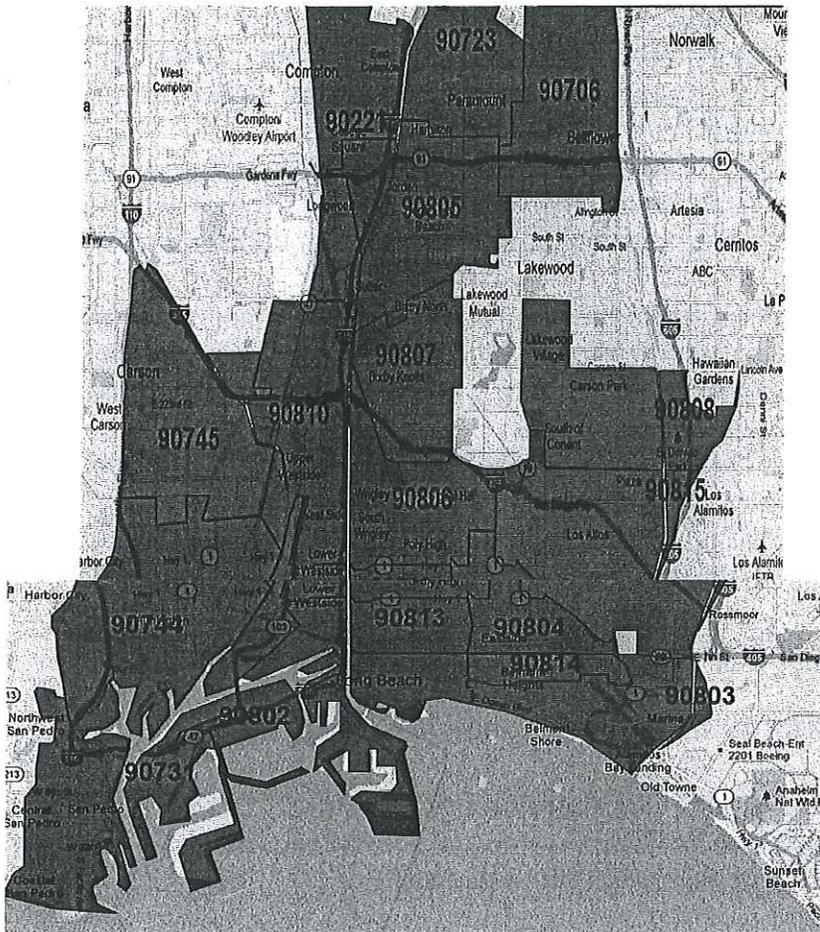
The Community Need Index (CNI), which is a tool standardized by Dignity Health and provides a “picture” of the community need and access to care. The CNI aggregates five socioeconomic variables by zip codes, which have demonstrated a link to health disparity (income, language, education, housing and insurance coverage). The scale is 1-5; higher the score, the greater the need for services. The St. Mary CNI average is 4.8 for the entire primary and secondary service area and more than 45% of the areas being 5.

**CNI Score Median: 4.8**

**Lowest Need**

**Highest Need**

1 – 1.7 Lowest
  1.8 - 2.5 2nd Lowest
  2.6 - 3.3 Mid
  3.4 - 4.1 2nd Highest
  4.2 - 5 Highest



## **Addendum C**

### **DIGNITY HEALTH SUMMARY OF PATIENT PAYMENT ASSISTANCE POLICY (June 2012)**

#### Policy Overview:

Dignity Health is committed to providing payment assistance to persons who have health care needs and are uninsured or under-insured, ineligible for a government program, and otherwise unable to pay for medically necessary care based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable health care services, and to advocate for those who are poor and disenfranchised, Dignity Health strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Payment assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with Dignity Health's procedures for obtaining payment assistance, and to contribute to the cost of their care based on individual ability to pay. Individuals with financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.

#### Eligibility for Patient Payment Assistance:

- Eligibility for payment assistance will be considered for those individuals who are uninsured, ineligible for any government health care benefit program, and unable to pay for their care, based upon a determination of financial need in accordance with the policy.
- The granting of payment assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, or immigration status, sexual orientation or religious affiliation.

#### Determination of Financial Need:

- Financial need will be determined through an individual assessment that may include:
  - a) an application process in which the patient or the patient's guarantor is required to cooperate and supply all documentation necessary to make the determination of financial need;
  - b) the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay;
  - c) a reasonable effort by the Dignity Health facility to explore and assist patients in applying for appropriate alternative sources of payment and coverage from public and private payment programs; and will take into account the patient's assets and other financial resources.
- It is preferred but not required that a request for payment assistance and a determination of financial need occur prior to rendering of services. The need for payment assistance may be re-evaluated at each subsequent rendering of services, or at any time additional information relevant to the eligibility of the patient for payment assistance becomes known.
- Dignity Health's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of payment assistance. Requests for payment assistance shall be processed promptly, and the Dignity Health facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

### Patient Payment Assistance Guidelines:

Services eligible under the policy will be made available to the patient on a sliding fee scale, in accordance with financial need as determined by the Federal Poverty Level (FPL) in effect at the time of the termination as follows:

- Patients whose income is at or below 200% of the FPL are eligible to receive free care;
- Patients whose income is above 200% but not more than 350% of the FPL are eligible to receive services at the average rates of payment the Dignity Health facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater in amount for the same services;
- Patients whose income is above 350% but not more than 500% of the FPL are eligible to receive services at 135% of the average rates the Dignity Health facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater for the same services;
- Patients whose income exceeds 500% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of the Dignity Health facility.

Dignity Health's administrative policy for Eligibility and Application for Payment Assistance shall define what qualifies as income for these purposes.

### Communication of the Payment Assistance Program to Patients and the Public:

- Information about patient payment assistance available from Dignity Health, including a contact number, shall be disseminated by the Dignity Health facility by various means, including the publication of notices in patient bills and by posting notices in the Emergency and Admitting Departments, and at other public places as the Dignity Health facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the Dignity Health facility.
- Any member of the Dignity Health facility staff or medical staff may make referral of patients for payment assistance. The patient or a family member, a close friend or associate of the patient may also make a request for payment assistance.

### Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient payment assistance will be included within the Social Accountability Budget of the Dignity Health facility. Dignity Health facilities will report patient payment assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.
- Patient payment assistance statistics shall be disclosed in annual financial statements but shall not include amounts that are properly considered to be bad debt or contractual discounts.

Relationship to Collection Policies:

- Dignity Health system management shall develop policies and procedures for internal and external collection practices by Dignity Health facilities that take into account the extent to which the patient qualifies for payment assistance, a patient's good faith effort to apply for a governmental program or for payment assistance from Dignity Health, and a patient's good faith effort to comply with his or her payment agreements with the Dignity Health facility.
- For patients who qualify for payment assistance and who are cooperating in good faith to resolve their hospital bills, Dignity Health facilities may offer interest-free extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences and will not send unpaid bills to outside collection agencies.

Regulatory Requirements:

IN IMPLEMENTING THIS POLICY, DIGNITY HEALTH MANAGEMENT AND DIGNITY HEALTH FACILITIES SHALL COMPLY WITH ALL FEDERAL, STATE AND LOCAL LAWS, RULES AND REGULATIONS THAT MAY APPLY TO ACTIVITIES CONDUCTED PURSUANT TO THIS POLICY.

## **Addendum D**

### **Hospital Community Board:**

Ruth Perez Ashley, Community Member  
Sandy Cajas, Community Member  
Chester Choi, M.D., Staff Physician  
Gloria Cordero, Community Member  
Jyoti Datta, M.D., Chief of Staff  
M. Hadi Emamian, M.D., Staff Physician  
Thomas Gates, M.D., Staff Physician  
Sr. Elizabeth Ann Hayes, CCVI, Sponsor  
Nancy Higginson, Community Member  
Sr. Kathleen Howard, CCVI, Sponsor

Bernita McTernan, VP, Dignity Health  
George Murchison, Chair, SMMC Foundation  
Eloy O. Oakley, **Chair**  
Daniel O'Callaghan, Community Member  
Juan M. Polanco, M.D., Staff Physician  
Thomas Salerno, SMMC President/CEO  
Shelly Schlenker, VP, Dignity Health  
Cynthia Terry, Community Member  
Robert Waestman, Community Member

### **Community Benefit Advisory Committee:**

Sr. Gerard Earls, Mission Advisor  
Minnie Douglas, Chair  
Ivy Goolsby  
Chan Hopson  
Patrick Kennedy  
Donna Nagaoka  
Pamela Shaw  
Jean Bixby Smith  
Cynthia Terry  
Anna Totta  
Maxie Viltz  
Felton Williams

#### Staff (non-voting)

Rachel Plotkin, SMMC Community Benefit  
Tiffany Cantrell, SMMC Foundation  
Janaya Nichols, SMMC Foundation