ST. JOSEPH HEALTH, ST. MARY

FY15 – 17 Community Benefit Plan/ Implementation Strategy Report

St. Joseph Health, St. Mary

St.JosephHealth
St. Mary

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EXECUTIVE SUMMARY

St. Joseph Health, St. Mary, is a hospital founded in 1956 and located at 18300 Highway 18 in Apple Valley, CA. It became a member of St. Joseph Health in December 1994. The facility has 212 licensed beds, 208 of which are currently available, and a campus that is approximately 32 acres in size. St. Joseph Health, St. Mary has a staff of more than 1,700 professional relationships with more than 300 local physicians. Major programs and services include: 24-hour emergency services, comprehensive cardiac services, outpatient surgery pavilion, pediatric care, physical, occupational and speech therapy, community clinics and mobile health services serving the poor, chest pain emergency center, open heart surgery program, Level II neonatal intensive care, diagnostic imaging services, diabetes education services, physical referral services, robotic-assisted surgery program and wound care and hyperbaric medicine.

In response to unmet health-related needs identified from a 2014 Community Health Needs Assessment, St. Joseph Health, St. Mary's FY15-FY17 Community Benefit Plan will focus on four programs for the broader and underserved disadvantaged members of the surrounding community.

1. Efforts improving Access to Care will address marked shortages of health services including primary and specialty care across the hospital's service areas. Additionally, access to care issues has been prioritized by each of the southern California SJH hospitals operating in Orange and San Bernardino counties and a regional assessment continues. The hospital's health assessment reports access concerns by 41.5% of respondents, an increase over 38.4% reported in 2007 and significantly higher than the 37.7% reported nationally. Access issues are exacerbated by San Bernardino County's only safety net hospital located 45 miles from the community. Chronic conditions including poverty and mental illness often impair people from accessing care. Access issues include, but are not limited to: lack of transportation, health insurance and cost related issues, the shortage of health care professionals particularly primary care providers who are bilingual and gaps in health services provided locally. Portion's of the hospital's service area are designated by Health and Human Services' Health Resources Services Administration (HRSA) as Medically Underserved Areas (MUA) and Medical Health Professional Shortage Areas (HPSA) for primary care and mental health. St. Joseph Health, St. Mary intends to:

- ❒ Develop a primary and specialty network of outpatient services to expand local health services while partnering to improve transportation and navigation of the local health system that many report not fully understanding how to use appropriately;
- ❒ Partner with community clinics and physicians to expand access. The hospital will work with partners and improve healthcare access for all residents including those living in eight (8) neighborhoods identified as the regions' poorest;
- ❒ Lead local health insurance enrollment efforts implementing Covered California; and
- ❒ Improve hospital clinic services providing health services to the area's uninsured, low income and undocumented while continuing regional efforts to improve access with St. Joseph Health, St. Mary High Desert Medical Group, San Bernardino County Public Health and a newly formed San Bernardino County Community Clinic Association.

2. Expanding Diabetes Services addressing the increase of the condition now reported at 15.3% of the community. The hospital intends to consolidate and better target its diabetes services with expanded education provided at the hospital, to patients served by physicians of St. Mary High Desert Primary Care offices, thru the hospital's community clinics and with the assistance of partners, in a range of community settings including schools, churches and neighborhoods. Addressing diabetes builds upon the hospital's success providing comprehensive diabetes programs to uninsured residents. The hospital will:

- ❒ Expand referrals to physicians providing specialized services at St. Mary High Desert Primary Care and its regional network of care;
- ❒ Recruit and train health partners to teach diabetes care in poorer communities reaching families at churches, schools and apartment complexes; and
- ❒ Assist San Bernardino County Public Health to develop diabetes education programs offered from its clinics in Adelanto and Hesperia.

3. Improving Mental Health Care where 18.4% of residents self-reported their mental health as either fair or poor a 3.9% increase over 2007 significantly higher than the national rate of 11.7%. As previously mentioned there is a recognized shortage of mental health providers in the hospital's service area. The hospital will:

- ❒ Join a local mental health collaborative and improve referral of hospital patients requiring out-patient care and to assist in the development of the community's wellness services;
- ❒ Partner with the county's FQHC clinic since it is expanding its mental health programs. The hospital will partner with mental health clinic providing low cost psychiatry care and assist a local partner providing mental health services as part of its substance abuse and recovery programs;
- ❒ Provide behavioral counseling to patients of its clinic programs while assessing regional opportunities to improve mental health services with other SJH hospitals and
- ❒ Conduct advocacy efforts targeting improved policy and resources for mental health care.

4. Addressing Obesity and nutrition campaigns where 37% and 33% of residents are identified as either overweight or obese. The hospital will:

- ❒ Expand its child obesity and Healthy City campaigns in schools, churches and at community settings including Head Start and other pre-school programs and include adult care;
- ❒ Continue its partnership with San Bernardino County Public Health implementing a Communities of Excellence campaign expanding neighborhood access to fresh fruits and vegetables and improving street safety, active transportation and development of physical activity resources;
- ❒ Expand partnerships with physicians referring overweight and obese patients for medical nutrition counseling. Nutrition counseling will continue to target changing underlying family behaviors with food and play/recreation while achieving weight loss and,
- ❒ Increase health eating education in schools, workplaces and churches as part of broad programs targeting employee and community wellness while continuing nutrition counseling at its clinics.

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

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

INTRODUCTION – WHO WE ARE AND WHY WE EXIST

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

Mission, Vision and Values and Strategic Direction

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

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

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

St. Joseph Health, St. Mary has been meeting the health and quality of life needs of the local community for over 60 years. Serving the communities of Adelanto, Apple Valley, Hesperia and Victorville, St. Joseph Health, St. Mary is an acute care hospital that provides quality care in the areas of 24 hour emergency services, comprehensive cardiac programs, outpatient surgery pavilion, pediatric care, physical, occupational and speech therapy, senior programs, community clinics and mobile health services, chest pain emergency center, open heart surgery program, Level II neonatal intensive care, diagnostic imaging services, diabetes education services, physical referral services, robotic-assisted surgery program and wound care and hyperbaric medicine. With over 1,500 employees committed to realizing the mission, St. Joseph Health, St. Mary is one of the largest employers in the region.

Strategic Direction
As we move into the future, St. Joseph Health, St. Mary is committed to furthering our mission and vision while transforming healthcare to a system that is health-promoting and preventive, accountable in its

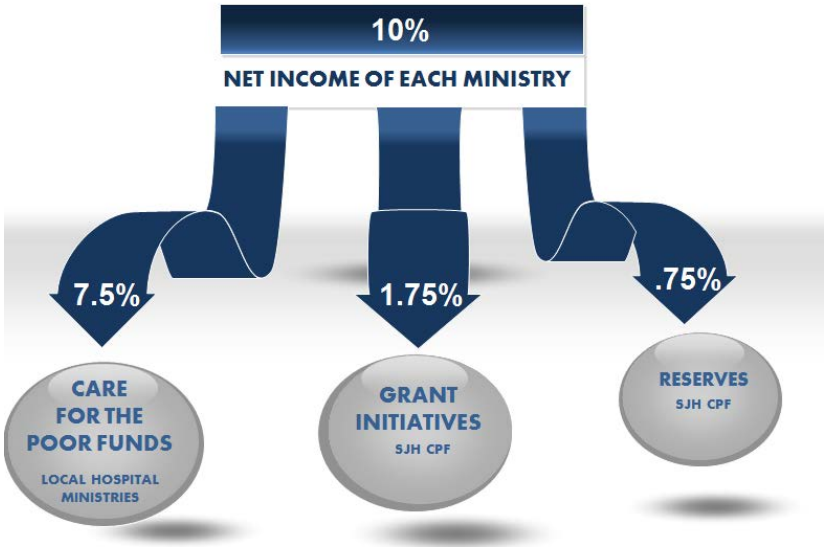
inevitable rationing decisions, integrated across a balanced network of care and financed according to its ability to pay. To make this a reality, over the next five years (FY14-18) St. Joseph Health, St. Mary are strategically focused on two key areas to which the Community Benefit (CB) Plan strongly align: population health management and network of care.

ORGANIZATIONAL COMMITMENT

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

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

Figure 1. Fund distribution



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

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

Community Benefit Governance and Management Structure

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

The Community Benefit (CB) Management Team provides orientation for all new Hospital employees on Community Benefit programs and activities, including opportunities for community participation.

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

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

Roles and Responsibilities

Senior Leadership

A. CEO and other senior leaders are directly accountable for CB performance.

Community Benefit Committee (CBC)

- CBC serves as an extension of trustees to provide direct oversight for all charitable program activities and ensure program alignment with Advancing the State of the Art of Community Benefit (ASACB) Five Core Principles. It includes diverse community stakeholders. Trustee members on CBC serve as 'board level champions'.
- The committee provides recommendations to the Board of Trustees regarding budget, program targeting and program continuation or revision.

Community Benefit (CB) Department

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

Local Community

- Partnership to implement and sustain collaborative activities.

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

COMMUNITY

Community Served

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

The SJH St. Mary Community Benefit Service Area is defined as serving the Victor Valley region of San Bernardino County with a total population of 430,795 as reported by 2010 U.S Census Data. The larger communities of Apple Valley, Hesperia and Victorville comprise the hospital's primary service area and the smaller communities of Adelanto, Barstow, Helendale, Lucerne Valley, Oro Grande, Phelan and Oak Hills and Wrightwood make-up the hospital's secondary service area. The hospital's primary and secondary service areas currently serve residents of three (3) of San Bernardino county's five (5) supervisory districts. The region is 90% desert and the largest nearest metropolitan area, the City of San Bernardino, is 40 miles away. The service area is noted as having significantly higher percentages of indigent and uninsured populations when compared with both state and national levels. Additionally, residents suffer from heart disease, diabetes, adult obesity and stroke at levels well above California and national benchmarks. Over 90% of the hospital's community benefit area has been identified as "High Need" from scoring and aggregating socioeconomic indicators (e.g. income, race, family size) contributing to health disparities. Areas within the hospital's primary and secondary service areas are listed as Medically Underserved Areas including the community of Barstow and Adelanto. Additionally, the region is listed as a Medical Health Professional Shortage Area for mental health. With some exceptions, these health and social conditions are largely homogenous across San Bernardino County. For this reason nonprofit hospitals in San Bernardino are reporting similar increases in chronic diseases and overwhelmed safety net providers. A detailed look at major population centers served by the hospital follows including a map depicting the hospital's primary and secondary service areas.

Apple Valley - has 69,135 residents as reported by the 2010 Census. The town is the home community to SJH. St. Mary. The Town is 73.5 square miles at an elevation of 2,946 feet with 23,598 households with 69% White, 29.2% Hispanic and 9.1% Black and 2.9% Asian. Approximately 31% of residents are between the ages of 0-19 years just higher than the county average and residents aged 50 to 85 years (a total of 35%) make up a higher percentage of residents than reported at the county and state level. The senior community has a high prevalence of adult obesity, problems accessing specialty care, diabetes and physical limitations. Asian household income is reported at $86,719 which is higher than county and state levels. Median household income is $56,547 which is higher than the county but lower than the state level. Hispanics and Blacks suffer unemployment rates of 17.0% and 20.9% respectively, nearly double the 9% rate for White residents. The Town of Apple Valley was the first community to start a Healthy City campaign The hospital and its physician partners provide extensive education services to the town's senior population from a Senior Select education center located in the community. This program reports the largest membership in the region offering weekly educational, health promotion and social programs

to its members. The hospital also operates a community clinic and a mobile medical service serving residents who are uninsured and/or low income. The mobile medical program serves the poorest neighborhood in Apple Valley located along Highway 18 and Navajo Road.

Victorville - The state of California's 50th largest city has a 2010 US Census reported population of 115,903. The city is approximately 74 square miles in size at an elevation of 2,726 ft. Demographic data reports 47.8% of residents are Hispanic with White 28.3% followed by Blacks at 16%. Over 30% of residents are between the ages of 0 to 19 years of age which as a percentage is larger than reported at the county level. Economic data reports the median income in Victorville is $52, 983 (among African American families just $44,767) with poverty highest (30%) in African American families followed by Hispanic (16%) and White (9%). The city has formed a "Healthy Victorville" campaign in partnership with county public health, SJH, St. Mary, Desert Valley Hospital, Kaiser and Victor Global Medical Center in a collaborative effort to promote health and improve neighborhoods with safer streets and access to healthy foods. The hospital provides a mobile medical clinic to many of the neighborhoods in the community and supports several local agencies with grants to serve a variety of persons in crisis. The hospital also assisted the opening of a non-profit clinic named Mission City which is currently providing some behavioral health services. Additionally, Molina Health has opened a primary care clinic serving low income patients. Both clinics expand access to care in this low income community of old-town Victorville which has been identified by the hospital has one of the poorest using a hardship index.

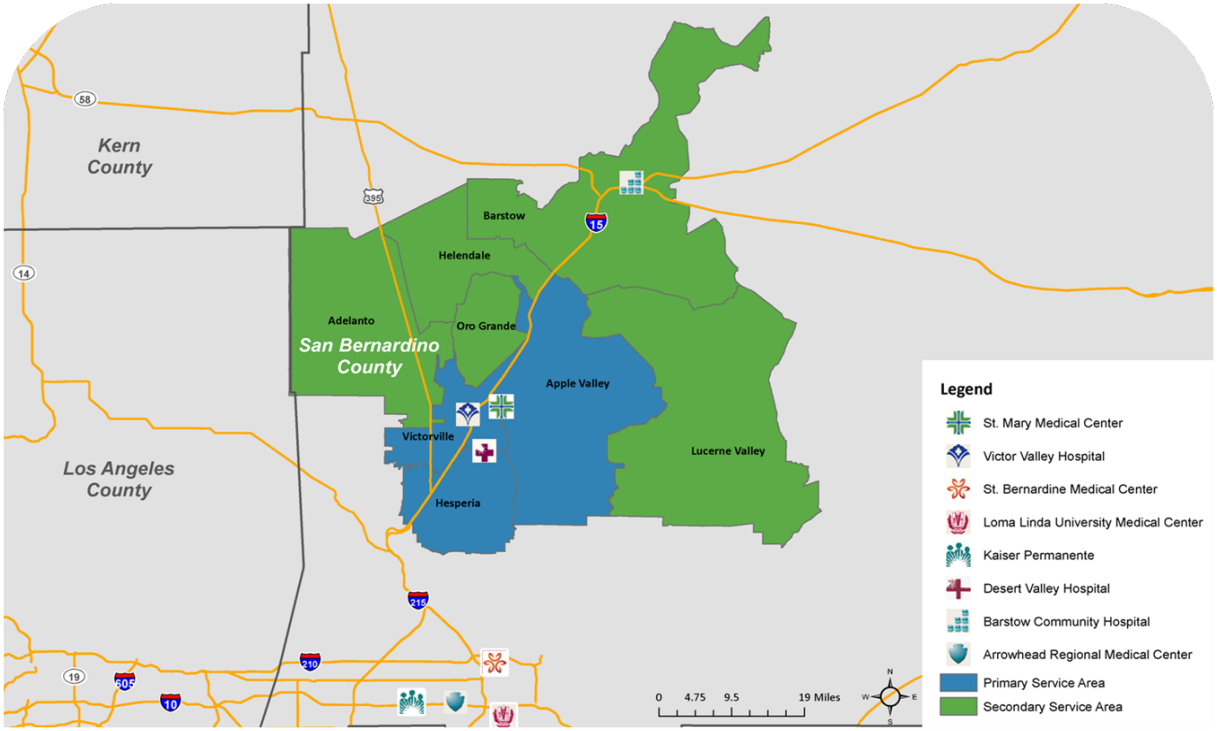
Hesperia - has 90,173 residents as reported by the 2010 Census. The city is 73 square miles at an elevation of 3,186 feet. The city has no hospital and residents are dependent on accessing acute care at Victorville and Apple Valley hospitals 10 to 15 miles away. There are a reported 26,431 households with 21.9% of black families living in poverty followed by 20.9% for Hispanic and 9.6% for White families. These poverty rates are higher than county and state levels. Household income is $51,676, (lower than county and state levels) with Hispanic family income reported at $42,897, Black at $49,185 and White at $61,795. An estimated 35.8% of residents are between the ages of 0-19 years of age a higher percentage than reported at the county and state level. The percentage of students who are reported as overweight/obese is 41% slightly higher than the county and state ratings of 39.3% and 38% respectively. Hesperia is in the early stages of a "Healthy Hesperia" campaign that includes city representatives, public health, SJH St. Mary and representatives from the school and park and recreation districts. The hospital operates a community clinic serving the poor and located near the city's poorest neighborhood.

Adelanto – has 31,765 residents as reported by the 2010 Census. The city is 56 square miles and at an elevation of 2,871 feet with 58.3% Hispanic, 43% White 20% Black. There are 7,809 households. Over 40% of residents are between the ages of 0 to 19 years several percentage points higher than county and state levels and conversely, fewer residents are aged 50 years and older than what is reported at county and state levels. The community is designated as Medically Underserved by HRSA. Median household income is $41,475 with Black families earning the lowest - only $28,310, which is almost half the county and state rate for Black households. Unemployment is 15.75% and as high as 28.8% for households of two or more races. The city has few employers, or college, very few retailers generating sales tax revenue, with several prisons in operation. Only 11.5% of residents are reported to have attained college degrees, significantly less than the county and state levels. The hospital works closely with city leaders who recently formed a Healthy City campaign. This campaign includes city, hospital and nonprofit representatives as well as local school leaders. The hospital operates a community clinic serving the poorest neighborhoods identified by the hospital's needs assessment process. Services include primary care, education, counseling, nutrition and maternal child care. Additionally, the hospital awards grants to

partners serving persons experiencing a variety of economic, health and social crisis. The hospital assisted Molina Health to open a primary care clinic serving Medi-Cal patients in 2013. The community has no Urgent Care or specialty care providers. San Bernardino County operates a community clinic and a Women, Infant and Children office provides services. The hospital serves on the Chamber of Commerce and makes grants to partners.

Barstow - has 22,639 residents as reported by the 2010 Census. The city is located midway between Los Angeles and Las Vegas and is 41 square miles in size at an elevation of 2,178 feet. There are 8,085 households with 52% White, 42% Hispanic and 14% Black. Economic data indicates 27% of families live below the federal poverty level with the highest levels reported in households with young children. Black families have the highest rates of poverty at 29.2% followed by Hispanic at 23% and Whites at 16.9%. The city is 31 miles east of St. Joseph Health, St. Mary. Barstow has a 30-bed hospital providing its residents 24 hour Emergency Room services, as well as OB and respiratory care. Patients with specialty care needs travel 40 miles to St. Joseph Health, St. Mary for treatment or, must travel an additional 45 miles to access care at the county's safety net hospital Arrowhead Regional Medical Center. Barstow is supported with a public health clinic offering some primary and behavioral health services, immunizations and health education.

Figure 1. Map depicting communities served by St. Joseph Health, St. Mary



Hospital Total Service Area

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

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

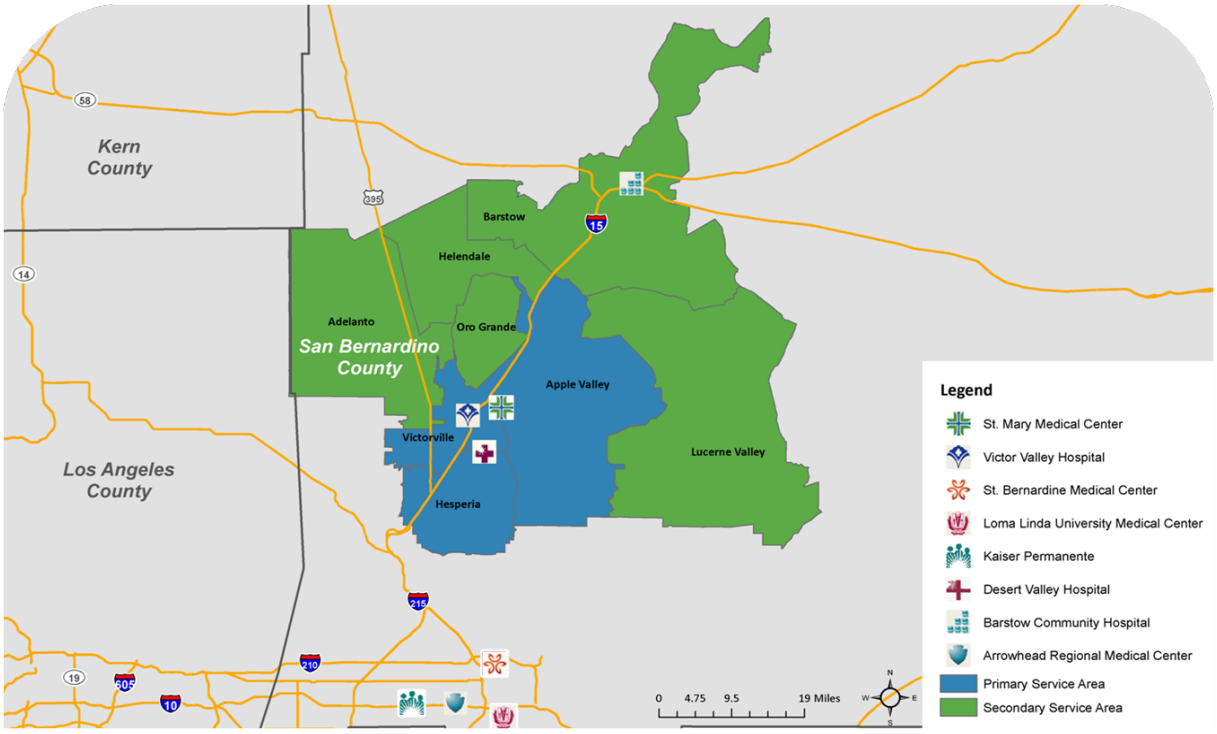
The Primary Service Area ("PSA") is the geographic area from which the majority of the Hospital's patients originate. The Secondary Service Area ("SSA") is where an additional population of the Hospital's inpatients resides. The PSA is comprised of Apple Valley, and portions of Hesperia and Victorville.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

Table 1. Cities and ZIP codes

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

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

Figure 2. St. Joseph Health, St. Mary Hospital Total Service Area



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

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

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

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

This objective measure is the combined effect of five socioeconomic barriers (income, culture, education, insurance and housing). A score of 1.0 indicates a zip code with the fewest socioeconomic barriers, while a score of 5.0 represents a zip code with the most socioeconomic barriers. Residents of communities with the highest CNI scores were shown to be twice as likely to experience preventable hospitalizations for manageable conditions such as ear infections, pneumonia or congestive heart failure compared to communities with the lowest CNI scores. (*Ref (Roth R, Barsi E., Health Prog. 2005 Jul-Aug; 86(4):32-8.)*

The CNI is used to a draw attention to areas that need additional investigation so that health policy and planning experts can more strategically allocate resources.

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

Figure 3 (below) depicts the Community Need Index for the ***hospital's geographic service area based on national need***. The map shows the location of the hospital in Apple Valley and two hospital-run community clinics located in Adelanto and Hesperia. A third community clinic operates in Apple Valley from the hospital campus. Located on the hospital campus is a Catholic Charities office serving persons in crisis.

Figure 3. St. Joseph Health, St. Mary Community Need Index (Zip Code Level)

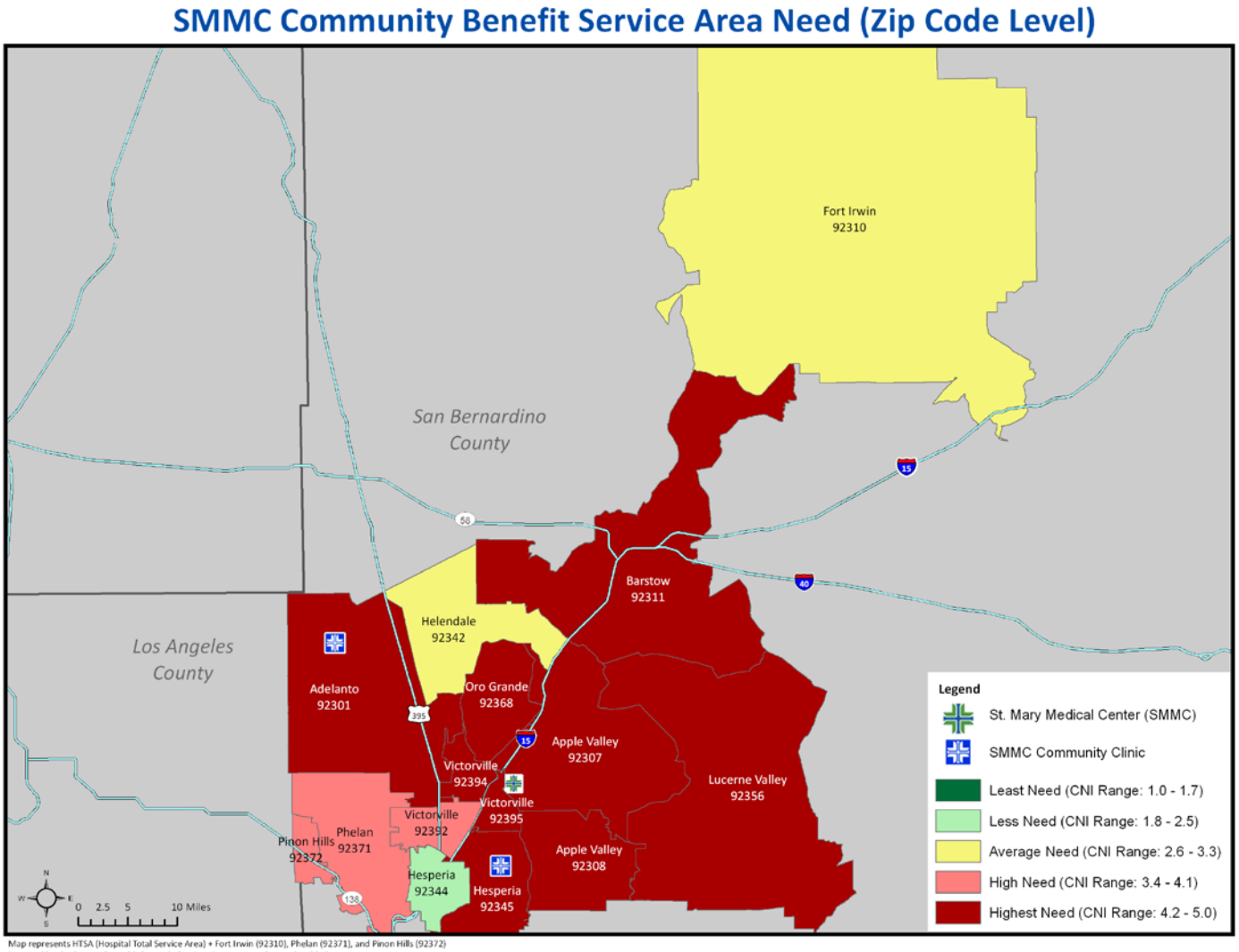
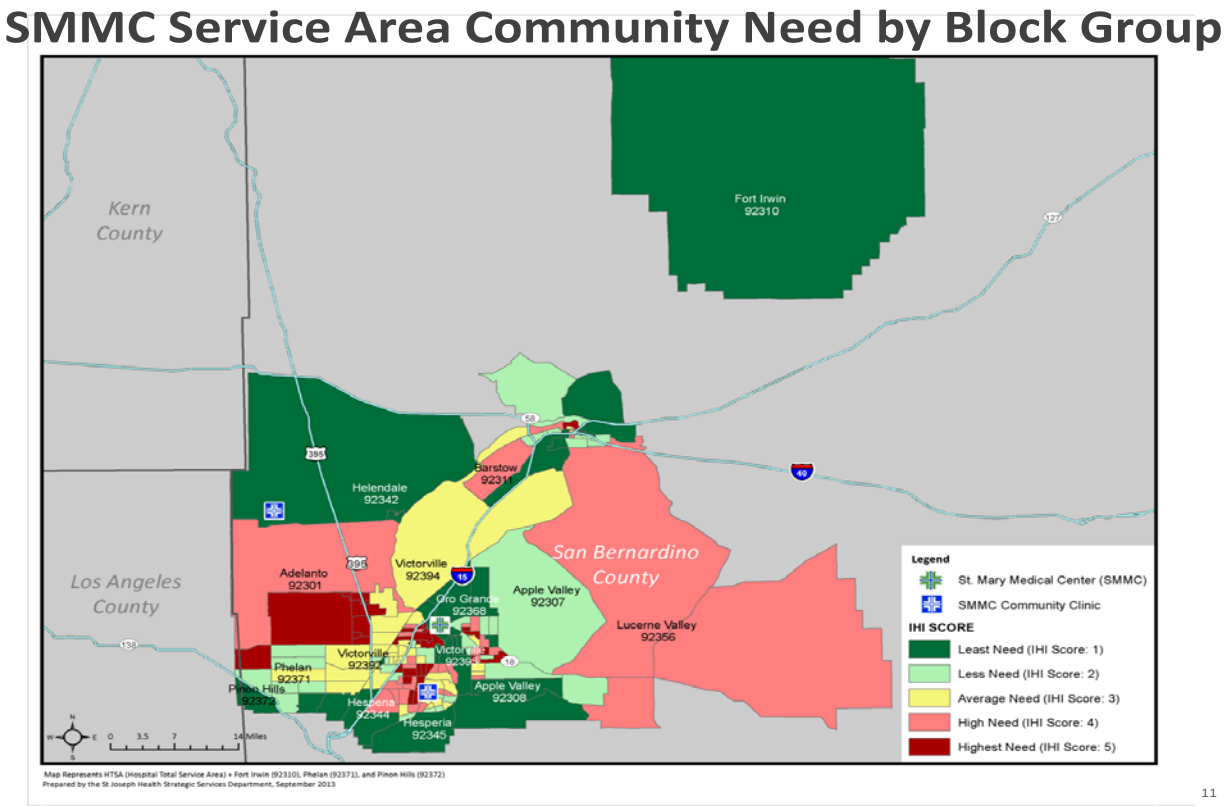


Figure 4 below depicts highest need communities at the block group levels indentifying census tracks in Adelanto, Apple Valley, Hesperia and Victorville. These highest need block groups are identified in red and have been scored a 5 for highest need.

Figure 4. St. Joseph Health, St. Mary Community Need Index (Block Group Level)



Intercity Hardship Index (Block group level) Based Geographic Need

The Intercity Hardship Index (IHI) was developed in 1976 by the Urban and Metropolitan Studies Program of the Nelson A. Rockefeller Institute of Government to reflect the economic condition of cities and allow comparison across cities and across time. The IHI ranges from 0-100, with a higher number indicating greater hardship. The IHI was used by St. Joseph Health to identify block groups with the greatest need.

The IHI combines six key social determinants that are often associated with health outcomes:

1) Unemployment (the percent of the population over age 16 that is unemployed)
2) Dependency (the percent of the population under the age of 18 or over the age of 64)
3) Education (the percent of the population over age 25 who have less than a high school education)
4) Income level (per capita income)
5) Crowded housing (percent of households with seven or more people)
6) Poverty (the percent of people living below the federal poverty level)

Based on the IHI, each block group was assigned a score from 1 (lowest IHI, lowest level of hardship/need) to 5 (highest IHI, highest level of hardship/need). The IHI is based on ***relative need within a geographic area***, allowing for comparison across areas. Similar to what is seen with the Community Need Index; the highest need areas are in the cities of Adelanto and Victorville. On the next page a listing of eight highest need block groups in the hospital's service area by community served.

Table 2 (below) depicts the **Intercity Hardship Index (IHI)** for the hospital's geographic service area for eight block groups demonstrates *relative need*. Additionally, maps of each highest need neighborhood in Adelanto, Apple Valley, Hesperia and Victorville are provided on the following page.

Table 2 St. Joseph Health, St. Mary Intercity Hardship Index (for eight block groups)

Zip Code	Block Group	City	Total Population	Intercity Hardship Index (IHI) Score	SMMC Total Service Area Position Based on IHI Score	IHI Need by Block Group	Indicators					
							% of Housing Units with 7+ People	% of Households Living Below Federal Poverty Level	% of Those Over the Age of 25 with Less than a High School Education	% of the Population Under the Age of 18 or Over the Age of 64	Per Capita Income	% of the Unemployed Civilian Population Over the Age of 16
92301	060710091161	Adelanto	1,065	76.89	1	5.00	71.06	96.18	74.06	53.28	100.00	66.73
92301	060710091171	Adelanto	6,430	70.75	2	5.00	100.00	72.31	83.37	39.76	73.06	56.01
92301	060710091163	Adelanto	2,099	69.10	3	5.00	66.06	78.10	74.01	62.63	91.19	42.60
92345	060710100143	Hesperia	2,077	68.28	4	5.00	69.44	54.13	85.56	57.29	89.23	54.02
92395	060710098002	Victorville	1,037	65.31	5	5.00	61.75	65.43	59.65	52.70	87.78	64.56
92395	060710098003	Victorville	1,519	64.83	6	5.00	80.96	44.65	93.35	56.28	81.02	32.70
92395	060710098001	Victorville	1,174	64.25	7	5.00	58.34	100.00	57.04	49.50	84.35	36.25
92308	060710097121	Apple Valley	1,093	57.62	15	5.00	27.41	62.63	71.94	56.66	78.63	48.44

On the next page community level maps for each of the eight block groups are provided with Adelanto and Hesperia maps also showing location of hospital clinics.

Figure 5. City of Adelanto's three highest need block groups with hospital clinic location

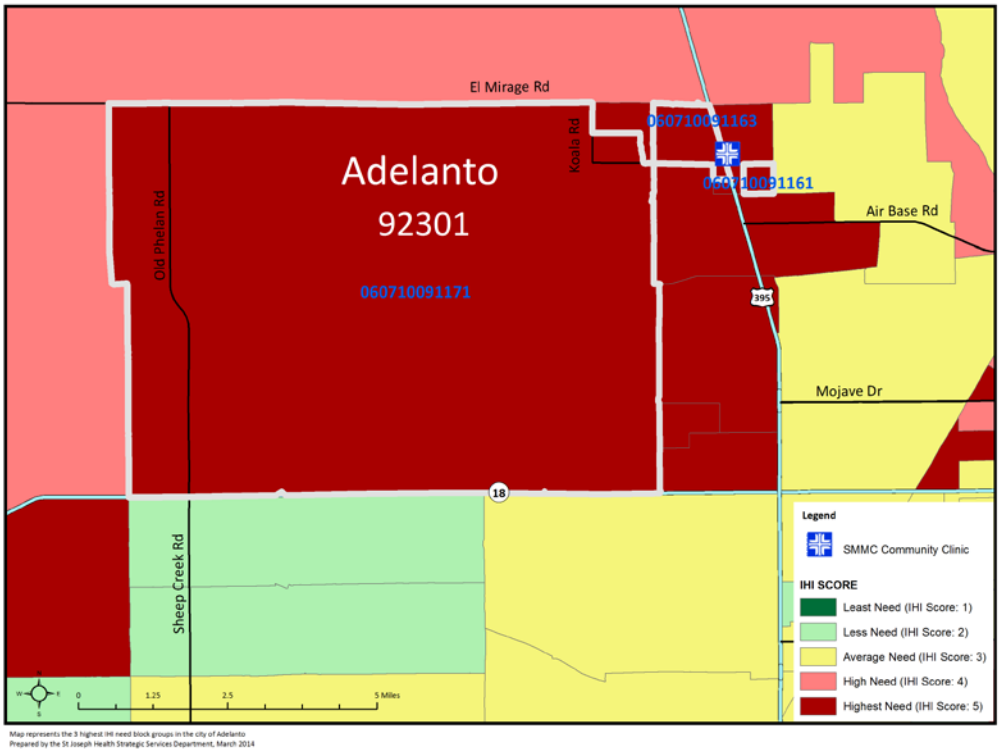


Figure 6. Town of Apple Valley's highest need block group

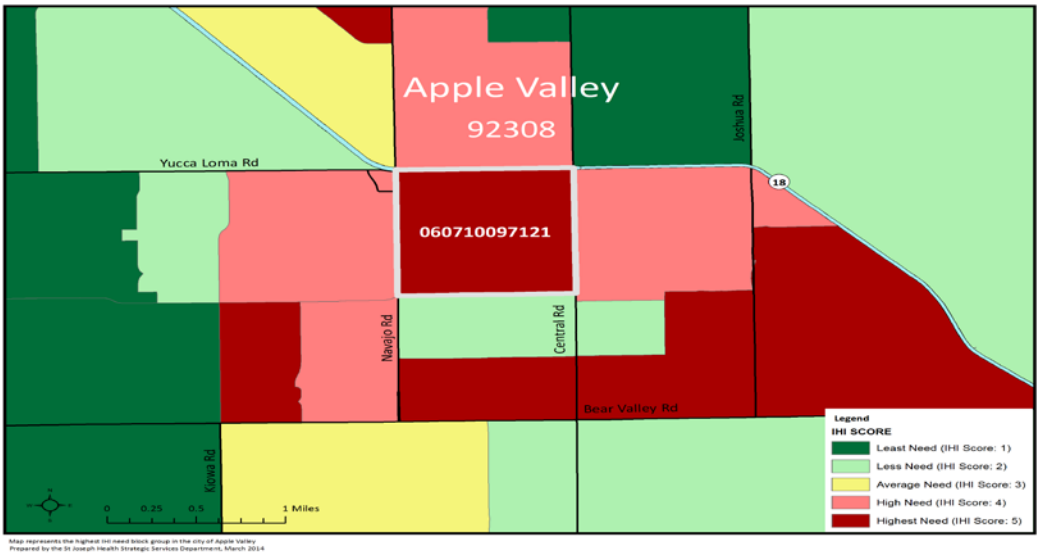


Figure 6. City of Hesperia's highest need block group with hospital clinic location

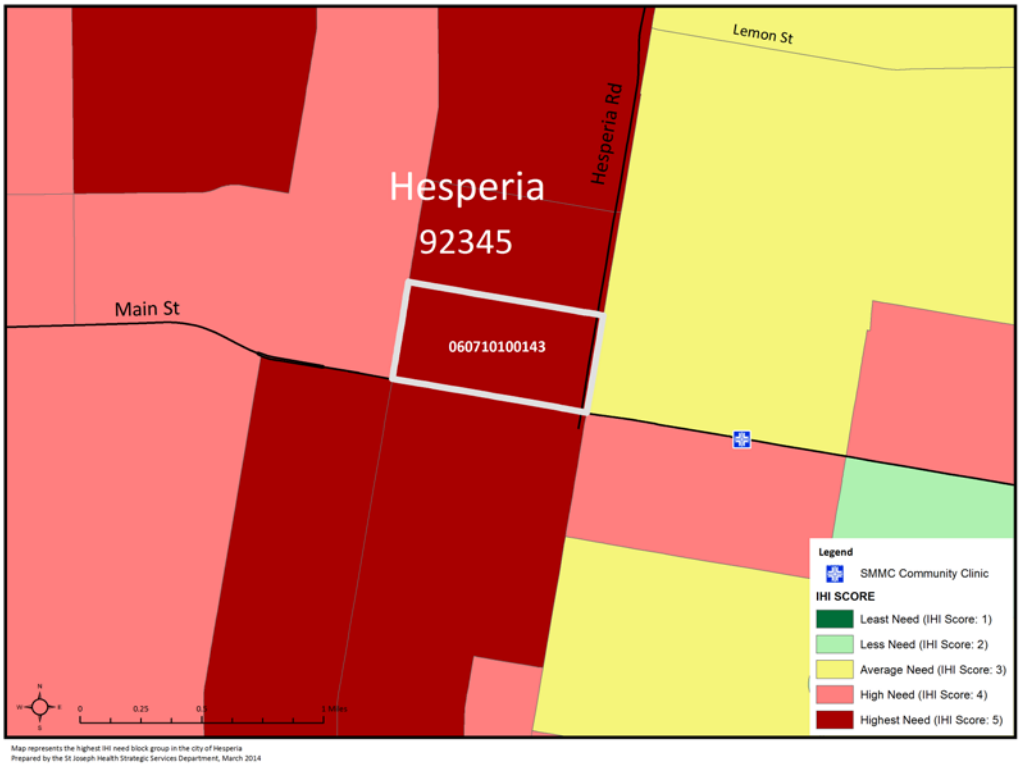
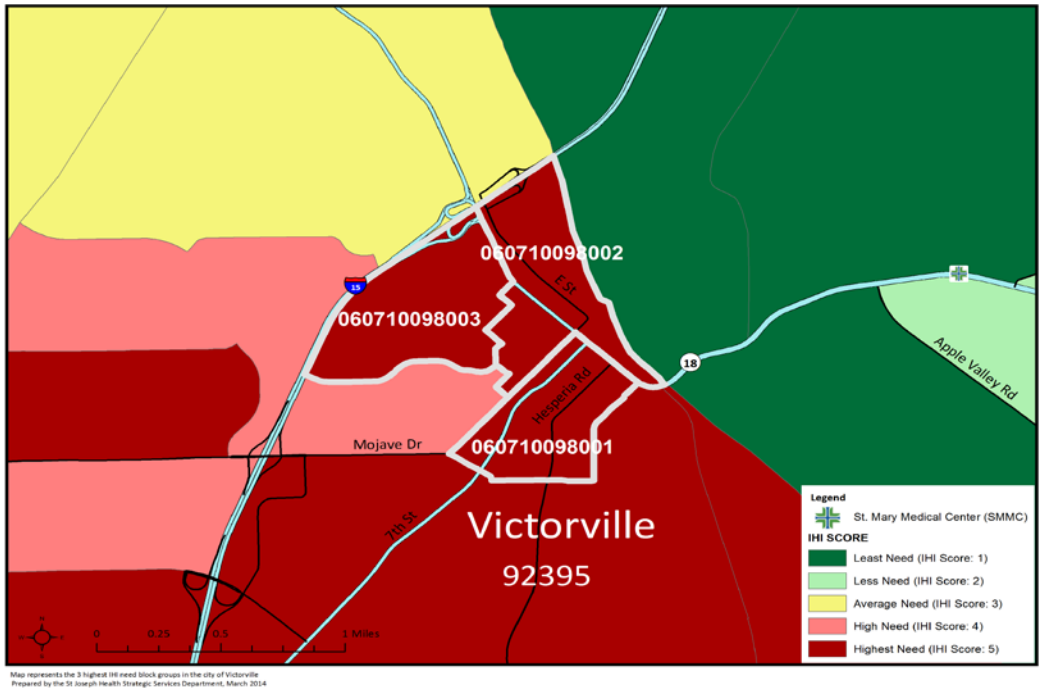


Figure 7. City of Victorville's three highest need block groups



COMMUNITY NEEDS AND ASSESSMENT PROCESS

Summary of Community Needs Assessment Process

St. Joseph Health, St. Mary completed a needs assessment in 2013. In 2011 St. Joseph Health contracted with Professional Research Consultants (PRC) a national health firm with expertise conducting comprehensive community health surveys. PRC worked with SJH to design, conduct and assess a comprehensive health survey for the communities located within SJH. St. Mary's Primary and Secondary service areas. The 146 question survey instrument was based largely on the Centers For Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS) and other national health sources including indicator data relative to national health promotion and disease prevention objectives targeted by Healthy People 2020. Collection of primary health data from the survey were based on responses from a sampling of 750 residents living in the hospital's Primary and Secondary Service areas. Survey results were cross referenced with a baseline of local health data (established using a PRC survey conducted in 2007) and the latest available state and national data including Healthy People 2020 targets. The assessment of 2012 with 2007 health data identified 16 health conditions of concern. In turn, this list was prioritized to seven and finally to four priorities. Three priorities address chronic health conditions identified at prevalence levels significantly higher than reported for the state. The fourth priority is access to care which addresses barriers preventing persons from accessing health services. This selection is based on community feedback, the implementation of Covered California, cutbacks in local programs serving the poor and recognition that poverty is a systemic issue accessing appropriate health services. Providing input during priority setting was a variety of local and county-wide partners including San Bernardino County Public Health, leaders of 52 local non-profits, homeless persons and residents living in North Adelanto.

The hospital conducted five focus groups and a homeless survey to gather community input and perspective with solutions and partners. One hundred and twenty-eight (128) low income and homeless persons identified pressing health and social needs including access to more food, and housing, employment and the need of eye care. PRC health survey results were studied and a list of 16 priority health and lifestyle issues developed. These findings were reviewed by the hospital's Community Benefit Committee which initially ranked seven issues significant. The Committee asked the hospital to seek community input asking that focus groups prioritize health findings from the list of 16 conditions. Additionally, committee members urged community feedback to also include quality of life concerns. Focus group meetings were then held with *leaders* from San Bernardino County's Departments of Public and Behavioral Health, resident leaders making up the Institute for Public Strategies, residents and city leaders of the City of Adelanto and Barstow. Focus group meetings in Adelanto and Barstow were both located in neighborhoods mapped by the hospital has having "highest needs". Thirty African American and Spanish speaking residents were engaged in feedback sessions hosted by IPS in Victorville and High Desert Outreach in Adelanto. Finally, the communities of Adelanto have been designated by the U.S. Department of Health and Human Services as a Medically Underserved Area with Barstow designated as being a Primary Care Health Professional Shortage Area and a Mental Health Professional Shortage Area. The hospital continues to operate a clinic serving Adelanto and in 2012 recruited Molina to open a primary care clinic there. Feedback representing the broader community was obtained by hosting a large focus group of 52 local non-profits serving the population in the hospital's primary and secondary service areas.

Identification and Selection of DUHN Communities
Communities with Disproportionate Unmet Health-Related Needs (DUHN) are communities defined by ZIP codes and census tracts where there is a higher prevalence or severity for a particular health concern than the general population within our ministry Service Area.

Communities with DUHN generally meet one of two criteria: *either* there is a high prevalence or severity for a particular health concern to be addressed by a program activity, or there is evidence that community residents are faced with multiple health problems and have limited access to timely, high quality health care.

The following table lists the DUHN communities/groups and identified community needs and assets

DUHN Group and Community Needs and Assets Summary Table

DUHN Population Group or Community ZIP code or block group	Community Needs	Community Assets
Undocumented residents	Accessing affordable primary and specialty care, obtaining health insurance, bilingual service providers	St. Joseph Health and community health clinics serving low income, Inland Congregations for Change Catholic Charities, Dr. Arvin Salwan, San Bernardino County Public health clinics
Low income residents with unstable transportation	Comprehensive public and private transportation resources	Victor Valley Transit Authority, private transit programs, Victor Community Services Council
Low income residents with chronic care and specialty care needs	Lack of affordable specialty care including laboratory, radiology, mental health and prescriptions	Arrowhead Regional Medical Center; San Bernardino County Public Health and Behavioral Health programs,
Adelanto 3 block groups 9,594 persons 82% poverty	Living in a designated Medically Underserved Area Poor economic development Underdeveloped community services	St. Joseph Health, St. Mary clinic, San Bernardino County public health clinic, Molina Health, Hope Medical Center, Woman, Infant and Child office, Adelanto School District, Healthy Adelanto campaign, Victor Union High School District, Boys and Girls Club, Stater Bros., City of Adelanto

DUHN Group and Community Needs and Assets Summary Table (continued)

DUHN Population Group or Community ZIP code or block group	Community Needs	Community Assets
Apple Valley 1 block group 1,093 persons 62% poverty	Economic Redevelopment Employment Coordinated Health Services GED, ESL College Education Health Insurance Mental Health Substance Abuse Job Training	Apple Valley Town Government SJH, St. Mary Choice Medical Group St. Mary High Desert Medical Healthy Apple Valley Apple Valley School District Paul Swick Center County Government CX3 Project Phoenix Resource Center Apple Valley Head Start
Hesperia 1 block group 2,077 persons 54% poverty	Health Services Economic Development Employers Improved Access to Services Health Insurance	Hesperia City Government Hesperia School District Hesperia Chamber Healthy Hesperia campaign Community Health Action Network County Public Health County Government
Victorville (old-town) 3 block groups 3,730 persons 69% poverty	Economic Redevelopment Employment Coordinated Health Services Coordinated College Education Health Insurance Mental Health Substance Abuse Job Training	City Government Victor Global Medical Center Desert Valley Hospital Victor School Districts Victor Valley Chamber Victor Rotary Victor Valley College County Public Health County Government Mission City Clinic Lords Table Victor Rescue Mission Healthy Victorville

San Bernardino: http://sanbernardino.networkofcare.org/mh/

PRIORITIZED COMMUNITY HEALTH NEEDS

The list below summarizes the seven prioritized community health needs identified through the FY14 Community Health Needs Assessment Process:

- Adult Obesity
- Diabetes
- Mental Health and Depression
- Health Access
- Alcohol and Tobacco
- Problems accessing grocery stores
- Hypertension and High Cholesterol

COMMUNITY BENEFIT PLAN

Summary of Community Benefit Planning Process

The FY15-17 CB Plan was developed in response to findings from the FY14 Community Health Needs Assessment and is guided by the following five core principles:

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

The hospital's community benefit committee prioritized health issues to address in a FY15-FY17 Community Benefit Plan after reviewing feedback obtained from the community. Community input was obtained from feedback sessions conducted with health leaders, leaders of local non profit organizations and residents attending focus group meetings. Community feedback back to the hospital included a prioritized ranking of health issues based on the conditions impacting the community and the extent to which the hospital or other community partners could assist. The hospital's community benefit committee used a matrix with an eleven point criteria to rate seven health conditions originally identified in the hospital's Community Health Needs Assessment and ranked by community and health leaders as priorities. The matrix included, but was not limited to examining health conditions on the relevancy to the hospital's mission, the scope and seriousness of the problem, the importance to the community, existing efforts addressing the health condition, implications for not proceeding and the effectiveness of interventions. These factors were rated on a five point scale for each prioritized health issue.
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Based on review of prioritized significant health needs and a thoughtful priority setting process, St. Joseph Health, St. Mary will address the following priority areas as part of its FY15-17 CB Plan:

Access to Care has been selected as a priority to address marked shortages of health services including primary and specialty care across the hospital's service areas. Additionally, access to care issues has been prioritized by each of the southern California SJH hospitals operating in Orange and San Bernardino counties and a regional assessment continues. Chronic conditions including poverty and mental illness impair people from accessing care. Access issues include, but are not limited to: lack of transportation, health insurance and cost related issues, the shortage of health care professionals particularly primary care providers who are bilingual and gaps in health services provided locally. St. Joseph Health, St. Mary intends to:

- ❒ Expand both primary and specialty networks of outpatient services to improve local health services and partner with physicians and community clinics and physicians to expand access;

- ❒ Improve healthcare access for all residents including those living in eight (8) neighborhoods identified as the hospitals poorest with local Covered California campaigns continuing; and

- ❒ Improve hospital clinic services providing health services to the area's uninsured, low income and undocumented and collaborate on regional efforts to improve access including efforts with St. Joseph Health, St. Mary High Desert Medical Group, San Bernardino County Public Health and a newly formed San Bernardino County Community Clinic Association.

Diabetes has been selected as a priority program as the prevalence has increased significantly from 11.4% to 15.3% the highest of all communities served by SJH. The hospital intends to:

- ❒ Consolidate and better target its diabetes services with expanded education provided at the hospital, to patients served by physicians of St. Mary High Desert Primary Care offices, thru the hospital's community clinics and with the assistance of partners, in a range of community settings including schools, churches and neighborhoods;

- ❒ Expand referrals to physicians providing specialized services at St. Mary High Desert Primary Care and its regional network of care. The hospital will continue to recruit health partners to teach diabetes care in poorer communities reaching families at churches, schools and apartment complexes. The hospital will assist San Bernardino County Public Health to develop diabetes education programs offered from clinics in Adelanto and Hesperia.

Mental Health has been selected as a priority program where 18.4% of residents self-reported their mental health as either fair or poor a 3.9% increase over 2007 significantly higher than the national rate of 11.7%. As previously mentioned there is a recognized shortage of mental health providers in the hospital's service area. The hospital will:

- ❒ Join a local mental health collaborative working to improve the referral of patients requiring out-patient care and to assist in the development of the community's wellness services. The hospital will partner closely with the county's FQHC clinic since it is expanding its mental health programs;

- ❒ Expand partnerships with mental health clinic providing low cost psychiatry care and assist a local partner providing mental health services as part of its substance abuse and recovery programs;

- ❒ Hospital clinics will continue to provide behavioral counseling and strengthen their referral of patients needing specialized care and,

- ❒ Conduct a mental health assessment across its southern California region that identifies opportunities developing referral and technology options and advocacy for expanding services and resources.

Obesity has been selected as a priority with 37% and 33% of residents identified as overweight or obese. The hospital will expand its successful child obesity and Healthy City campaigns addressing obesity at the family, school and community levels. Additionally, the hospital will:

- ❒ Continue its obesity campaign targeting pre-school aged families at Head Start sites and local schools including its partnership with San Bernardino County Public Health implementing a Communities of Excellence campaign expanding neighborhood access to fresh fruits and vegetables and improving street safety, active transportation and development of physical activity resources;

- ❒ Continue its partnership with local physicians who refer overweight and obese children for medical nutrition counseling. Nutrition counseling will continue to target changing underlying family behaviors with food and play/recreation while achieving weight loss; and

- ❒ Continue to partner on a county-wide child/family obesity program in partnership with San Bernardino County's Pre-School Services Department and the nursing programs of Azusa Pacific. The hospital will increase health eating education in schools, workplaces and churches as part of broad programs targeting employee and community wellness. Medical nutrition counseling will be provided to patients seen at the hospital's clinics.

Addressing the Needs of the Community – Access to Care
FY15 –17 Key Community Benefit Plan

Evaluation
St. Joseph Health, St. Mary will monitor and evaluate strategies listed below for the purpose of tracking progress on the implementation of those strategies and document anticipated impact. Evaluation efforts to monitor each strategy will include the collection and documentation of strategy measures, number of partnerships made, percent improvement in health-related metrics, including behavioral and health outcomes as appropriate.

Initiative: *FY14 CHNA identifies that 41.5% of residents report barriers when attempting to access medical care*

Goal (anticipated impact): *Increase the number of low income and uninsured patients receiving appropriate medical care*

Outcome Measure	*Baseline*	*FY15 Target*	*FY17 Target*
Increase access to low income persons seeking medical care	*Will establish baseline in collaboration with partners, fellow SJH ministries and system office*	*Will establish target measures in collaboration with partners, fellow SJH ministries and system office.*	*Will establish target measures in collaboration with partners, fellow SJH ministries and system office.*

Strategy(ies)	*Strategy Measure*	*Baseline*	*FY15 Target*
1.Improve efficiency caring for patients in clinics			
2. Conduct Covered CA enrollment campaigns at hospital and clinics and in community			
3. Improve referral of patients to community clinics and physicians providing care			

Key Community Partners: *San Bernardino County Public Health, Arrowhead Regional Medical Center, St. Joseph Health, Covenant Health Network, St. Mary High Desert Medical Group, San Bernardino County Community Clinic Association, Molina, Mission City, Dr. Milani, Dr. Arvin Salwan*

Addressing the Needs of the Community – Diabetes
FY15 –17 Key Community Benefit Plan

Evaluation

St. Joseph Health, St. Mary will monitor and evaluate strategies listed below for the purpose of tracking progress on the implementation of those strategies and document anticipated impact. Evaluation efforts to monitor each strategy will include the collection and documentation of strategy measures, number of partnerships made, percent improvement in health-related metrics, including behavioral and health outcomes as appropriate.

Initiative: FY14 CHNA shows a marked increase in diabetes prevalence to a reported 15.3%

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

Outcome Measure	*Baseline*	*FY15 Target*	*FY17 Target*
Percentage of diabetic patients whose HbA1c levels are less than 7%, less than 8, less than or equal to 9% or greater than 9%	*Will establish baseline in collaboration with partners, fellow SJH ministries and system office.*	*Will establish target measures in collaboration with partners, fellow SJH ministries and system office.*	*Will establish target measures in collaboration with partners, fellow SJH ministries and system office.*

Strategy(ies)	*Strategy Measure*	*Baseline*	*FY15 Target*
1.Increase screening for diabetes with patients seeking care in the clinics			
2.Coordinate care securing a medical home for patients admitted to St. Mary with diabetes			
3. Develop options for improving access to low income patients to screening for retinopathy			

Key Community Partners: *St. Mary High Desert Primary Care, Healthy Adelanto, Healthy Apple Valley, Healthy Hesperia, Healthy Victorville and Healthy Snowline, San Bernardino County Public Schools, physician partners, Community Health Action Network*

Addressing the Needs of the Community – Mental Health
FY15 –17 Key Community Benefit Plan

Evaluation

St. Joseph Health, St. Mary will monitor and evaluate strategies listed below for the purpose of tracking progress on the implementation of those strategies and document anticipated impact. Evaluation efforts to monitor each strategy will include the collection and documentation of strategy measures, number of partnerships made, percent improvement in health-related metrics, including behavioral and health outcomes as appropriate.

Initiative: FY14 CHNA reports increases in self reported depression at 13.5% and self reported fair to poor mental health at 18.4%

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

Outcome Measure	*Baseline*	*FY15 Target*	*FY17 Target*
The number of system and program changes resulting in increased access to mental health services	*Will establish baseline in collaboration with partners, fellow SJH ministries and system office.*	*Will establish target measures in collaboration with partners, fellow SJH ministries and system office.*	*Will establish target measures in collaboration with partners, fellow SJH ministries and system office.*

Strategy(ies)	*Strategy Measure*	*Baseline*	*FY15 Target*
1. Partner with mental health providers to assess opportunities for improving services and determining advocacy action			
2. Partner to improve services in a regional effort with SJH health ministries of southern CA			
3. Develop and implement a mental health advocacy plan			

Key Community Partners: *San Bernardino County Public Health and Behavioral Health , Mission City Clinic, St. Joseph Health, California Hospital Association, Family Assist, St. John of God Healthcare Services, El Sol Promotores De Salud*

Addressing the Needs of the Community – Obesity
FY15 –17 Key Community Benefit Plan

Evaluation

St. Joseph Health, St. Mary will monitor and evaluate strategies listed below for the purpose of tracking progress on the implementation of those strategies and document anticipated impact. Evaluation efforts to monitor each strategy will include the collection and documentation of strategy measures, number of partnerships made, percent improvement in health-related metrics, including behavioral and health outcomes as appropriate.

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

Goal (anticipated impact): *Body Mass Index improvements in Adults and children*

Outcome Measure	*Baseline*	*FY15 Target*	*FY17 Target*
Body Mass Index	*Will establish baseline in collaboration with partners, fellow SJH ministries and system office.*	*Will establish target measures in collaboration with partners, fellow SJH ministries and system office.*	*Will establish target measures in collaboration with partners, fellow SJH ministries and system office.*

Strategy(ies)	*Strategy Measure*	*Baseline*	*FY15 Target*
1.Partnering with schools to identify at-risk children/families	# of referrals		
2. Partnering with physicians for referral of at-risk patients	# of referrals		
3. Creating environmental changes that increase access to healthy foods and exercise in low income neighborhoods	# of improvements		

Key Community Partners: *San Bernardino County Pre School Department, Azusa Pacific University, Apple Valley Unified School District, Hesperia Unified School District, First 5 of San Bernardino, St. Mary High Desert Medical Group, High Desert Valley Pediatrics, Alliance Desert Physicians, La Salle Medical Clinic, Apple Valley Park and Recreation Department, Hesperia Park and Recreation District, Victorville Park and Recreation Department, Squash4Friends, Think Together, A Dietitian's Exchange, Loma Linda Medical Center*

Planning for the Uninsured and Underinsured

Patient Financial Assistance Program

Our mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why we have a **Patient Financial Assistance Program**[1] that provides free or discounted services to eligible patients.

One way, St. Joseph Health, St. Mary informs the public of the Patient Financial Assistance Program is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible.

Medicaid and Other Local Means-Tested Government Programs

St. Joseph Health, St. Mary provides access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California, and other local means-tested government programs.

[1] *Information about* St. Joseph Health, St. Mary *Financial Assistance Program is available:*
http://www.stmaryapplevalley.com/For-Patients/Financial-Arrangements-Patient-Financial-Assista.aspx

Other Community Benefits

In addition to the preceding priority areas, the St. Joseph, St. Mary plans to provide other community benefit programs responsive to the health needs identified in the 2014 CHNA. Community Benefit programs listed below only includes additional Community Services for the Low-income and Broader Community that have not been previously covered in this CB Plan/Implementation Strategy Report.

Initiative (community need being addressed):	Program(s)	Description	Target Population (Low Income or Broader community)
1. ***Arthritis/Activity Limitations***	*Senior Select*	*Senior Health and Wellness*	*Broader Community*
2. ***Tobacco Use***	*Smoke Free Campus Healthy City Campaigns*	*Expanding smoke free zones across in Healthy Cities (e.g. parks, apartment buildings)*	*Broader Community*
3. ***Hypertension/High Cholesterol/Obesity***	*Employee Wellness Education*	*Employee wellness campaigns with local employers*	*Broader Community*
4. ***Stroke***	*STEMI Receiving Center*	*Stroke education in community in support of hospital's STEMI designation*	*Broader Community*
5. ***Uninsured***	*Inland Empire Health Collaborative*	*Coordinate local campaigns assisting uninsured; expanded health access for children*	*Low Income*
6. ***Access to Care***	*Bridges for Families*	*Health, education & counseling to low income/undocumented*	*Low Income*
7. ***Access to Care***	*Healthy Beginnings – Apple Valley*	*Health services to low income/undocumented*	*Low Income*
8. ***Access to Care***	*Family Resource Center*	*Health and education to low income/undocumented*	*Low Income*
9. ***Access to Care***	*Healthy Beginnings - Adelanto*	*Health services to low income/undocumented*	*Low Income*
10. ***Access to Care***	*Hesperia Clinic*	*Health services to low income/undocumented*	*Low Income*

Other Community Benefits (cont'd)

Initiative (community need being addressed):	Program(s)	Description	Target Population (Low Income or Broader community)
11. ***Access to Care***	*Mother/Baby Assessment Center*	*Health services to low income/undocumented mothers*	*Low Income*
12. ***Access to Care***	*Physician care (primary and specialty) to uninsured patients*	*Physicians providing primary and specialty care services to uninsured patients*	*Low Income*
13. ***Access to Care***	*Bright Futures*	*Mobile medical van services to uninsured*	*Low Income*
14. ***Transportation/Access to Care***	*Patient transportation*	*Transport of patients*	*Low Income*
15. ***Obesity***	*Teaching principals living a 5-2-1-0 lifestyle*	*Teach nutrition and healthy cooking education in community*	*Broader Community*
16. ***Hypertension***	*Heart Care Education*	*Teaching Heart Education in community*	*Broader Community*
17. ***Access to Grocery Stores/Healthy Foods/ Recreation***	*Healthy City Campaigns*	*Influence development of healthy foods and exercise options in community*	*Broader Community and Low Income*
18. ***Access to Care***	*340B Pharmacy program*	*Staff costs operating program providing discounted medications to low income patients*	*Low Income*
19. ***Access to Care***	*Homeless Care referral*	*Patients provided transitional housing post hospital discharge*	*Low Income*
20. ***Access to Care***	*Health Career Programs*	*Develop pipeline for next generation of healthcare professionals*	*Broader Community*

Needs Beyond the Hospital's Service Program

Although no health care facility can address all of the health needs present in its community, we are committed to continue our Mission through community benefit efforts and by funding other non-profits through the St. Joseph Community Partnership Fund.

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

Alcohol and Tobacco Services: *The hospital does not directly address substance abuse; however we partner with several organizations that serve this population, including Catholic Charities and St. John of God Health Care Services. The hospital also is partnering with Institute for Public Strategies on approval of city ordinances to ban the sale of Spice and Bath Salts and, where possible, limit or ban tobacco and alcohol use.*

Food Security*: The hospital does not directly address food insecurity; however we partner with several organizations that service this population, including Catholic Charities, Community Action Partnership of San Bernardino County, Desert Manna, Feed My Sheep Ministries, High Desert Outreach, The Lords Table and Victor Rescue Mission.*

Homelessness Services: *The hospital does not directly address homelessness; however we partner with several organizations that serve the homeless, including Catholic Charities, St. John of God, The Victor Valley Homeless Shelter, Desert Manna, New Hope Transitional Living, San Bernardino County's Homeless Outreach and Proactive Enforcement program, Family Assist, Victor Rescue Mission and a Better Way Domestic Violence.*

Oral Health Services: *The hospital does not directly address dental care; however we partner with several organizations that provide dental services to the uninsured and low income, including: Victor Community Services Dental Program, Western University College of Dental Medicine and San Bernardino County Public Health.*

Transportation Services: *The hospital does not directly address community barriers with public transportation; however we partner with several organizations that address public transportation services, including Victor Valley Transit Authority and Victor Community Services Council.*

In addition, St. Joseph Health, St. Mary will collaborate with 30 organizations that address aforementioned community needs, to coordinate care and referral and address these unmet needs.

Governance Approval

This Community Benefit Plan/Implementation Strategy Report was approved at the May 27, 2014, meeting of the St. Joseph, St. Mary Community Benefit Committee of the Board of Trustees.

Chair's Signature confirming approval of the FY15-17 Community Benefit Plan

5/27/14
Date