



# St. Mary Medical Center

## Community Benefit Report 2014 Community Benefit Implementation Plan 2015

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

The **Hello humankindness** campaign launched by Dignity Health is a movement ignited and based on the proven idea that human connection, be it physical, verbal, or otherwise, leads to better health. At Dignity Health the comprehensive approach to community health improvement recognizes the multi-pronged effort needed to meet immediate and pressing needs, to partner with and support others in the community, and to invest in efforts that address the social determinants of health.

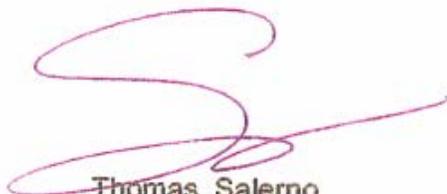
At St. Mary Medical Center we share a commitment to improve the health of our community and have offered programs and services to achieve that goal. The 2014 Annual Report and 2015 Plan for Community Benefit fulfills section 501 (r) of the Patient Protection and Affordable Care Act, where each hospital must complete a community health needs assessment every three years and develop a community health implementation plan to document how it will address the significant health needs of the community. We are proud to provide this report as a continuation of the work we have done over the past 91 years to better the health of the communities we serve.

In addition, California State Senate Bill 697 requires not-for-profit hospitals to annually report their community benefit efforts and measurable objectives as well as its plans for the coming year. Encouraged and mandated by its governing body, Dignity Health hospitals comply with both mandates at each facility, including those in Nevada and Arizona, and is proud of the outstanding programs and services that have been offered to improve the health of the communities we serve.

In fiscal year 2014, St. Mary Medical Center provided \$52, 050,853 in financial assistance, community benefit, and unreimbursed patient care. The unreimbursed cost of caring for patients covered by Medicare was \$8,065,354. Total expense was \$60,116,207.

Dignity Health's St. Mary Medical Center's Board of Directors has reviewed and approved the annual Community Benefit Report and Implementation Plan at their October 23, 2014 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at 562-491-9837.



Thomas Salerno  
President / CEO  
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 1389 employees and 518 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 54,728 visits in Fiscal Year 2014 with 22% 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. SMMC received Dignity Health's BLUE STAR recognition in all three FY 14 goals: hospital quality metrics, stroke care and in communication about medication. This achievement is attributed to the high level collaboration between nursing, medical, ancillary staff, and our community board.

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 health needs assessment, St. Mary Medical Center provides active inpatient as well as community outreach programs targeting the poor and underserved. For FY 2014, 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 Wellness Center, Low Vision Center, the C.A.R.E. Program (Comprehensive AIDS Resources and Education,) Families in Good Health (FiGH,) 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 2014 was \$60,116,207 which includes the unreimbursed costs of Medicare of \$8,065,354; without this cost the total value of Community Benefits for FY 2014 would be \$52,050,853.

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, and West Coast 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.

47 Some examples of our commitment to living our mission include:

- The **Low Vision Center** provides free vision screening to more than 18 private 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 **Mobile Clinic** works with many underserved communities by providing education, health screenings, participation in health fairs, and other endeavors. This offers increased access to vulnerable populations who find access to care burdensome.
- St. Mary "**Life Begins Here**" Childbirth Services provide the following services to more than 3600 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 23,000 visits annually.

## **MISSION STATEMENT**

### **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

**St. Mary Medical Center Organizational Commitment.** 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.

St. Mary Medical Center Administrative Leadership reviews all the community benefits 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 FY2014 the community grants program awarded \$120,660 among the following organizations:

- 1) Alliance for Housing and Healing
- 2) Beacon House Association of San Pedro
- 3) Jewish Family Children's Service
- 4) Lutheran Social Services of So. California
- 5) United States Veterans Initiatives
- 6) Westside Neighborhood Clinic

The Community Benefit Advisory Committee (CBAC) of the Community Board has been an ongoing driver of community benefit priorities and helps to determine program focusing 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 and the Manager of the Bazzeni Wellness Center. The directors of the major community benefit programs attend as requested. (Please see Addendum D for Roster.)

## **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 FY2014 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 pounds of food have been donated by staff and volunteers in support of their food bank.

## COMMUNITY

### Definition of Community

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 469,000 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.

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.

#### 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.

#### 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**

### **Community Health 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 2014 Community Benefit Report and 2015 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.

The Long Beach Health Needs Assessment (LBHNA) included the Key Informant Survey Data, Long Beach Health Needs Assessment Data, California Health Interview Survey 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.

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.

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 2020 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.

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.

## **Assets Assessment**

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.

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).

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

**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.

**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.

**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 Wellness Center, and Families in Good Health (FiGH.) These programs have been enhanced as a result of the Community Need Index (CNI) which assisted SMMC in identifying the areas that should be targeted for outreach with the limited resources available.

**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

**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.

**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.

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

**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.)

**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.

**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 St. Mary Clinics and community partners by providing information and discussion regarding the policy and how to access the assistance.

St. Mary Medical Center partnered with the Long Beach Department of Health through the Health Access Collaborative, a group of Long Beach community programs that help uninsured persons access health care and health benefits. Certified Enrollment Counselors from the St. Mary Clinics and Families in Good Health programs participated in various enrollment events throughout the city as part of the collaborative. St. Mary established a Certified Enrollment Entity through the St. Mary Foundation, created educational brochures, and hosted multiple enrollment events at its Health Enhancement Center to facilitate the Affordable Care Act enrollment initiatives.

## **PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES**

### Summary of Key Programs and Initiatives – FY 2014

Below are the major initiatives and key community based programs operated or substantially supported by St. Mary Medical Center in Fiscal Year 2014. Programs were developed in response to the current Community Health Needs Assessment and are guided by the following five core principles:

- 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
- “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

## 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-Westside Neighborhood Clinic
- Bazzeni Wellness Center Education and Screenings: Health Promotion/Disease Prevention including the Chronic Disease Self Management Program
- 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 (C.A.R.E.)	
Hospital CB Priority Areas	<input type="checkbox"/> Access to Health Care Resources <input type="checkbox"/> Prenatal Care/Teen Pregnancy/Low Birth Rate <input type="checkbox"/> Chronic Conditions <input type="checkbox"/> Obesity among children
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Access to care
Program Description	Comprehensive AIDS Resource and Education (C.A.R.E.) Program at St. Mary Medical Center was founded in 1986. Since its inception, C.A.R.E. 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. C.A.R.E. 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, C.A.R.E. 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. C.A.R.E. 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 C.A.R.E.'s services are the following:</p> <ul style="list-style-type: none"> <li>▪ On-site HIV counseling, testing, referral, partner notification, and linkage to care, 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>▪ Extensive community outreach services 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 HIV specialist medical clinic that provides a full spectrum of culturally competent medical and health services to nearly 1,350 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>▪ Oral health services providing care to over 650 clients through the C.A.R.E. 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>▪ Comprehensive medical and non-medical case management services which coordinate client care for over 250 clients and support access to medication adherence, including nurse case management services for clients with multiple diagnoses or severe needs.</li> <li>▪ Outpatient mental health and substance abuse treatment services, 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>▪ Nutritional services provided by an on-site Registered Dietitian, provided as part of each client's regular HIV medical management. C.A.R.E. also makes food available to the client and family through a weekly food bank.</li> <li>▪ Housing assistance services provided through a contract to the City of Long Beach, which bases two full-time City-funded Housing Coordinators directly within C.A.R.E.'s offices to provide client housing placement and referral services.</li> </ul>
FY 2014	
Goal 2014	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.
2014 Objective Measure/Indicator of Success	<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>▪ C.A.R.E. will track all patients who are eligible for service and all related service deliveries through the County-mandated CaseWatch system.</li> <li>▪ C.A.R.E. 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>

Baseline	The number of individuals seeking services at C.A.R.E. has continued to grow at approximately 20% in the past year. C.A.R.E. will use the number of new cases, as it does every year, to demonstrate need in the greater Long Beach community.
Intervention Strategy for Achieving Goal	Improve partnerships with referral sources including HIV testing centers, Shelters, Jails/Prisons, and providers of substance abuse and mental health services. C.A.R.E. also continues its expansion of the electronic medical record. C.A.R.E. is providing services to patients in the ER department and screening in the Mobile Clinic.
Result FY 2014	100% of those HIV positive clients were offered linkages to care. During this fiscal year C.A.R.E. saw over 350 new clients.
Hospital's Contribution / Program Expense	Hospital contributed additional support to the program by assigning an administrative director to the C.A.R.E. 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. \$256,422.00
<b>FY 2015</b>	
Goal 2015	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 2015. 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.
2015 Objective Measure/Indicator of Success	<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>▪ C.A.R.E. 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>▪ C.A.R.E. will track all patients who are eligible for service and all related service deliveries through the County-mandated CaseWatch system.</li> <li>▪ C.A.R.E. 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>
Baseline	Currently over 750 clients are at risk for a disruption in benefits if they do not initiate enrollment into a managed care plan. C.A.R.E. will track the at risk clients to ensure that they are supported through the benefits transition. The number of individuals seeking services at C.A.R.E. has continued to grow at approximately 10% in the past year. C.A.R.E. will use the number of new cases to demonstrate need in the greater Long Beach community.
Intervention Strategy for Achieving Goal	<p>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.</p> <ul style="list-style-type: none"> <li>▪ 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 C.A.R.E. 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> </ul> </li> <li>▪ Dissemination of pertinent benefits information to CARE providers and staff</li> </ul>

	members to ensure that medical and dental treatments are not adversely impacted by changes to health plans.
Community Benefit Category	Community based clinical services

**Mary Hilton Family Health Center (OB, Antenatal, and Pediatric Clinics)**

Hospital CB Priority Areas	<ul style="list-style-type: none"> <li>x Access to Health Care Resources</li> <li>x Prenatal Care/Teen Pregnancy/Low Birth Rate</li> <li>x Chronic Conditions</li> <li>x Obesity among children</li> </ul>
Program Emphasis	<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> <li><input type="checkbox"/> Build Community Capacity</li> <li><input type="checkbox"/> Collaborative Governance</li> </ul>
Link to Community Needs Assessment	Obesity prevention, access to care and CHDP program.
Program Description	<p>Mary Hilton Family Health Center has OB, perinatal, and pediatric services:</p> <p>St. Mary OB Clinic's Mission Statement reflects the clinic's service overview. In the spirit of God's love, St. Mary Medical Center OB, Perinatal Center, and Pediatric Clinic 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> <p>St. Mary Medical Center Clinic's vision is to be the leading obstetric, perinatal, and pediatric clinic in Long Beach. Over 1,000 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>• Testing. Free pregnancy and STD testing is offered at the OB Clinic.</li> <li>• Benefits Assistance, Clients can obtain Medi-Cal coverage through an on-site enrollment coordinator.</li> <li>• Education in English, Spanish, and Khmer on nutrition, child safety, child development, breast-feeding and Welcome Baby Program.</li> <li>• Comprehensive Perinatal Services Program (CPSP). 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>• High-risk care from a multi-disciplinary team of healthcare professionals such as a dietician, health educator, social worker associate and perinatal specialists.</li> </ul>

	<ul style="list-style-type: none"> <li>• Perinatal testing, counseling, and risk assessments for high-risk pregnancy are offered through our perinatal center. Screening services include serum integrated screening, amniocentesis, non-stress test, and ultrasound.</li> <li>• California Diabetes and Pregnancy Program, 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>• Pediatric care. 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>• Vaccines for Children program to provide free vaccines to children in low income households.</li> </ul>
<b>FY 2014</b>	
Goal 2014	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.
2014Objective Measure/Indicator of Success	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.
Baseline	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
Intervention Strategy for Achieving Goal	Health Fairs, Marketing. Established / Refresh program objectives. Monitor and report measurable outcomes. Community outreach with education and information about our services
Result FY 2014	The clinics delivered over 26,000 individual services to women and children during FY2014 to support the increased service delivery of women's and children's services to the community.
Hospital's Contribution / Program Expense	Antenatal remodel completion and new Ultrasound machine. Cost of program is \$972,535.
<b>FY 2015</b>	
Goal 2015	To support access to care for clients that may experience challenges with implementation of the Affordable Care Act To support increased access to in home and post-partum and pediatric services through implementation of the Welcome Baby Program. To support obesity prevention by partnering with California State University of Long Beach to facilitate Sanos y Fuertes childhood obesity prevention program. To increase and provide prenatal care and education to 2500 women.

	To increase and provide pregnancy testing to 3200 women. To provide pediatric care to over 1500 children.
2015 Objective Measure/Indicator of Success	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. Access to prenatal care for over 2500 women. Access to pregnancy testing for over 3200 women. Access to pediatric care to over 1500 children. Enrollment in the Sanos y Fuertes program in collaboration with California State University of Long Beach to provide education for childhood obesity prevention.
Baseline	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.
Intervention Strategy for Achieving Goal	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. 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 Pediatric providers and staff will assist with promotion of the Sanos y Fuertes childhood obesity prevention program to identified clients of the pediatric clinic.
Community Benefit Category	Community based clinic service

<b>Mobile Care Clinic</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>x Access to Health Care Resources</li> <li>x Prenatal Care/Teen Pregnancy/Low Birth Rate</li> <li>x Chronic Conditions</li> <li>x Obesity among children</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>	<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>	For the 2014 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) and to provide EKG screenings as well as HIV services.
<b>FY 2014</b>	
<b>Goal FY 2014</b>	The objectives of the Breathe Easy Mobile Outreach Program were as follows:  (1) Forge partnerships with senior residential facilities, schools and community centers in target areas.

	<p>(2) Provide 22,750 units of service:</p> <ul style="list-style-type: none"> <li>- Respiratory testing and screenings</li> <li>- One-on-one respiratory health education</li> <li>- Respiratory care provided at St. Mary's Emergency Department</li> <li>- Pediatric Asthma Clinic at St. Mary's Pediatric Clinic</li> <li>- In-home assessments for asthma triggers</li> </ul> <p>(3) Conduct and outreach campaign to advise residents of the Mobile Care Clinic's services and to provide respiratory health prevention and management education.</p> <p>(4) Provide 390 EKG services</p> <p>(5) Provide HIV screenings and refer positive results to our Care Clinic.</p>
<b>2014 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 underinsured.</p>
<b>Intervention Strategy for Achieving Goal</b>	<p>Implementation of the Breathe Easy Mobile Outreach Program involved the following activities:</p> <p>(1) Objective 1: Forge partnerships in target areas</p> <ul style="list-style-type: none"> <li>- Provide mobile clinic services to patients from at least 30 senior housing facilities, schools, or community centers in the target areas</li> </ul> <p>(2) Objective 2: Provide 22,750 units of service and 390 EKGs</p> <ul style="list-style-type: none"> <li>- Respiratory testing and screenings</li> <li>- One on one respiratory health education</li> <li>- Respiratory care provided at St Mary's Emergency Department</li> <li>- Pediatric Asthma Clinic at St. Mary Pediatric Clinic</li> <li>- In-home assessments for asthma triggers</li> </ul> <p>(3) Objective 3: Conduct an outreach campaign</p> <ul style="list-style-type: none"> <li>- Achieve a total of 280,000 impressions through outreach efforts as well as media and public relations coverage.</li> </ul>
<b>Result FY 2014</b>	<p>The following outcomes were achieved (as organized by Objective):</p> <p>Objective 1: Forge partnerships in target areas</p> <ul style="list-style-type: none"> <li>- St. Mary facilitated services to patients from at least 40 sites in the target areas (nine of which are senior residential facilities)</li> </ul> <p>Objective 2: Provide 22,750 units of service</p> <ul style="list-style-type: none"> <li>- In aggregate, a cumulative total of 25,450 units of service were provided over the grant period</li> <li>- Respiratory screening</li> <li>- Home visitation(to provide respiratory health education as well facilitate in-home assessments)</li> <li>- Follow-up phone calls with patients seen by Mobile Clinic</li> </ul>

	<p>Objective 3: Conduct an outreach campaign</p> <ul style="list-style-type: none"> <li>- In aggregate, a cumulative total of 1,296,099 impressions were achieved</li> <li>- Distribution of outreach flyer at various community events</li> <li>- Coverage of Mobile Clinic services in local media outlets</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	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.
<b>FY 2015</b>	
<b>Goal 2015</b>	<p>The objectives of the Breathe Easy Mobile Outreach Program are as follows:</p> <p>(1) Forge partnerships with parks and recreation facilities, low-income housing, senior residential facilities, schools and community center in target areas</p> <p>(2) Provide 7,500 units of service:</p> <ul style="list-style-type: none"> <li>- Assistance with Medi-Cal and low-income health plan enrollment to support community need for benefits resources as part of Covered California and Medicaid expansions.</li> <li>- Respiratory testing and screenings</li> <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 leader 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>
<b>2015 Objective Measure/Indicator of Success</b>	<p>(1) Provides 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 a Nurse Practitioner</li> <li>- Screenings and exams e.g. spirometry, EKG, HIV and other diagnostic exams by the Respiratory Therapist.</li> <li>- Benefits assessment, patient education</li> <li>- Follow-up visits with health care providers at St. Mary</li> </ul> <p>(2) Provide units of services to at least 350 unique individuals during the 12-month period. Patients 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, EKG and HIV 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 education service</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</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>
<b>Baseline</b>	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

	<p>(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 Breath Easy Mobile Outreach Program will require that the mobile clinic complete an application designating it as a Certified Enrollment Entity, so that staff interventions will involve the following activities:</p> <p>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 and community centers in the target areas.</li> </ul> <p>Objective 2: Provide 7,500 units of service:</p> <ul style="list-style-type: none"> <li>- Benefits counseling and Medi-cal enrollment</li> <li>- One-on-one respiratory health education</li> <li>- Respiratory care provided at St. Mary's Emergency Department</li> <li>- Respiratory testing and screening</li> <li>- HIV and EKG screening</li> <li>- Pediatric Asthma Clinic at St. Mary's Pediatric Clinic</li> </ul> <p>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>	Community Based Clinical Services

<b>Family Clinic of Long Beach</b>	
	<ul style="list-style-type: none"> <li>x Access to Health Care Resources</li> <li>x Prenatal Care/Teen Pregnancy/Low Birth Rate</li> <li>x Chronic Conditions</li> <li>x Obesity among children</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> <li><input type="checkbox"/> Build Community Capacity</li> <li><input type="checkbox"/> Collaborative Governance</li> </ul>
<b>Link to Community Needs Assessment</b>	Chronic Conditions; Access to Health Care Resources
<b>Program Description</b>	<p>The Family Clinic of Long Beach has been providing primary care to the Long Beach Community for over 25 years. Developed as part of the St. Mary residency program, The Family Clinic continues to support the residency and of over 30 medical students and dozens of pharmacy students each year.</p> <p>Clients are often referred to the Family Clinic after a visit to the hospital ER or inpatient stay. It is not uncommon to hear of clients that were in our hospital, in dire critical condition, that have been able to stay healthy once they experienced the health benefits of receiving regular medical care from our team of medical providers at the clinic.</p> <p>The Family clinic serves as the hub of medical services for our group of clinics, serving as the Medical Home for adult patients seeking primary care services or</p>

	<p>referrals to specialists in our clinic network. Serving over 2,000 residents of Long Beach in calendar year 2013, the clinic focuses on internal medicine with additional services such as:</p> <ul style="list-style-type: none"> <li>▪ <b>Travel Clinic</b>, Our infectious disease specialist, Dr. Chester Choi, has been providing travelers with vaccination and treatment for exotic diseases. Recognized as the travel clinic of choice in the region, the Family Clinic prepares clients for their upcoming trip so that they may complete mission work in isolated regions or relax on their tropical vacation.</li> <li>▪ <b>Coumadin Clinic</b>, Our team of pharmacists has successfully cared for hundreds of seniors that need regular monitoring while taking blood thinning medication prescribed to prevent strokes and embolism.</li> <li>▪ <b>Diabetes Education Program</b>- Pharmacy based diabetes education program providing 1:1 education and recommended changes to insulin orders for all clients identified as diabetic within the Family Clinic. The hospital diabetes education group education program will be complementing the clinic based program.</li> <li>▪ <b>Medication Therapy Management</b>- Providing pharmacy based services to review duplications of therapy, medication adherence issues, and access to medications. The MTM program is intended to address one of the key priorities of transitional care and readmission prevention.</li> <li>▪ <b>Benefits Assistance</b> - Provide Medi-Cal and covered California enrollment services to all clients of Family Clinic and St. Mary Hospital seeking navigation into insurance programs.</li> </ul> <p><b>Case Management Services</b>, Case Management to coordinates with hospital representatives and outreach personnel to link clients in the community with stable medical care at the Family Clinic. Clients receive health coaching and social services to improve compliance with their health maintenance goals.</p> <ul style="list-style-type: none"> <li>▪ <b>Specialty Medicine</b>, The Family Clinic partners with physicians specializing in Rheumatology (Joint pain), Endocrinology (Diabetes and glands), and Pulmonology (Lungs) to provide clients with on-site services for disease specific treatment that may be difficult to obtain for low-income patients.</li> </ul>
<b>2014</b>	
<b>Goal FY 2014</b>	To meet the health care needs of a diverse population, provide access to primary health care services.
<b>2014 Objective Measure/Indicator of Success</b>	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 members that are not accessing continuous primary care services through a medical home. The Family Clinic, with its access to Medi-Cal programs and coordination with hospital departments will serve as the primary medical home for clients that need a medical home so that we can improve the health outcomes of community members needing regular access to medical services.
<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 2014</b>	The clinics service over 1637 patients
<b>Hospital's Contribution / Program Expense</b>	The hospital has provided additional space in the 1045 Atlantic building for family clinic to expand its support services.
<b>FY 2015</b>	
<b>Goal 2015</b>	To increase patients access to Medi-Cal and Covered California To increase the number of community members entry into the primary care

	<p>medical home To provide patients with diabetes, medication therapy management, and stroke prevention services through the clinic's specialty services.</p>
<b>2015 Objective Measure/Indicator of Success</b>	At least, 50 new clients a month establishing care at the family clinic. At least 90% of the clients intake into the benefits screening process will have insurance program identified. At minimum, 90% of clients identified as qualified for specialty services will be enrolled into the programs.
<b>Baseline</b>	The community has many members that are not accessing continuous primary care services through a medical home. The Family Clinic, with its access to Medi-Cal programs and coordination with hospital departments will serve as the primary medical home for clients that need a medical home so that we can improve the health outcomes of community members needing regular access to medical services.
<b>Intervention Strategy for Achieving Goal</b>	Referrals from Mobile Clinic, Emergency Room and unassigned discharge patients. Monitor and report measurable outcomes. Community outreach with education and information about our services.
<b>Community Benefit Category</b>	Subsidized Service
<b>Imaging Center</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>x Access to Health Care Resources</li> <li>x Prenatal Care/Teen Pregnancy/Low Birth Rate</li> <li>x Chronic Conditions</li> <li>x Obesity among children</li> </ul>
<b>Program Emphasis</b>	<ul style="list-style-type: none"> <li>x Disproportionate Unmet Health-Related Needs</li> <li>x Primary Prevention <ul style="list-style-type: none"> <li><input type="checkbox"/> Seamless Continuum of Care</li> <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>	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>	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 2014</b>	
<b>Goal FY 2014</b>	Our goal for FY 2014 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>2014 Objective Measure/Indicator of Success</b>	Surveys and attendance for health screenings will give an accurate picture of the results of our outreach with the community.
<b>Baseline</b>	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>	Partnered with the Senior Center, the Mobile Unit and our business relations department to assure patients were informed by way of flyers of the programs available to them here at the center. Participated in health fairs to help educate women of the importance of early screening and free services available to them. Partnered with the YWCA of San Pedro who performs community outreach.
<b>Result FY 2014</b>	5460 services were performed to women under the Cancer Detection Program: Every Woman Counts. 528 services were performed to evaluate for breast masses under the Susan G. Komen Grant.

<b>Hospital's Contribution / Program Expense</b>	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. \$57.86/Hour (\$96,549.00/Annual)
<b>FY 2015</b>	
<b>Goal 2015</b>	Our goal for FY2015 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>2015 Objective Measure/Indicator of Success</b>	Number of women enrolled into the free programs will be tracked by the department and will give an accurate picture of the results of our outreach with the community.
<b>Baseline</b>	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>	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. Continued partnership with the YWCA of San Pedro who will continue to provide community outreach.
<b>Community Benefit Category</b>	Community Health Education

<b>Bazzeni Wellness Center</b>	
Hospital CB Priority Areas	<ul style="list-style-type: none"> <li>x Access to Health Care Resources</li> <li>x Prenatal Care/Teen Pregnancy/Low Birth Rate</li> <li>x Chronic Conditions</li> <li>x Obesity among children</li> </ul>
Program Emphasis	<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> <li>x Build Community Capacity</li> <li>x Collaborative Governance</li> </ul>
Link to Community Needs Assessment	The Community Needs Assessment identified Seniors as a vulnerable community and access to services as being a major barrier to health.
Program Description	<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 Medical Office Building. For Fiscal Year 2014, there were approximately 2,800 members.</p> <p>Services include:</p> <ul style="list-style-type: none"> <li>• Insurance counseling—assisting seniors to clarify insurance needs, issues, and concerns.</li> <li>• Hospital and community referral service – assist with access to hospital and community services and programs in the greater Long Beach area.</li> <li>• Free Health Resource library – health and health care resources are available.</li> <li>• Fitness program, 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>• Free health screenings include: fall risk assessment, foot check, blood pressure, cholesterol and blood sugar and hearing evaluations.</li> </ul>

	<ul style="list-style-type: none"> <li>• Health and Wellness education— 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>• Estate Planning and Financial Counseling assisted seniors with financial issues and retirement planning.</li> <li>• Advanced directives assistance—assisting seniors with filling out necessary paperwork for health care directives before the need for hospitalization.</li> <li>• Transportation service—free van service for seniors, which transports them to and from hospital and medical appointments.</li> <li>• Monthly low cost excursions — build camaraderie among the seniors, and promote companionship, as well as opportunities to make new acquaintances.</li> <li>• Annual flu vaccines - Provided annually to uninsured adults 50 and older.</li> <li>• AARP Safe Driver Classes – provided quarterly.</li> <li>• AARP CarFit – provided annually.</li> </ul>
FY 2014	
Goals FY 2014	<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>
2014 Objectives Measure/Indicator of Success	<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>
Baseline	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.
Intervention Strategy for Achieving Goals	<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>
Result FY 14	<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. Process started still expanding resource center.</li> <li>• Provide educational workshops and seminars on campus monthly. Completed</li> <li>• Provide exercise programs on campus monthly. Completed</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. Began working on transforming current exercise/fall balance prevention programs to CDC STEADI Tool Kit - Trained on Stepping On.</li> <li>• Hold one major safety summit on fall prevention on campus. - Fall prevention summit held 9/2013.</li> </ul>

	<ul style="list-style-type: none"> <li>• Provide education lectures on heart disease, diabetes and fall prevention to a minimum of 6 residential or community settings in catchment area. Provided 2 lectures at Brethren Manor, 2 lectures at Lutheran Towers.</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. Stilling working on this strategy. Developed advisory Board to help with research.</li> </ul>
Hospital's Contribution / Program Expense	\$138,793
<b>FY 2015</b>	
Goals 2015	<ul style="list-style-type: none"> <li>• Continue to work with community partners and SMMC Outpatient Physical Therapy Department to enhance current exercise program and fall balance screenings to meet CDC STEADI Tool Kit requirements.</li> <li>• Continue to work with Advisory Council and local university to assist with consumer/program satisfaction surveys.</li> <li>• Provide three Stepping On workshops.</li> <li>• Continue to provide education lectures and screenings when appropriate.</li> <li>• Provide two major safety summits during the year.</li> </ul>
2015 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> <li>• Continue to work with community partners and SMMC Outpatient Physical Therapy Department to enhance current exercise program and fall balance screenings to meet CDC STEADI Tool Kit requirements. <ul style="list-style-type: none"> <li>○ Partnership with Heart of Ida and Partners in Care Foundation will result in providing CDC STEADI to Wellness Center – stages will be determined as program is rolled out.</li> </ul> </li> <li>• Continue to work with Advisory Council and local university to assist with consumer/program satisfaction surveys. Pilot survey project to be done by the end of the year.</li> <li>• Provide three Stepping On workshops. <ul style="list-style-type: none"> <li>○ Complete of three workshops with pre and post evaluations</li> </ul> </li> <li>• Continue to provide education lectures and screenings when appropriate. <ul style="list-style-type: none"> <li>○ Monthly or quarterly as needed.</li> </ul> </li> <li>• Provide two major safety summits during the year. <ul style="list-style-type: none"> <li>○ Trauma, Safety, Stroke and Awareness Summit held in May</li> <li>○ Fall prevention summit held in September.</li> </ul> </li> </ul>
Baseline	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.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> <li>• Continue to work with community partners and SMMC Outpatient Physical Therapy Department to enhance current exercise program and fall balance screenings to meet CDC STEADI Tool Kit requirements. <ul style="list-style-type: none"> <li>○ Partnership with Heart of Ida and Partners in Care Foundation will result in providing CDC STEADI to Wellness Center – stages will be determined as program is rolled out.</li> </ul> </li> <li>• Continue to work with Advisory Council and local university to assist with consumer/program satisfaction surveys. Pilot survey project to be done by the end of the year.</li> <li>• Provide three Stepping On workshops. <ul style="list-style-type: none"> <li>○ Complete of three workshops with pre and post evaluations</li> </ul> </li> <li>• Continue to provide education lectures and screenings when appropriate. <ul style="list-style-type: none"> <li>○ Monthly or quarterly as needed.</li> </ul> </li> <li>• Provide two major safety summits during the year. <ul style="list-style-type: none"> <li>○ Trauma, Safety, Stroke and Awareness Summit held in May</li> <li>○ Fall prevention summit held in September.</li> </ul> </li> </ul>

<b>Chronic Disease Self-Management Program</b>	
<b>Hospital CB Priority Areas</b>	<input type="checkbox"/> Access to Health Care Resources <input type="checkbox"/> Prenatal Care/Teen Pregnancy/Low Birth Rate <input checked="" type="checkbox"/> Chronic Conditions <input type="checkbox"/> Obesity among children
<b>Program Emphasis</b>	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" 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>	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>	Chronic Disease Self Management Program (CDSMP)—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 2014</b>	
<b>Goals FY 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 Objectives 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 sufferers 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 Goals</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>Result FY 2014</b>	<ul style="list-style-type: none"> <li>▪ Train 10 Community Lay Leaders for the Chronic Disease Self Management Program.               <ul style="list-style-type: none"> <li>- Goal was not met – there is a general lack of knowledge in the community about what evidence-based programs are and the importance of these programs in the community.</li> <li>- Exception in FIGH trained two Lay Leaders in the Spanish version of the workshop.</li> </ul> </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>- Trainers are now trained in Spanish and will be conducting workshops in FY 2015.</li> <li>- One workshop in Khmer (Lay Leader became a caregiver to a family member and needed to take a hiatus from teaching. Will resume again in FY 2015.</li> <li>- Three workshops in English</li> <li>- Two off campus - In process – started in FY 2014 and will be completed in FY 2015</li> </ul> </li> </ul>

<b>Hospital's Contribution / Program Expense</b>	\$2357
<b>FY 2014-15</b>	
<b>Goals 2014-15</b>	<p><b>Goal #1</b></p> <ul style="list-style-type: none"> <li>▪ Train 5 Community Lay Leaders for the Chronic Disease Self Management Program with the assistance of Partners in Care Foundation.</li> </ul> <p><b>Goal #2</b></p> <ul style="list-style-type: none"> <li>▪ Provide Chronic Disease Self Management classes: <ul style="list-style-type: none"> <li>○ One in workshop in Spanish Families in Good Health with facilitate and arrange for this workshop</li> <li>○ One workshop in Khmer</li> <li>○ Three workshops in English <ul style="list-style-type: none"> <li>▪ Two on campus</li> <li>▪ One off campus</li> </ul> </li> </ul> </li> </ul>
<b>2014-15 Objective Measure/Indicator of Success</b>	<p><b>Goal #1</b></p> <ul style="list-style-type: none"> <li>▪ Collaboration with Partners in Care Foundation on recruitment and training.</li> <li>▪ Stringer internal recruitment efforts.</li> </ul> <p><b>Goal #2</b></p> <ul style="list-style-type: none"> <li>• Internal and external collaboration efforts.</li> <li>• Work with SMMC Readmissions Team to recruit participants for classes.</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>	<p><b>Goal #1</b></p> <ul style="list-style-type: none"> <li>▪ Collaboration with Partners in Care Foundation on recruitment and training.</li> <li>▪ Stringer internal recruitment efforts.</li> </ul> <p><b>Goal #2</b></p> <ul style="list-style-type: none"> <li>• Internal and external collaboration efforts.</li> <li>• Work with SMMC Readmissions Team to recruit participants for classes.</li> </ul>
<b>Community Benefit Category</b>	Community Health Education

<b>Diabetes Self-Management Education and Support Program</b>	
<b>Hospital CB Priority Areas</b>	<input type="checkbox"/> Access to Health Care Resources <input type="checkbox"/> Prenatal Care/Teen Pregnancy/Low Birth Rate <input checked="" type="checkbox"/> Chronic Conditions <input type="checkbox"/> Obesity among children
<b>Program Emphasis</b>	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" 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>	Insured, uninsured, Medi-Cal and Medicare
<b>Program Description</b>	Outpatient Self-Management Education and Support Program for individuals living with diabetes.

<b>FY 2014</b>	
<b>Goals FY14</b>	<ul style="list-style-type: none"> <li>To provide effective and appropriate education to meet the medical and psychological, social and spiritual needs of the person with diabetes.</li> <li>To prevent or minimize the acute or chronic complications associated with diabetes</li> <li>To reduce inpatient hospitalization stay as appropriate.</li> <li>To develop partnerships with referring physicians.</li> </ul>
<b>2014 Objectives Measure/Indicator of Success</b>	By Goal Setting, Foot Assessment, Nutrition by verbalizing understanding of meal planning, glucose monitoring, A1C results and BMI 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 Goals</b>	3 month, 6 month, and 1 year follow-up from time of initial visit with A1C results
<b>Result FY 14</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" to provide funds for uninsured patients, a quarterly support group and an annual November fair. The expenses were absorbed in the category of means-tested programs.
<b>FY 2014-15</b>	
<b>Goals 2014-15</b>	<ul style="list-style-type: none"> <li>To provide effective and appropriate education to meet the medical and psychological, social and spiritual needs of the person with diabetes.</li> <li>To prevent or minimize the acute or chronic complications associated with diabetes.</li> <li>To reduce inpatient hospitalization stay as appropriate.</li> <li>To develop partnerships with referring physicians.</li> <li>To develop partnership with Outreach Mobile Clinic to identify newly diagnosed patient with diabetes and refer for diabetes education.</li> <li>To develop a relationship with staff of Stanford Chronic Care Model for continued education for people with diabetes.</li> <li>To develop partnership with the Outpatient Medicine Clinic, and provide patients for diabetes education and support.</li> </ul>
<b>2014-15 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>	Community Health Education

<b>Low Vision Center</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>X Access to Health Care Resources</li> <li><input type="checkbox"/> Prenatal Care/Teen Pregnancy/Low Birth Rate</li> <li><input type="checkbox"/> Chronic Conditions</li> <li><input type="checkbox"/> Obesity among children</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> <li>X Build Community Capacity</li> <li><input type="checkbox"/> Collaborative Governance</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 area schools providing evaluations, examination by doctors, and eyeglasses</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> <li>• Senior Vision Program providing evaluations, examinations, and glasses free of charge (New Program)</li> <li>• Adult Vision Program providing evaluations, examinations, and glasses free of charge (New Program)</li> </ul>
<b>FY 2014</b>	
<b>Goals FY 2014</b>	<ul style="list-style-type: none"> <li>• Continue to maintain successful LVC School Screening Program</li> <li>• Continue to maintain successful Senior Glasses Program</li> <li>• Continue to maintain successful Adult Glasses 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>2014 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• Increase in 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. Within the schools, the Low Vision Center provides children

	whose parents do not have vision insurance the opportunity to obtain a comprehensive exam and glasses free of charge. This invaluable service allows a child to compete and succeed in the school setting with his / her peers.
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>▪ Increase in schools, seminars, Independent Living Skills classes</li> <li>▪ Promotion of Low Vision Center at health fairs, through newsletters and marketing</li> <li>▪ Scheduled vision screenings to be performed at Harbor Area Halfway House, WSLB (Women's Shelter), The Village, CSULB – SEE US SUCCEED (Homeless children's camp) and Centro Shalom.</li> <li>▪ Promotion of Low Vision Center within St. Mary Medical Center to visitors, physicians and free screenings within the hospital grounds.</li> <li>▪ Collaboration with SMMC departments, (e.g. C.A.R.E. Program) for free vision evaluations.</li> </ul>
<b>Result FY 2014</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. Specific screening sites and lots are provided by the hospital to support underserved populations.
<b>FY 2015</b>	
<b>Goal 2015</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>2015 Objective Measure/Indicator of Success</b>	Measurement of success is obtained through computer data, feedback from LVC patients, the public, businesses, follow-up with physicians, letters of appreciation, 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. Many patients are from out-of-state.</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>	<ul style="list-style-type: none"> <li>▪ Continue to build community awareness through health fairs, marketing, lectures, advertising</li> <li>▪ Continued personal contact with physicians to promote the Low Vision Center's services.</li> <li>▪ Continued promotion of LVC services to senior centers, schools, businesses, health fairs</li> </ul>

	<ul style="list-style-type: none"> <li>▪ Acquisition of grants through SMMC Grant Writing Department for the acquisition of new and innovative technology for redistribution to the visually impaired.</li> <li>▪ Continued maintenance of successfully established programs</li> <li>▪ Acquisition of grants to maintain all free services</li> </ul>
<b>Community Benefit Category</b>	Subsidized Health Services

<b>Families in Good Health Department</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>X Access to Health Care Resources</li> <li>X Prenatal Care/Teen Pregnancy/Low Birth Rate</li> <li>X Chronic Conditions</li> <li><input type="checkbox"/> Obesity among children</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><input type="checkbox"/> Seamless Continuum of Care</li> <li>X Build Community Capacity</li> <li><input type="checkbox"/> Collaborative Governance</li> </ul>
<b>Link to Community Needs Assessment</b>	<ul style="list-style-type: none"> <li>▪ Access to care for chronic conditions with an emphasis on vulnerable communities in the greater Long Beach area, including the following: Southeast Asian (i.e., Khmer, Lao), teens, seniors, women and children</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>	Families in Good Health's (FiGH's) mission is to empower individuals and their families to make healthy choices regarding their health and welfare. Because FiGH is completely grant-driven, its programs, goals, and objectives must address not only St. Mary Medical Center's priority areas but also the priorities of the funding agencies. Therefore, each grant-funded program reflects its own specific goals and objectives.
<b>Families in Good Health: Best Babies Collaborative (BBC)</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>X Access to Health Care Resources</li> <li>X Prenatal Care/Teen Pregnancy/Low Birth Rate</li> <li><input type="checkbox"/> Chronic Conditions</li> <li><input type="checkbox"/> Obesity among children</li> </ul>
<b>Program Emphasis</b>	<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> <li><input type="checkbox"/> Collaborative Governance</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>	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.
<b>FY 2014</b>	
<b>Goals FY 2014</b>	To improve maternal and infant mortality rates in targeted high risk communities in the greater Long Beach area.
<b>2014 Objectives Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>▪ Provide home visitation services to 10-15 high-risk pregnant and parenting teens at a time</li> <li>▪ Healthy second births to be measured over time</li> <li>▪</li> </ul>

<b>Baseline</b>	<ul style="list-style-type: none"> <li>▪ High teen pregnancy rate</li> <li>▪ High infant mortality rate</li> <li>▪ Incidence of low birth weight</li> </ul>
<b>Intervention Strategy for Achieving Goals</b>	Implementation of home visitation modules account for, but are not limited to, prenatal health and nutrition, infant development, maternal health, and bonding and attachment
<b>Result FY 2014</b>	<ul style="list-style-type: none"> <li>▪ Conducted outreach and education to 453 individuals one-on-one and at various community events</li> <li>▪ Case load would total 12-17 clients for a given month</li> </ul>
<b>Hospital's Contribution/ Program Expense</b>	\$18,000 grant award
<b>FY 2015</b>	
<b>Goals 2015</b>	<b>(Not applicable as grant funding ended in December 2013)</b>
<b>Families in Good Health: Culturally Specific Services Program (CLSSP)</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>X Access to Health Care Resources</li> <li><input type="checkbox"/> Prenatal Care/Teen Pregnancy/Low Birth Rate</li> <li><input type="checkbox"/> Chronic Conditions</li> <li><input type="checkbox"/> Obesity among children</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> <li>x Build Community Capacity</li> <li><input type="checkbox"/> Collaborative Governance</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 Culturally Specific Services Program (CLSSP) is funded through a subcontract from the Center for Pacific Asian Family to raise awareness around sexual assault while building capacity through the delivery of culturally appropriate materials and support within Asian/Pacific Islander communities.
<b>FY 2014</b>	
<b>Goals FY 2014</b>	To increase Asian/Pacific Islander capacity to provide culturally specific resources and support for victims and survivors of sexual assault, focusing on the Cambodian community in the greater Long Beach area.
<b>2014 Objectives Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>▪ Conduct two sexual assault outreach and education activities per quarter, including the distribution of Khmer outreach materials</li> <li>▪ Develop relationships with key stakeholders in the local Cambodian community, including ethnic media</li> </ul>
<b>Baseline</b>	There is a demonstrated need to provide culturally appropriate support for Cambodian victims of sexual assault, particularly as sexual assault can be a culturally stigmatizing issue amongst families.
<b>Intervention Strategy for Achieving Goals</b>	Sexual assault outreach and education activities include targeting individuals, faith-based sites and ethnic small businesses located in the local Cambodian community (both one-on-one and community event venues). Additional outreach strategies involve engaging local partners (such as community-serving organizations and ethnic media) to further program aims in reaching the local Cambodian community.
<b>Result FY 2013-14</b>	<ul style="list-style-type: none"> <li>▪ Conducted outreach and education to 306 individuals one-on-one, via in-reach through other Families in Good Health grant programs, at local Buddhist temples, at ethnic small businesses and at ethnic-specific community events. Distributed English, Khmer educational brochures on sexual assault.</li> </ul>
<b>Hospital's Contribution/ Program Expense</b>	\$7,200 grant award
<b>FY 2015</b>	
<b>Goals 2015</b>	To increase Asian/Pacific Islander capacity to provide culturally specific resources and support for victims and survivors of sexual assault, focusing on

	the Cambodian community in the greater Long Beach area.
<b>2015 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>▪ Conduct two sexual assault outreach and education activities per quarter, including the distribution of Khmer outreach materials</li> <li>▪ Develop relationships with key stakeholders in the local Cambodian community, including ethnic media</li> </ul>
<b>Baseline</b>	There is a demonstrated need to provide culturally appropriate support for Cambodian victims of sexual assault, particularly as sexual assault can be a culturally stigmatizing issue among families.
<b>Intervention Strategy for Achieving Goal</b>	Program activities include conducting a support group, convening Cambodian females to engage in discussion around sexual assault. Additional activities include continuing to build relationships with key stakeholders (including local ethnic media) so as to provide appropriate support to the Long Beach Cambodian community around sexual assault.
<b>Community Benefit Category</b>	Community Health Education
<b>Families in Good Health: Educated Men with Meaningful Messages (EM3)</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>X Access to Health Care Resources</li> <li><input type="checkbox"/> Prenatal Care/Teen Pregnancy/Low Birth Rate</li> <li><input type="checkbox"/> Chronic Conditions</li> <li><input type="checkbox"/> Obesity among children</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> <li><input type="checkbox"/> Collaborative Governance</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>	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 social determinants of health, 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 2014</b>	
<b>Goals FY 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 Objectives 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 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 Advocacy Collaborative.</li> </ul>

<b>Baseline</b>	High-risk, vulnerable participant population
<b>Intervention Strategy for Achieving Goals</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 2014</b>	<ul style="list-style-type: none"> <li>▪ Recruitment and engagement of 25-30 multiethnic male youth for active participation in EM3, with some youth actively involved in advocating for health promoting policies. Male youth successfully completed 15-module EM3 Leadership, Empowerment and Life Skills Curriculum.</li> <li>▪ Continued active participation in the implementation of the Every Student Matters campaign, particularly as this advocacy effort relates to school discipline reform.</li> <li>▪ Successful participation of EM3 staff in Train-the-Trainers Advocacy Training with the Long Beach Cambodian Advocacy Collaborative. Advocacy Training is intended to develop policy advocates among EM3 youth participants, further building capacity to advocate for local campaigns on housing, language access, student concerns and violence prevention.</li> </ul>
<b>Hospital's Contribution/ Program Expense</b>	\$85,000 grant award
<b>FY 2015</b>	
<b>Goals 2015</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>2015 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 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 Advocacy Collaborative.</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>	Community Health Education; Community Building
<b>Families in Good Health: Educating Providers, Supporting Children Project (EPSC)</b>	
<b>Hospital CB Priority Areas</b>	<input checked="" type="checkbox"/> Access to Health Care Resources <input type="checkbox"/> Prenatal Care/Teen Pregnancy/Low Birth Rate <input type="checkbox"/> Chronic Conditions <input type="checkbox"/> Obesity among children
<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,</li> </ul>

	cultural diversity
<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.
<b>FY 2014</b>	
<b>Goals FY 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 Objectives 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 as well as 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 Goals</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>Result FY 2014</b>	<ul style="list-style-type: none"> <li>▪ A total of 34 child care providers participated in the 19-module training curriculum (i.e., 10 African American, 12 Latino and 12 Southeast Asian).</li> <li>▪ A total of 24 child care providers participated in social connectedness events (e.g., Holiday Social, Graduation).</li> <li>▪ A total of 24 child care providers participated in field trip opportunities to increase access to relevant resources on child care and child development (e.g., local library).</li> </ul>
<b>Hospital's Contribution/ Program Expense</b>	\$200,000 grant award
<b>FY 2015</b>	
<b>Goals 2015</b>	<b>(Not applicable as grant funding ended in June 2014)</b>
<b>Families in Good Health: Healthy Families America (HFA)</b>	
<b>Hospital CB Priority Areas</b>	<input checked="" type="checkbox"/> Access to Health Care Resources <input type="checkbox"/> Prenatal Care/Teen Pregnancy/Low Birth Rate <input type="checkbox"/> Chronic Conditions <input type="checkbox"/> Obesity among children
<b>Program Emphasis</b>	<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>	Healthy Families America (HFA) is funded by First 5 LA and is an evidence-based program model that facilitates home-based intervention for clients identified as needing more focused and intensive support. Through a client-centered and strength-based approach, clients can receive information and support on such issues as parent-child bonding and attachment, child health and development, and safe home environment.
<b>FY 2014</b>	
<b>Goals FY 2014</b>	HFA aims to achieve the following goals: <ul style="list-style-type: none"> <li>▪ Goal 1: Cultivate and strengthen nurturing parent-child relationships</li> </ul>

	<ul style="list-style-type: none"> <li>▪ Goal 2: Promote healthy growth and development for children</li> <li>▪ Goal 3: Enhance family functioning by reducing risk and promoting protective factors</li> </ul>
<b>2014 Objectives Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>▪ Establishment of a HFA Community Advisory Board</li> <li>▪ Enrollment rate of 70% of Welcome Baby client referrals as based on Select Home Visitation eligibility criteria</li> <li>▪ 90% of actively enrolled clients complete various assessments (e.g., Life Skills Progression, Patient Health Questionnaire for Depression Screening, Ages and Stages Questionnaires)</li> <li>▪ 80% of target children are linked to a medical home, with at least 80% of target children being up-to-date with their immunizations</li> </ul>
<b>Baseline</b>	HFA represents one home visitation component of Best Start. Best Start is 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 universal home visitation services.
<b>Intervention Strategy for Achieving Goals</b>	Utilizing a client-centered, strength-based approach, delivery of engagement points (i.e., up to five years postpartum) occurs via home visitation by trained home visitors.
<b>Result FY 2014</b>	Launch of the HFA program (and subsequent enrollment of eligible clients) occurred in the next fiscal year. During the 2013-2014 fiscal year, the following ramp-up activities occurred: <ul style="list-style-type: none"> <li>▪ Hiring of HFA staff;</li> <li>▪ Training of hired HFA staff by the Oversight Entity and through other appropriate avenues; and</li> <li>▪ Convening of HFA staff with other community-based organizations also implementing the HFA program within the Long Beach and Wilmington region.</li> </ul>
<b>Hospital's Contribution/ Program Expense</b>	\$219,432 grant award
<b>FY 2015</b>	
<b>Goals 2015</b>	HFA aims to achieve the following goals: <ul style="list-style-type: none"> <li>▪ Goal 1: Cultivate and strengthen nurturing parent-child relationships</li> <li>▪ Goal 2: Promote healthy growth and development for children</li> <li>▪ Goal 3: Enhance family functioning by reducing risk and promoting protective factors</li> </ul>
<b>2015 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>▪ Establishment of a HFA Community Advisory Board</li> <li>▪ Enrollment rate of 70% of Welcome Baby client referrals as based on Select Home Visitation eligibility criteria</li> <li>▪ 90% of actively enrolled clients complete various assessments (e.g., Life Skills Progression, Patient Health Questionnaire for Depression Screening, Ages and Stages Questionnaires)</li> <li>▪ 80% of target children are linked to a medical home, with at least 80% of target children being up-to-date with their immunizations</li> </ul>
<b>Baseline</b>	HFA represents one home visitation component of Best Start. Best Start is 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 universal home visitation services.
<b>Intervention Strategy for Achieving Goal</b>	Utilizing a client-centered, strength-based approach, delivery of engagement points (i.e., up to five years postpartum) occurs via home visitation by trained home visitors.
<b>Community Benefit Category</b>	Health Care Support Services

<b>Families in Good Health: Integrated Network for Cambodians (INC)</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>X Access to Health Care Resources</li> <li><input type="checkbox"/> Prenatal Care/Teen Pregnancy/Low Birth Rate</li> <li>X Chronic Conditions</li> <li><input type="checkbox"/> Obesity among children</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> <li><input type="checkbox"/> Collaborative Governance</li> </ul>
<b>Link to Community Needs Assessment</b>	<ul style="list-style-type: none"> <li>▪ Access to care for chronic conditions with an emphasis on vulnerable communities in the greater Long Beach area, including the following: Southeast Asian (i.e., Khmer, Lao), teens, seniors, women and children</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>Integrated Network for Cambodians (INC) is funded through a subcontract from Pacific Asian Counseling Services to facilitate comprehensive, integrated health care services for Cambodian community members who present with a mental health condition and either a chronic condition or substance abuse. INC is one demonstration project implemented through the Los Angeles County Department of Mental Health's Community-Designed Integrated Service Management Model.</p>
<b>FY 2014</b>	
<b>Goals FY 2014</b>	<p>The primary goal of INC is to outreach to, educate and navigate eligible Cambodian clients to appropriate medical and behavioral health care services. To qualify, clients must present with co-occurring conditions – i.e., mental health/chronic condition or mental health/substance abuse.</p>
<b>2014 Objectives Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>▪ Outreach and engagement through existing avenues of access to Cambodian male youth and older adults</li> <li>▪ Outreach and engagement through existing connections with ethnic media, mailing and social marketing</li> <li>▪ Support of enrolled clients with medical and behavioral diagnoses so that clients can be better educated about their chronic conditions and medication requirements</li> <li>▪ Delivery of navigation services to enable Cambodian clients to access medical and behavioral health services (including enrollment in health care coverage)</li> </ul>
<b>Baseline</b>	<p>There is a demonstrated need to provide culturally appropriate support and patient navigation for Cambodian clients needing access to comprehensive medical and behavioral health services, particularly as mental health can be a culturally stigmatizing issue amongst families.</p>
<b>Intervention Strategy for Achieving Goals</b>	<p>Engagement of prospective clients occurs through approaches such as the following: (1) Home visitation; (2) Outreach at appropriate community venues; (3) Referral from other Families in Good Health grant programs (including the Educated Men with Meaningful Messages male youth program.)</p>
<b>Result FY 2014</b>	<ul style="list-style-type: none"> <li>▪ Conducted outreach and education to at least 1,164 individuals, of which at least 440 lacked health insurance coverage at the point of contact</li> </ul>
<b>Hospital's Contribution/ Program Expense</b>	<p>\$57,000 grant award</p>
<b>FY 2015</b>	
<b>Goals 2015</b>	<p>The primary goal of INC is to outreach to, educate and navigate eligible Cambodian clients to appropriate medical and behavioral health care services. To qualify, clients must present with co-occurring conditions – i.e., mental health/chronic condition or mental health/substance abuse.</p>
<b>2015 Objective Measure/ Indicator of Success</b>	<ul style="list-style-type: none"> <li>▪ Outreach and engagement through existing avenues of access to Cambodian male youth and older adults</li> </ul>

	<ul style="list-style-type: none"> <li>▪ Outreach and engagement through existing connections with ethnic media, mailing and social marketing</li> <li>▪ Support of enrolled clients with medical and behavioral diagnoses so that clients can be better educated about their chronic conditions and medication requirements</li> <li>▪ Delivery of navigation services to enable Cambodian clients to access medical and behavioral health services (including enrollment in health care coverage)</li> </ul>
<b>Baseline</b>	There is a demonstrated need to provide culturally appropriate support and patient navigation for Cambodian clients needing access to comprehensive medical and behavioral health services, particularly as mental health can be a culturally stigmatizing issue amongst families.
<b>Intervention Strategy for Achieving Goal</b>	Engagement of prospective clients occurs through approaches such as the following: (1) Home visitation; (2) Outreach at appropriate community venues; (3) Referral from other Families in Good Health grant programs (including the Educated Men with Meaningful Messages male youth program).
<b>Community Benefit Category</b>	Health Care Support Services
<b>Families in Good Health: Medi-Cal Expansion Program</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>X Access to Health Care Resources</li> <li><input type="checkbox"/> Prenatal Care/Teen Pregnancy/Low Birth Rate</li> <li><input type="checkbox"/> Chronic Conditions</li> <li><input type="checkbox"/> Obesity among children</li> </ul>
<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</li> <li><input checked="" type="checkbox"/> Build Community Capacity</li> <li><input type="checkbox"/> Collaborative Governance</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 Medi-Cal Expansion Program is funded through a subcontract from Asian Americans Advancing Justice-Los Angeles to facilitate outreach, education, enrollment and advocacy efforts around Covered California and Medi-Cal for families in the greater Long Beach area.
<b>FY 2014</b>	
<b>Goals FY 2014</b>	The goal of the Medi-Cal Expansion Program is to support outreach, education, enrollment and advocacy activities, to create a culture of health care coverage, and to strengthen community partnerships that result in improved access to health homes that support healthy behaviors for families in Long Beach and Wilmington.
<b>2014 Objectives Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>▪ Conduct outreach, education, enrollment and advocacy activities to reach target audiences through local cultural, faith-based, small business and social service networks at community events and through existing local networks. <ul style="list-style-type: none"> <li>○ Reach at least 2,600 contacts through one-on-one outreach and education and at various community venues.</li> <li>○ Reach at least 50 small business owners and their employees.</li> <li>○ Facilitate at least 24 small group presentations through existing local networks.</li> </ul> </li> <li>▪ Distribute culturally and linguistically appropriate outreach materials on Covered California, Medi-Cal to the public.</li> <li>▪ Provide input on health care reform implementation throughout the state, and conduct local, state and federal-level advocacy with relevant administrative agencies (as appropriate.)</li> </ul>

<b>Baseline</b>	With the implementation of the Patient Protection and Affordable Care Act, there is an urgent need to ensure that all eligible individuals and families are enrolled in health care coverage. Culturally appropriate outreach, education and advocacy become critical for the multiethnic families residing in Long Beach and Wilmington.
<b>Intervention Strategy for Achieving Goals</b>	Families in Good Health will target individuals and families in Long Beach and Wilmington through the following outreach and education approaches: (1) One-on-one, in-reach; (2) Ethnic small businesses, restaurants; (3) Health fairs, ethnic-specific community events; (4) Small groups through existing local community networks.
<b>Result FY 2014</b>	<ul style="list-style-type: none"> <li>▪ Completed enrollment in Covered California or Medi-Cal for at least 156 individuals</li> <li>▪ Assisted at least 51 individuals experiencing barriers to enrollment in Covered California or Medi-Cal</li> <li>▪ Conducted outreach to at least 158 individuals</li> </ul>
<b>Hospital's Contribution/ Program Expense</b>	\$30,000 grant award
<b>FY 2014-15</b>	
<b>Goals 2014-15</b>	The goal of the Medi-Cal Expansion Program is to support outreach, education, enrollment and advocacy activities, to create a culture of health care coverage, and to strengthen community partnerships that result in improved access to health homes that support healthy behaviors for families in Long Beach and Wilmington.
<b>2014-15 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>▪ Conduct outreach, education, enrollment, and advocacy activities to reach target audiences through local cultural, faith-based, small business and social service networks at community events and through existing local networks. <ul style="list-style-type: none"> <li>○ Reach at least 2,600 contacts through one-on-one outreach and education and at various community venues</li> <li>○ Reach at least 50 small business owners and their employees</li> <li>○ Facilitate at least 24 small group presentations through existing local networks</li> </ul> </li> <li>▪ Distribute culturally and linguistically appropriate outreach materials on Covered California, Medi-Cal to the public</li> <li>▪ Provide input on health care reform implementation throughout the state, and conduct local, state and federal-level advocacy with relevant administrative agencies (as appropriate)</li> </ul>
<b>Baseline</b>	With the implementation of the Patient Protection and Affordable Care Act, there is an urgent need to ensure that all eligible individuals and families are enrolled in health care coverage. Culturally appropriate outreach, education and advocacy become critical for the multiethnic families residing in Long Beach and Wilmington.
<b>Intervention Strategy for Achieving Goal</b>	Families in Good Health will target individuals and families in Long Beach and Wilmington through the following outreach and education approaches: (1) One-on-one, in-reach; (2) Ethnic small businesses, restaurants; (3) Health fairs, ethnic community events; (4) Small groups through existing local community networks.
<b>Community Benefit Category</b>	Health Care Support Services
<b>Families in Good Health: United in Health</b>	
<b>Hospital CB Priority Areas</b>	X Access to Health Care Resources <input type="checkbox"/> Prenatal Care/Teen Pregnancy/Low Birth Rate <input type="checkbox"/> Chronic Conditions <input type="checkbox"/> Obesity among children

<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 in 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 2014</b>	
<b>Goals FY 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 Objectives Measure/Indicator of Success</b>	Program objectives are as follows: <ul style="list-style-type: none"> <li>▪ Establish four 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 Farmers 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 Goals</b>	<ul style="list-style-type: none"> <li>▪ Identify and establish relationships with project partners prior to executing Memoranda of Understanding</li> <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 2014</b>	<ul style="list-style-type: none"> <li>▪ Collaborated with LA Care and local child care centers to develop a tailored curriculum around implementation of the Let's Move Childcare campaign</li> <li>▪ Identified and collaborated with four community sites for implementation of the evidence-based Chronic Disease Self Management Program in Spanish (i.e., Tomando Control de Su Salud)</li> <li>▪ Collaborated with the Wilmington Healthy Eating Task Force to facilitate the development of a local farmers market, utilizing community-driven approaches</li> </ul>
<b>Hospital's Contribution/ Program Expense</b>	\$162,719 grant award (October 2013-September 2014)

<b>FY 2015</b>	
<b>Goals 2015</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>2015 Objective Measure/Indicator of Success</b>	<p>Program objectives are as follows:</p> <ul style="list-style-type: none"> <li>▪ Establish four 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 Farmers 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>	Community Health Education; Community Building/Coalition Building

<b>Families in Good Health: Welcome Baby (WB)</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>X Access to Health Care Resources</li> <li>X Prenatal Care/Teen Pregnancy/Low Birth Rate</li> <li><input type="checkbox"/> Chronic Conditions</li> <li><input type="checkbox"/> Obesity among children</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> <li><input type="checkbox"/> Collaborative Governance</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>	<p>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 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.</p>

<b>FY 2014</b>	
<b>Goals FY 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 Objectives 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> <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>	<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 Goals</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 2014</b>	<p>Launch of the Welcome Baby program occurred in October 2013, with prospective clients being eligible for enrollment by that time.</p> <ul style="list-style-type: none"> <li>▪ At least 445 clients were enrolled in the Welcome Baby program (with over 40% being enrolled prenatally, and nearly 60% postpartum)</li> <li>▪ The majority of enrolled clients are Latino (i.e., over 60%)</li> </ul> <p>(Comprehensive reporting on the identified objectives was unavailable due to the ongoing development of the Stronger Families Database, which gathers relevant information for reporting.)</p>
<b>Hospital's Contribution/ Program Expense</b>	<p>\$1,585,524 grant award</p>
<b>FY 2015</b>	
<b>Goals 2015</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> </ul>

	<ul style="list-style-type: none"> <li>▪ Goal 7: Create or enhance existing linkages with social service, educational and healthcare agencies to obtain needed services</li> </ul>
<b>2015 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> <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>	<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>Community Benefit Category</b>	A3. Health Care Support Services

<b>St. Mary Medical Center Disaster Resource Center (DRC)</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>X Access to Health Care Resources</li> <li><input type="checkbox"/> Prenatal Care/Teen Pregnancy/Low Birth Rate</li> <li><input type="checkbox"/> Chronic Conditions</li> <li><input type="checkbox"/> Obesity among children</li> </ul>
<b>Program Emphasis</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Disproportionate Unmet Health-Related Needs</li> <li><input type="checkbox"/> Primary Prevention</li> <li><input type="checkbox"/> Seamless Continuum of Care</li> <li>X Build Community Capacity</li> <li><input type="checkbox"/> Collaborative Governance</li> </ul>
<b>Link to Community Needs Assessment</b>	<p>Access to health care resources during a time of disaster is vitally important for the community.</p>
<b>Program Description</b>	<p>St. Mary Medical Center is designated as a Disaster Resource Center by Los Angeles County EMS Agency. The hospital is designated to store disaster materials and be the coordinator of any disaster related issues in the immediate area. The hospital participates in planning area disaster fairs and drills.</p> <p>Mitigation and preparedness are the key goals of the Disaster Resource Center of St. Mary Medical Center in Long Beach, California. Due to its prime location as a high-risk Tier 1 terrorism alert area, this geographically-focused disaster center coordinates stockpiling of equipment, pharmaceutical caches, and provides education, training and disaster drills for the community. The DRC was founded in 2002 and continues to work with the Long Beach area to assist communities in being better disaster prepared.</p> <p>In the event of a large-scale chemical, biological, radiological, nuclear or explosive/incendiary device, pandemic or mass casualty trauma patients will require coordinated and organized triage and treatment. Designing surge capacity plans and healthcare capabilities to address mass casualties is a daunting task. St. Mary Medical Center is one of the eleven Los Angeles County Disaster Resource Centers. LA County is a direct recipient of Health Resources</p>

Services Administration (HRSA) grant funding through the National Bioterrorism Hospital Preparedness Program (NBHPP). The mission of the St. Mary Medical Center Disaster Resource Center is to ready local Long Beach area hospitals to deliver coordinated care to victims of terrorism and other disaster related emergencies.

The function of the DRC at St. Mary Medical Center is to coordinate, plan and implement effective regional disaster response for the Long Beach community. The DRC stockpiles disaster supplies, houses portions of the CDC Strategic National Stockpile and other pharmaceutical caches, and provides education for neighboring community partners on hospital incident command, mass casualty triage, hospital coordination and disaster management.

St. Mary Medical Center DRC collaborates, meets and drills with its neighboring umbrella hospitals and agencies at least quarterly:

- Long Beach Memorial Medical Center/Miller Children Hospital
- The Veteran's Administration Hospital, Long Beach
- Tri City Regional Medical Center
- Avalon Municipal Hospital, Catalina Island
- Community Hospital Long Beach
- Kaiser Foundation Downey
- Lakewood Regional Medical Center
- College Hospital Medical Center
- The Children's Clinics

The St. Mary Medical Center DRC implements disaster plans, provides educational services and consults with its surrounding community partner agencies. The DRC works with The Long Beach Emergency Operations Command (EOC) Center/ Long Beach Fire Department Disaster Management Division and holds a seat and plays an active role on the city wide EOC Disaster Committee. As the paramedic base station of Long Beach, St. Mary Medical Center also hosts paramedic and fire education symposiums for pre-hospital and first responder agencies. St. Mary coordinates disaster fairs and safety fairs for the community on an annual basis.

St. Mary Medical Center DRC also networks with local agencies that sit on the EOC: American Red Cross, Long Beach Unified School District, City of Long Beach Department of Parks Recreation and Marine, Long Beach Water Department, Long Beach Gas and Oil, City of Long Beach, Harbor Department Port of Long Beach, The Aquarium of the Pacific, Long Beach Police Department and it's Homeland Security Division, The Queen Mary, Long Beach Fire CERT, as well as the Los Angeles County Medic Alert Center and the California Emergency Medical Services Agency Authority.

The City of Long Beach has its own Public Health Department so the DRC works along with the health professionals of the Long Beach Department of Health and Human Services to coordinate emergency management activities, tabletop exercises and disaster drills. Pandemic planning is done by the DRC and public health agency and point of distribution pharmaceutical planning is done in conjunction with Department of Health and Human Services, the Center for Disease Control with the DRC as a point of distribution and coordinating resource.

Hazardous materials training for health care providers is a key function of the DRC. Mass decontamination awareness and operational training is offered on the campus of the DRC. State of the art decontamination equipment and a trailer capable of decontaminating fifty ambulatory and non-ambulatory victims is

	<p>maintained in a ready state at St. Mary Medical Center. Donning and doffing first responder training is done at the DRC for all health care workers and hospital employees to address immediate needs of disaster victims.</p> <p>Multiagency drills are a focus of the DRC. Every year the Dignity Health SMMC DRC coordinates large scale mass casualty drills in the community as well as the Triennial Long Beach Airport Drill.</p> <p>Disaster education is a primary mission of the St. Mary Medical Center Disaster Resource Center. Monthly the physicians of the house staff are trained and educated at noon conference on disaster topics of Chemical/Biological/Radiological/Pandemic/Active Shooter and START Triage. St. Mary Medical Center as a trauma center and DRC is an active advocate of preparing the entire community of Long Beach to be a disaster prepared neighborhood.</p>
<b>FY 2014</b>	
<b>Goals FY 2014</b>	The Goal for 2014 was to continue education and training to all staff, neighborhoods, and the public on emergency management.
<b>2014 Objectives Measure/Indicator of Success</b>	Rosters are maintained for all drills, education programs, safety fairs and disaster fairs in the public sector.
<b>Baseline</b>	We are the closest trauma center to the Port of Long Beach and a Major Disaster hospital for the area so we focus on disaster management for the Long Beach area.
<b>Intervention Strategy for Achieving Goals</b>	Safety Fairs, Disaster Meetings, Disaster trainings, decontamination drills, Long Beach Unity Festival taught 250 people how to make a disaster kit. Ready Long Beach 2014 will teach approximately 1000 citizens how to prepare for a disaster.
<b>Result FY 2014</b>	Long Beach is a better prepared neighborhood because the DRC exists at SMMC.
<b>Hospital's Contribution / Program Expense</b>	No hospital expense is put into the DRC program. The ASPER/HPP grant funds all salary, equipment, pharmaceutical caches, required by the HPP grant to continue with this program. \$435,152.
<b>FY 2015</b>	
<b>Goals 2015</b>	Continue with education, training and drills for the year 2014-2015
<b>2015 Objective Measure/Indicator of Success</b>	Rosters will be maintained for all classes, fairs, drills, training and educational symposiums that the DRC conducts for the year.
<b>Baseline</b>	St. Mary Medical Center prepares all surrounding agencies to be better prepared for disasters - natural or man-made.
<b>Intervention Strategy for Achieving Goal</b>	Continue with meetings, trainings and drills.
<b>Community Benefit Category</b>	Community Building: Community Support

332 St. Mary Medical Center Long Beach  
 Complete Summary - Classified Including Non Community Benefit (Medicare)  
 For period from 7/1/2013 through 6/30/2014  
 Expenses calculated using a clinical cost accounting system.

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses Revenues	
<b><u>Benefits for Living In Poverty</u></b>						
Financial Assistance	4,206	11,573,820	0	11,573,820	5.0	5.4
Medicaid	66,698	103,417,274	80,049,948	23,367,326	10.0	10.8
Means-Tested Programs	234,462	9,304,812	2,236,558	7,068,254	3.0	3.3
<b>Community Services</b>						
Community Health Improvement Services	47,449	5,025,167	2,633,439	2,391,728	1.0	1.1
Financial and In-Kind Contributions	63	1,117,195	0	1,117,195	0.5	0.5
<b>Totals for Community Services</b>	<b>47,512</b>	<b>6,142,362</b>	<b>2,633,439</b>	<b>3,508,923</b>	<b>1.5</b>	<b>1.6</b>
	<b>352,878</b>					
<b>Totals for Living In Poverty</b>		<b>130,438,268</b>	<b>84,919,945</b>	<b>45,518,323</b>	<b>19.5</b>	<b>21.0</b>
<b><u>Benefits for Broader Community</u></b>						
<b>Community Services</b>						
Community Building Activities	927	701,794	297,588	404,206	0.2	0.2
Community Health Improvement Services	1,538	0	0	0	0.0	0.0
Health Professions Education	205	7,871,348	1,763,138	6,108,210	2.6	2.8
Subsidized Health Services	1,427	20,114	0	20,114	0.0	0.0
<b>Totals for Community Services</b>	<b>4,097</b>	<b>8,593,256</b>	<b>2,060,726</b>	<b>6,532,530</b>	<b>2.8</b>	<b>3.0</b>
	<b>4,097</b>					
<b>Totals for Broader Community</b>		<b>8,593,256</b>	<b>2,060,726</b>	<b>6,532,530</b>	<b>2.8</b>	<b>3.0</b>
<b>Totals - Community Benefit</b>	<b>356,975</b>	<b>139,031,524</b>	<b>86,980,671</b>	<b>52,050,853</b>	<b>22.3</b>	<b>24.1</b>
<b>Medicare</b>	<b>16,829</b>	<b>53,284,348</b>	<b>45,218,994</b>	<b>8,065,354</b>	<b>3.5</b>	<b>3.7</b>
<b>Totals with Medicare</b>	<b>373,804</b>	<b>192,315,872</b>	<b>132,199,665</b>	<b>60,116,207</b>	<b>25.8</b>	<b>27.8</b>
<b>Totals Including Medicare</b>	<b>373,804</b>	<b>192,315,872</b>	<b>132,199,665</b>	<b>60,116,207</b>	<b>25.8</b>	<b>27.8</b>

 10/10/14  
 Harold F. Way, VP Chief Financial Officer

## Telling the Story

The final version of the 2014 Community Benefit Report and 2015 Plan will be made available to our Community Board members and hospital leadership. Information will also be shared with 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. It is also posted on the Dignity Health website at <http://www.dignityhealth.org>.

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:

Blackwell/Spencer Cancer Center	Long Beach Emergency Medical Care System (LBEMCS)
Commission on Cancer approved Community Hospital Comprehensive Cancer Program with a 3-year accreditation with commendations including a Cancer Registry	Low Vision Center
C.A.R.E.(Comprehensive AIDS Resources and Education) Program: CARE Clinic, CARE Dental Clinic, CARE Family Services Program	Mary Hilton Family Center: St. Mary OB Clinic; St. Mary Antenatal Clinic (Perinatology—High Risk Obstetrics) St. Mary Pediatric Clinic
Cardiac Rehabilitation Clinic	Medi-Cal Assistance
Cardiac Cath Lab	Medical Library
Cardiac Care	Neurodiagnostics
Center for Surgical Treatment of Obesity	Neonatal Intensive Care Unit (NICU)
Charity Care Assessment: Financial Assistance Applications	American Academy of Pediatric (AAP) Level IIIB-25 beds
Chemotherapy	Newborn Nursery
Childbirth Services “Life Begins Here”	Orthopedics
Community Education	Palliative Care
American Diabetes Association Certified Outpatient Diabetes Program	Passages: Geropsych Outpatient Pediatrics, California Children’s Services approved Community level
Disaster Resource Center	Perinatal Center (Antenatal Clinic)
Echography Lab	Physician Referral Services
Emergency Medical Services	Professional Education for nurses and other allied health professionals
Emergency Department Approved for Pediatrics (EDAP)	Radiation Oncology
Emergency Department—Base Station for the City of Long Beach	Radiology including ultrasound
Emergency Department “Rapid Triage” for non-emergent cases	Rehabilitation Services including Physical & Occupational Therapies
Endoscopy	Respiratory Care and Pulmonary Lab including Bronchoscopy Lab
Every Woman Counts --Breast Center- Breast Cancer Early Detection Program (BCEDP) participant	Speech Pathology
Families in Good Health (FiGH) including the Best Babies Collaborative (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	Spiritual Care Services
Graduate Medical Education	STEMI (ST-Elevation Myocardial Infarction) Center
Intensive Care Unit—24 beds	Stroke Center, certified by Joint Commission
John E. Parr Health Enhancement Center	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
	Wellness Center including the Senior Center and Senior Connections
	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.

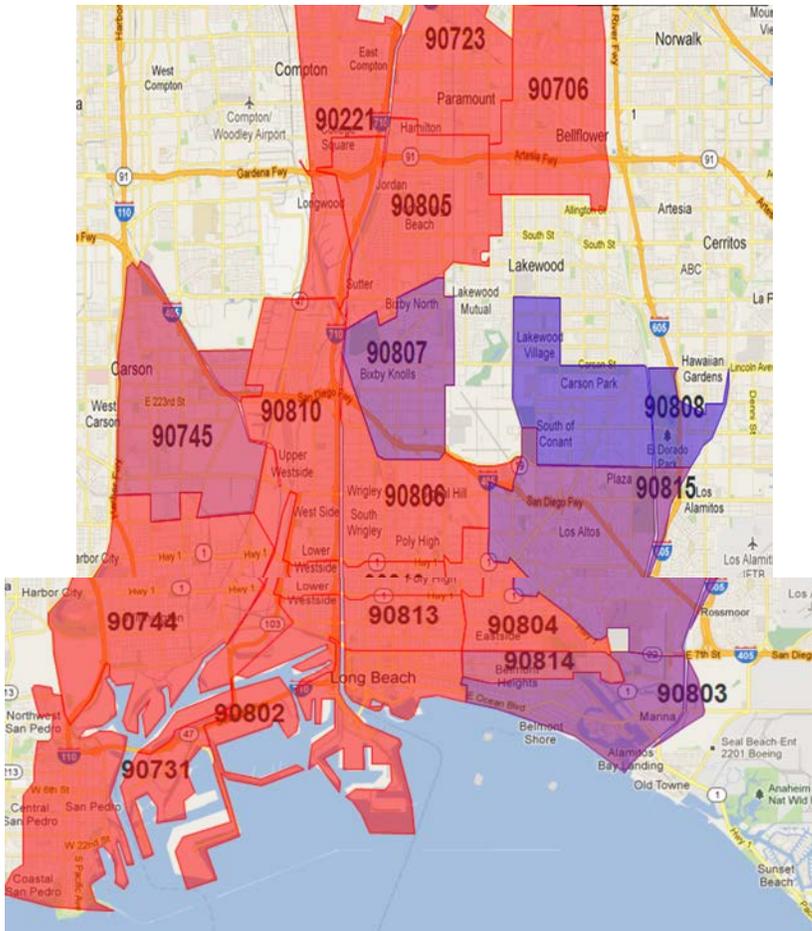
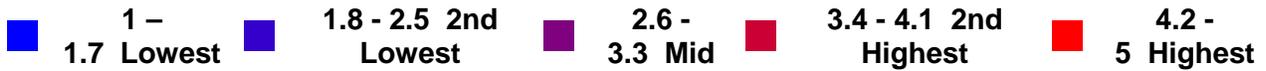
## Addendum B

### 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**



## **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  
Suny Lay Chang, Community Member  
Chester Choi, M.D., Staff Physician  
M. Hadi Emamian, M.D., Staff Physician  
Ivy A. Goolsby, Community Member  
Sr. Elizabeth Ann Hayes, CCVI, Sponsor  
Bernita McTernan, VP, Dignity Health  
Allen Miller, Community Member

Sr. Christina Murphy, CCVI, Sponsor  
Eloy O. Oakley, Community Member  
Daniel O'Callaghan, **Chair**  
Christopher Pook, Community Member  
Thomas Salerno, SMMC President/CEO  
Shelly Schlenker, VP, Dignity Health  
Bertram Sohl, M.D., Chief of Staff  
Robert Waestman, Community Member  
Mike Walter, SMMC Foundation Chair

### **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)

Kit Katz, Bazzeni Wellness Center  
Tiffany Cantrell, SMMC Foundation  
Janaya Nichols, SMMC Foundation