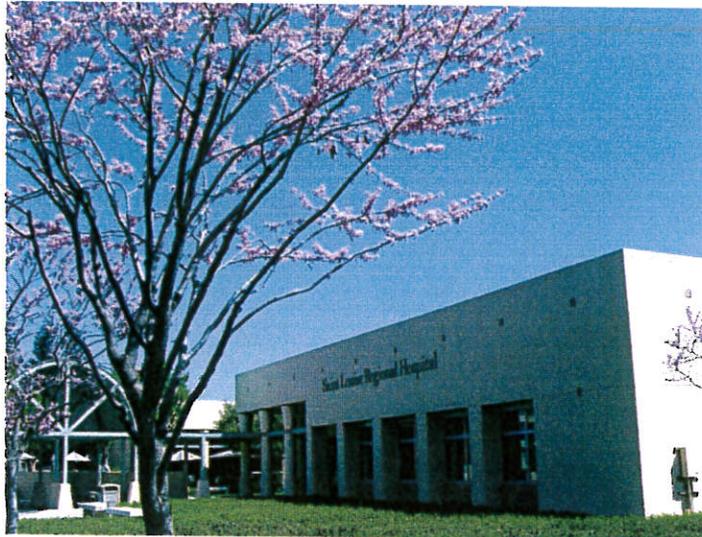




Saint Louis Regional Hospital



Community Benefit Report and Plan

2014-2015

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SAINT LOUISE REGIONAL HOSPITAL: OVERVIEW

Saint Louise Regional Hospital, a California nonprofit religious corporation, is a 93 bed acute care hospital in Gilroy, CA which serves South Santa Clara County and North San Benito County including the cities of Morgan Hill, Gilroy, and Hollister and the towns of San Martin and San Juan Bautista. Our community is determined by the patient base. Saint Louise Regional Hospital is the largest hospital serving these communities with only one other small hospital in our service area. Currently we also operate an Urgent Care Center on our Morgan Hill campus: De Paul Health Center. We believe our Catholic-sponsored, not-for-profit hospital plays a vital role in continuing to emphasize high quality, compassionate service to the underserved in this changing, challenging environment. The hospital has served the community since 1989, under sponsorship of the Daughters of Charity of St. Vincent de Paul.

Saint Louise Regional Hospital provides the only emergency services within 20 miles, is a Certified Stroke Center and has diagnostic services, ICU, general medical surgical services including pediatrics and OB services. A Calstar emergency helicopter transport is based on our premises. Saint Louise also provides the latest minimally invasive surgical procedures available today; general medicine covering specialties that are not often seen in a small community hospital; maternal and child health services; wound care and hyperbaric medicine with two hyperbaric oxygen chambers on site; stroke and a telemedicine program; physician referral services; and support groups. The hospital's Breast Care Center provides mammography and advanced methods of cancer detection. Bone density screening is also available at the Breast Care Center.

About Saint Louise Regional Hospital Community Benefits

In fiscal year 2014, Saint Louise Regional Hospital provided over 2 million dollars in Charity Care for 1507 persons and over 8.5 million dollars in services to 10,461 persons on MediCal.

The Health Benefits Resource Center provides a one stop service center for low cost health insurance enrollment for children and adults. The Center also provides referrals to Santa Clara Valley Medical Center Specialty clinics when ongoing medical care is needed.

Saint Louise Regional Hospital provides free individual and group classes and support groups in English and Spanish for persons with diabetes and their families. Scholarships for Childbirth Education are provided as needed. Breastfeeding support is provided in English and Spanish. Support Groups: Bereavement, Essential Tremors, NAMI, Surgical Weight Loss; are available to anyone in the community.

Health screenings are provided at a variety of locations and businesses. Sponsorship of Community Health events such as the Gilroy Community Health Day is ongoing. In addition, SLRH participates in other community events such as the Mushroom Mardi Gras and Taste of Morgan Hill providing first aid services. SLRH also sponsors many community events related to health and wellness such as the "Run for Fitness" for Gilroy Unified School District; the St. Mary's School Walk-a-thon in Gilroy and the St Catherine's School Walk-a-thon in Morgan Hill.

Saint Louise Regional Hospital uses the Lyon Software Community Benefit Inventory for Social Accountability tool to evaluate its community benefit work. With this program we are continually improving the data input to provide more precise and accurate reporting to our board, associates, and community.

Social accountability budgeting, reporting and oversight for implementation of community benefit activities are the responsibility of the President and CEO of Saint Louise Regional Hospital, as well as the Director of Community Health, along with the input and support of senior leadership. The Board of Directors is responsible for approving the Community Benefit Report and Plan annually and reviewing the quarterly reports for the purpose of suggesting changes or improvements as appropriate. Additionally, the quarterly and annual reports and plans are reviewed by the Internal and External Community Benefit Committees.

Mission

The hospital operates with the Mission statement and Vincentian Values of the Daughters of Charity Health System.

In the spirit of our founders, St. Vincent de Paul, St. Louise de Marillac, and St. Elizabeth Ann Seton, the Daughters of Charity Health System is committed to serving the sick and the poor. With Jesus Christ as our model, we advance and strengthen the healing mission of the Catholic Church by providing comprehensive, excellent healthcare that is compassionate and attentive to the whole person; body, mind, and spirit. We promote healthy families, responsible stewardship of the environment, and a just society through value-based relationships and community-based collaboration.

Vincenian Values

Our values are based on those of Saint Vincent de Paul and thereby called Vincentian.

The Charity of Christ urges us to:

- **Respect:** Recognizing our own value and the value of others
- **Compassionate Service:** Providing excellent care with gentleness and kindness
- **Simplicity:** Acting with integrity, clarity and honesty
- **Advocacy for the Poor:** Supporting those who lack resources for a healthy life and full human development
- **Inventiveness to Infinity:** Being continuously resourceful and creative.

Vision Statement

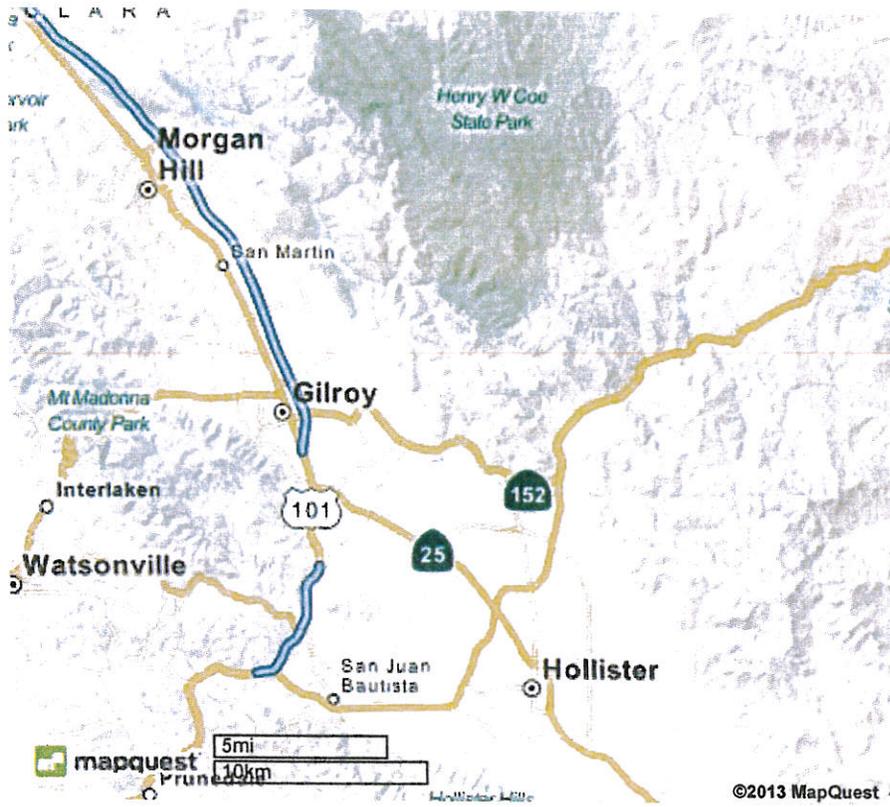
In the context of our Mission and Vincentian Values, Saint Louise Regional Hospital is to be the center for health and healing for our communities and to nurture the spiritual and physical well being of all.

Demographic Profile of Community Served

Data	<u>Gilroy</u>	<u>Morgan Hill</u>	<u>Hollister</u>	<u>San Juan Bautista</u>	<u>San Martin</u>
Total Population	48821	37882	34928	1862	7027
% Hispanic	57.8%	34%	65.7%	48.7%	46.2%
Language at home – other than English	38.7%	22.3%	46.4%	21.8%	30.5%
Median Age	32.4	36.8	30.8	38.7	38.5
Educational Attainment: less than 9 th grade	12.6%	6.4%	18.5%	8.3%	12.9%
Educational Attainment 9 th - 12 th grade – no diploma	10.4%	7.3%	11.6%	1.2%	12.4%
Unemployment	10.9%	9.3%	11.7%	11.5%	13.0%
Income under \$50,000/year	35%	26.3%	38.8%	41.3%	28.1%
Median Household Income	\$ 75,483	\$ 94,301	\$ 62,570	\$ 56,897	\$77,188
% above 30% total income spent on rent	55.7%	59%	60.4%	54.3%	42.4%
% of renters	37.9%	25.7%	40.8%	62.5%	24.5%
% of people living under Federal Poverty Level	11.0%	11.0%	13.2%	13.4%	11.9%

Source: American Fact Finder – American Community Survey 2007 - 2011

Map of Community Served by Hospital Facility



Saint Louise Regional Hospital Priority-Setting Process 2013 - 2014

The CHNA of Santa Clara County provided the basis of the priority setting process for the Saint Louise Regional Hospital Community Benefit Plan for 2013 -2014. We were active participants in the Santa Clara Community Benefits Coalition responsible for the preparation of the Santa Clara County Community Health Needs Assessment.

SLRH has a Master Site Planning document which has had input from many local community leaders. Senior leadership and department directors participate in reviewing and approving the quarterly data collection of benefits provided to the community through our charity care program and other community services. An External Community Benefit Advisory Committee has reviewed and approved the identified priorities.

Participation in local and county wide collaboratives also provides input in our planning process. The collaboratives include the following: South County Collaborative, Nutrition and Health Sub-Committee, and the Board of Directors of the South County Collaborative. Additionally various members of senior leadership participate on local Chambers of Commerce, Rotary Clubs and the Gilroy Economic Development Corporation.

This year, we have participated on the Leadership Teams of the Santa Clara Public Health Department's Community Transformation Grant and the Silicon Valley YMCA's REACH grant. Additionally, we have provided input into the Santa Clara County Public Health Department's Community Health Assessment.

Health Screenings are provided at various locations: the Learning and Loving Center in Morgan Hill, the Gilroy Community Health Day, community events at Arteaga's Super Market in Gilroy, the Senior Centers in Morgan Hill and Gilroy as well as health fairs and several businesses who employ low income persons. Results of these screenings assist in the Priority Setting Process.

Saint Louise Regional Hospital Community Benefit Report Implementation Plan Quarterly Results: 2013 - 2014

Diabetes Goal:

To provide culturally sensitive Diabetes Education based on the Self-Management Behaviors of the American Association of Diabetes Educators.

Objectives	Strategies	Outcome Indicators	Results: Q1	Results: Q2	Results: Q3	Results: Q4
1) To provide Diabetes Education, based on the Self-Management Behaviors of the American Association of Diabetes Educators, in a culturally sensitive manner to those admitted to Saint Louise Regional Hospital and/or identified as having diagnosis of diabetes.	1) Schedule classes in English and Spanish at a variety of times and places during the week to accommodate various schedules.	1) Provide Diabetes Education to 80% of those identified.	100% of those identified have received follow-up and educational support.	92% of those identified have received follow-up and educational support.	100% of those identified have received follow-up and educational support.	97% of those identified have received follow-up and educational support.
2) To increase client knowledge of Diabetes Self-Management.	2) Obtain a Pre Test and Post Test to ascertain knowledge.	2) 80% will demonstrate knowledge increase.	80% have had knowledge increase.	100% have had knowledge increase.	100% have had knowledge increase.	100% have had knowledge increase.
3) To promote behavior change related to Diabetes Self-Management.	3) Follow up evaluation after 3 months to ascertain behavior change in nutritional intake and blood glucose levels.	3) 80% will report behavior change related to Diabetes Self-Management.	68% have reported behavior change as a result of attending classes.	78% have reported behavior change as a result of attending classes.	93% have reported behavior change as a result of attending classes.	79% have reported behavior change as a result of attending classes.

4) To provide screenings for diabetes in the community and follow up of those identified as having diabetes or at risk for having diabetes.	4) Assure that client is aware the follow up will occur and obtain phone number.	4) 80% will receive follow up after screening reveals need.	124 persons were screened for diabetes. 100% followed up with their physician.	175 persons were screened for diabetes. 100% followed up with their physicians.	163 persons were screened for diabetes. 93% followed up with their physicians. Some do not have physicians.	215 persons were screened for diabetes. 100% followed up with their physicians.
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Additional Data: Outreach Risk assessments were provided to 110 persons. Of those, 61 were identified as "having diabetes" and 39 were identified as "At Risk". A total of 187 persons received education related to diabetes either in English or Spanish.

Obesity Goal:

To reduce the rates of obesity in our service area.

Objectives	Strategies	Outcome Indicators	Results: Q1	Results: Q2	Results: Q3	Results: Q4
1) To schedule the series of 10 Healthy Nutrition Classes in English and Spanish.	1) Schedule the series of Healthy Nutrition Classes in a variety of locations and times.	1) 50% of those identified as overweight and/or obese will show 1% - 3% reduction in BMI after attending classes.	These programs are being provided by the SV YMCA based on a REACH grant obtained after the Implementation Plan was developed.	These programs are being provided by the SV YMCA based on a REACH grant obtained after the Implementation Plan was developed.	These programs are being provided by the SV YMCA based on a REACH grant obtained after the Implementation Plan was developed.	These programs are being provided by the SV YMCA based on a REACH grant obtained after the Implementation Plan was developed.
2) To increase client understanding of Healthy Nutrition.	2) Provide Pre Test and Post Test at each session.	2) 80% will show knowledge increase on Post Test.	YMCA as above (1)	8 persons have received Nutrition Education utilizing the "Plate Method" No pre/post test given.	56 persons have received Nutrition Education utilizing the "Plate Method" No pre/post test given.	111 persons have received Nutrition Education utilizing the "Plate Method" No pre/post test given.
3) To provide screenings for BMI at beginning and end of each Healthy Nutrition Class series.	3) Determine BMI at beginning and end of each series.	3) 80% will receive follow up if need indicates.	As above (1)	As above (1)	As above (1)	As above (1)
4) To provide BMI screenings at health events and to provide information regarding	4) Assure that those persons identified at health events as overweight and/or obese		No BMI screenings were done during this time.	BMI Screenings were provided by the SVYMCA and data was not collected as requested.	No BMI Screenings were completed during this quarter.	No BMI Screenings were completed during this quarter.

Healthy Nutrition Classes to those identified as overweight and/or obese.	are aware that follow up will occur and obtain phone number.					
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Cardiovascular Disease, Heart Attack, and Stroke Goal:

To increase the number of people who know they have hypertension and/or high cholesterol, take their medication correctly and understand the signs and symptoms of a stroke and what to do if the symptoms occur.

Objectives	Strategies	Outcome Indicators	Results: Q1	Results: Q2	Results: Q3	Results: Q4
1) To provide screenings for hypertension and cholesterol in the community and follow up of those identified with hypertension and/or high cholesterol.	1) Provide screenings at health events.	500 persons will be screened. 80% will receive follow up if the need indicates.	114 persons were screened for hypertension, 119 persons were screened for cholesterol. 100% followed up with their MD.	289 persons were screened for hypertension, 325 persons were screened for cholesterol. 100% followed up with their MD.	141 persons were screened for hypertension. 162 persons were screened for cholesterol. 100% followed up with their MD.	203 persons were screened for hypertension. 200 persons were screened for cholesterol. 100% followed up with their MD.
2) To provide community education re symptoms of stroke and what to do if the symptoms occur.	2) Provide education at Senior Centers and residences.	200 people will be educated.	No specific education was provided this quarter.	Fliers and information was given out to 700 persons.	Education was provided to 20 nursing students.	Education was provided to 70 persons at a health fair and 20 nursing students.
3) To provide community education re the importance of taking medications as prescribed and to notify physician if medication is not taken as ordered.			Side Effects of uncontrolled diabetes: hypertension, heart attack, and stroke are discussed during the diabetes classes and at all screening sessions. Additionally there is focus on taking medications as ordered.	Side Effects of uncontrolled diabetes: hypertension, heart attack, and stroke are discussed during the diabetes classes and at all screening sessions. Additionally there is focus on taking medications as ordered.	Side Effects of uncontrolled diabetes: hypertension, heart attack, and stroke are discussed during the diabetes classes and at all screening sessions. Additionally there is focus on taking medications as ordered.	Side Effects of uncontrolled diabetes: hypertension, heart attack, and stroke are discussed during the diabetes classes and at all screening sessions. Additionally there is focus on taking medications as ordered.

Cancers Goal:

To educate the community regarding the importance of screening for each cancer.

Objectives	Strategies	Outcome Indicators	Results: Q1	Results: Q2	Results: Q3	Results: Q4
1) To develop a flier for women and men related to recommended screenings for Pap Smears, Mammography, Lung, Colorectal, and Prostate.	1) Flier to be in English and Spanish with sufficient but minimal wording.		Fliers have been developed.	Fliers have been developed.	Fliers have been developed.	Fliers have been developed.
2) To distribute 5000 fliers at health events, educational sessions and to hospitalized patients.		5000 Fliers will have been distributed.	Fliers have been distributed on the Med/Surg unit and at all external events.	1000 fliers have been distributed on the Med/Surg unit and at all external events.	500 fliers were distributed at a Community Event and on the Med-Surg unit.	300 fliers were distributed at a Community Event and on the Med-.Surg unit
3) To promote our reduced cost for mammography screening during October.	Additional fliers related to mammography screening opportunities.		Fliers are present in the hospital and at external events.	Fliers are present in the hospital and at external events.	Fliers are present in the hospital and at external events.	Fliers are present in the hospital and at external events.

Respiratory Conditions Goal:

To promote smoke free environments in the communities we serve.

Objectives	Strategies	Outcome Indicators	Results: Q1	Results: Q2	Results: Q3	Results: Q4
1) To designate Saint Louis Regional Hospital as a smoke free campus.	1) To develop a policy related to being a smoke free campus at Saint Louis Regional Hospital.	1) Saint Louis Regional Hospital will be a designated smoke free campus.	In Process	Remains in process	Remains in process	Smoke free designation was adopted on April 8, 2014.
2) To support efforts of SCC-CTG grant to promote more smoke free environments.	2) Encourage persons with respiratory issues to speak out to City Council members	2) All parks in Gilroy will be designated as smoke free.	In process with SCCPHD	In process with SCCPHD	In process with SCCPHD	In process with SCCPHD.

	regarding the need for smoke free environments.					
3) To provide education regarding smoking cessation to clients who currently smoke.	3) Educate clients who smoke regarding smoking cessation programs available in their local area.	3) 80% of clients who smoke will receive educational information related to smoking cessation programs in their local area.	All patients receive information regarding smoking cessation.			

Access Goal:

To assist all those who come to Saint Louise Regional Hospital to obtain the insurance they qualify for or to assist in completing the Charity Care Application if necessary.

Objectives	Strategies	Outcome Indicators	Results: Q1	Results: Q2	Results: Q3	Results: Q4
To assist clients in completing all necessary application forms for MediCal, Healthy Kids, Kaiser Kids, Cal-Fresh, Valley Care, State Disability, and Covered CA.	Visit all inpatients without insurance and those in the emergency department that are under 21 years or over 65 years.	60% of those eligible will receive insurance or Financial Assistance.	85% of persons eligible received assistance.	81% of persons eligible received assistance.	44% of persons eligible received assistance. Many persons did not follow up as needed and many are still pending.	63% of persons eligible received assistance. Many (60%) persons did not follow up as needed despite continuing efforts to reach them.

2013 Santa Clara County Community Health Needs Assessment Overview

The 2013 Santa Clara County Community Health Needs Assessment was developed by the members of the Santa Clara County Community Benefit Coalition in collaboration with the Santa Clara County Public Health Department.

Health Needs were identified through Secondary Data Collection and Primary Data Collection which included Community Leader Input, Key Informant Interviews, Stakeholder Focus Groups and Resident Input. The focus was then narrowed to 12 Health Needs which were determined to be most significant.

The 12 Health Needs included:

1. Diabetes
2. Obesity
3. Violence
4. Poor Mental Health
5. Poor Oral/Dental Health
6. Cardiovascular Disease, Heart Disease and Stroke
7. Substance Abuse
8. Cancer
9. Respiratory Conditions
10. STD's/HIV – Aids
11. Birth Outcomes
12. Alzheimers Disease

A cross-cutting driver was identified as Access to Health Care.

Health Needs Profiles were then developed for each identified need. The status of each need is described in terms of:

- Key Indicators
- Key Drivers or Factors influencing the condition
- Community Input
- Assets available in the community

This document provides the basis for the Saint Louise Regional Hospital Community Benefit Implementation Plan for 2014 – 2015.

Saint Louise Regional Hospital Priority-Setting Process 2014 - 2015

The CHNA of Santa Clara County provides the basis of the priority setting process for the Saint Louise Regional Hospital Community Benefit Implementation Plan for 2014 -2015. We were active participants in the Santa Clara Community Benefits Coalition responsible for the preparation of the Santa Clara County Community Health Needs Assessment.

SLRH has a Master Site Planning document which has had input from many local community leaders. Senior leadership and department directors participate in reviewing and approving the quarterly data collection of benefits provided to the community through our charity care program and other community services. An External Community Benefit Advisory Committee has reviewed and approved the identified priorities.

Participation in local and county wide collaboratives also provides input in our planning process. The collaboratives include the following: South County Collaborative, Nutrition and Health Sub-Committee, and the Board of Directors of the South County Collaborative. Additionally various members of senior leadership participate on local Chambers of Commerce, Rotary Clubs and the Gilroy Economic Development Corporation.

This year, we continue to participate on the Leadership Team of the Santa Clara Public Health Department's Community Transformation Grant.

Health Screenings are provided at various locations: the Learning and Loving Center in Morgan Hill, the Gilroy Community Health Day, community events at Arteaga's Super Market in Gilroy, the Senior Centers in Morgan Hill and Gilroy as well as health fairs and several businesses who employ low income persons. Results of these screenings assist in the Priority Setting Process.

Saint Louise Regional Hospital Community Benefit Implementation Plan 2014 – 2015

The Saint Louise Regional Hospital Community Benefits Internal and External Committees reviewed the Santa Clara County Community Health Needs Assessment and incorporated input from those in Northern San Benito County as they are in our service area. The Saint Louise Regional Hospital Board of Directors approved the 2014 - 2015 Community Benefit Implementation Plan.

It was determined that we could not meet all 12 addressed Needs but could meet 5 of the Needs. What follows is the plan for the 5 Needs we will address and the list of those which we cannot address. Many of those Needs we are unable to address are being addressed in the CTG grant that are designed specifically for South Santa Clara County.

Community Needs that Saint Louise Regional Hospital Will Address

Diabetes

Goal: To provide culturally sensitive Diabetes Education based on the Self-Management Behaviors of the American Association of Diabetes Educators.

Objectives: 1) To provide Diabetes Education, based on the Self-Management Behaviors of the American Association of Diabetes Educators, in a culturally sensitive manner to those admitted to Saint Louise Regional Hospital and/or identified as having diagnosis of diabetes.

2) To increase client knowledge of Diabetes Self –Management.

3) To provide screenings for diabetes in the community.

Strategies: 1) Provide opportunity for classes at a variety of times and places during the week to accommodate various schedules.

2) Obtain a Pre Test and Post Test to ascertain knowledge.

3) To provide screenings in the community.

Outcome Indicators: 1) Provide Diabetes Education to 80% of those identified.

2) 80% of those educated will demonstrate knowledge increase.

3) 500 persons will be screened.

Collaboration: -San Benito Health Foundation Community Health Center in their efforts to assist persons with diabetes.

-Promote the ADA Diabetes Camp for Kids with Families in San Benito County .

Obesity

Goal: To reduce the rates of obesity in our service area.

Objective: 1) To increase client understanding of Healthy Nutrition.

2) To provide BMI screenings at health events and to provide information regarding Healthy Nutrition to those identified as overweight and/or obese.

Strategies: 1) Assure that those persons identified at health events as overweight and/or obese receive information regarding Healthy Nutrition options.

Outcome Indicators: 1) 100% will receive Healthy Nutrition Information.

Collaboration: Second Harvest Food Bank

San Benito Health Foundation Community Health Center: Farm to Table Project

Morgan Hill Senior Produce Market and Produce Carts

Santa Clara County Public Health Department: Rethink Your Drink and My Plate

Cardiovascular Disease, Heart Attack, and Stroke

Goal: To increase the number of people who know they have hypertension and/or high cholesterol, take their medication correctly and understand the signs and symptoms of a stroke and what to do if the symptoms occur.

Objectives: 1) To provide screenings for hypertension and cholesterol in the community.

2) To provide community education re symptoms of stroke and what to do if the symptoms occur.

3) To provide community education re the importance of taking medications as prescribed and to notify physician if medication is not taken as ordered.

Strategies: 1) Provide screenings at health events.

2) Provide education at Senior Centers and residences

Outcome Indicators: 1) 500 persons will be screened.

2) 200 people will be educated.

Collaboration: Senior Centers and Residences

Cancers

Goal: To educate the community regarding the importance of screening for each cancer.

Objectives: 1) To distribute 500 fliers related to cancer screening recommendations at health events, educational sessions and to hospitalized patients.

2) To promote our reduced cost for mammography screening during October.

Strategies: 1) Fliers are in English and Spanish and distributed in the hospital and at all community health events.

2) Fliers related to mammography screening opportunities are available throughout the hospital and at community health events.

Outcome Indicator: 500 Fliers will be distributed.

Collaboration: Latinas Contra Cancer

American Cancer Society

Respiratory Conditions

Goal: To promote smoke free environments in the communities we serve.

Objectives: 1) To maintain Saint Louise Regional Hospital as a smoke free campus.

2) To provide education regarding smoking cessation to clients who currently smoke.

3) To provide education and exercise for persons with Pulmonary Disease.

Strategies: 1) To continue to implement the policy related to being a smoke free campus at Saint Louise Regional Hospital.

2) Educate clients who smoke regarding smoking cessation programs available in their local area.

3) Encourage clients with pulmonary dysfunction to attend the Pulmonary Rehabilitation Program.

Outcome Indicators: 1) Saint Louise Regional Hospital will remain a designated smoke free campus.

2) 100% of clients who smoke will receive educational information related to smoking cessation programs in their local area.

3) 70% of clients will demonstrate improved quality of life as indicated by completion of the Health Survey for Pulmonary Rehabilitation Patients questionnaire.

Collaboration: Breathe CA
Santa Clara Public Health Department

Access

Goal: To assist all those who come to Saint Louise Regional Hospital to obtain the insurance they qualify for or to assist in completing the Charity Care Application if necessary.

Objective: To assist clients in completing all necessary application forms.

Strategy: Visit all inpatients without insurance and those in the emergency department that are under 21 years or over 65 years.

Outcome Indicator: 60% of those eligible will receive insurance or Charity Care.

Community Needs that Saint Louise Regional Hospital Will Not Address

Violence: This health need will not directly be addressed. This is due to lack of resources and there are other community organizations that provide services.

Mental Health: This health need will not directly be addressed. This is due to lack of resources and there are other community organizations that provide services.

Oral Health: This health need will not directly be addressed. This is due to lack of resources and we refer to other services in the area.

Substance Abuse: This health need will not directly be addressed. This is due to lack of resources and other organizations that focus on this.

STD'S: This health need will not directly be addressed. This is due to lack of resources and there are others who provide needed services.

Birth Outcomes: This health need will not be addressed as this need appears to be more localized in northern Santa Clara County. Low birth weight is being addressed through other hospitals monitoring their scheduled deliveries prior to 39 weeks gestation. There is more concern in our service area related to high birth weight due to the possibility of diabetes.

Alzheimer's: This need will not be directly addressed. This is due to lack of resources and the presence of persons from the Alzheimer's Association in South Santa Clara County.

Collaboration: Refer to Case Manager at Morgan Hill Senior Center.

8/31/2014

Saint Louise Regional Hospital

Complete Summary - Classified Including Non Community Benefit (Medicare and Bad Debt)

For period from 7/1/2013 through 6/30/2014

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses	Revenues
<u>Benefits for Living In Poverty</u>						
Financial Assistance	1,507	2,042,627	0	2,042,627	8.9	10.3
Medicaid	10,461	22,126,775	13,545,955	8,580,820	37.4	43.1
Community Services						
Cash and In-Kind Contributions	500	5,000	0	5,000	0.0	0.0
Community Health Improvement Servic	4,371	473,903	390,976	82,927	0.4	0.4
Totals for Community Services	4,871	478,903	390,976	87,927	0.4	0.4
Totals for Living In Poverty	16,839	24,648,305	13,936,931	10,711,374	46.6	53.8
<u>Benefits for Broader Community</u>						
Community Services						
Cash and In-Kind Contributions	10,327	63,327	37,542	25,785	0.1	0.1
Community Benefit Operations	0	113,189	0	113,189	0.5	0.6
Community Building Activities	3	371,300	0	371,300	1.6	1.9
Community Health Improvement Servic	4,987	63,972	0	63,972	0.3	0.3
Health Professions Education	102	72,178	0	72,178	0.3	0.4
Subsidized Health Services	0	3,329	0	3,329	0.0	0.0
Totals for Community Services	15,419	687,295	37,542	649,753	2.8	3.3
Totals for Broader Community	15,419	687,295	37,542	649,753	2.8	3.3
Totals - Community Benefit	32,258	25,335,600	13,974,473	11,361,127	49.5	57.0
Medicare	8,060	37,773,167	24,737,041	13,036,126	56.7	65.4
Totals with Medicare	40,318	63,108,767	38,711,514	24,397,253	106.2	122.5
Totals Including Medicare and Bad Del	40,318	63,108,767	38,711,514	24,397,253	106.2	122.5