



ST. JOSEPH HEALTH, ST. MARY

FY2018 -FY 2020 Community Benefit Plan/Implementation Strategy Report



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TABLE OF CONTENTS

EXECUTIVE SUMMARY	3
MISSION, VISION, AND VALUES	6
INTRODUCTION – WHO WE ARE AND WHY WE EXIST	6
ORGANIZATIONAL COMMITMENT	6
Community Benefit Governance and Management Structure	
PLANNING FOR THE UNINSURED AND UNDERINSURED	8
COMMUNITY	9
Definition of Community Served	
COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS	16
Summary of Community Needs, Assets, Assessment Process, and Results	
Identification and Selection of Significant Health Needs	
Community Health Needs Prioritized	
COMMUNITY BENEFIT PLAN	
Summary of Community Benefit Planning Process	30
Addressing the Needs of the Community: FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan	
Other Community Benefit Programs and Evaluation Plan	
GOVERNANCE APPROVAL	44

EXECUTIVE SUMMARY

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

Community Benefit is the cornerstone of who we are as a ministry of the Sisters of St. Joseph of Orange. We serve the dear neighbor and provide much needed services to our most vulnerable communities. Our programs include, but are not limited to: financial assistance/charity care for those needing acute and emergency care as well as initiatives providing fixed and mobile clinic care, health and wellness, advocacy and community building. The hospital's programs also serve the broader community to improve health and quality of life.

In response to unmet health-related needs identified from a 2017 Community Health Needs Assessment (CHNA), St. Joseph Health, St. Mary's 2018-2020 Community Benefit Plan will focus on three programs for the broader and underserved disadvantaged members of the surrounding community.

2018-2020 CB Plan Priorities/Implementation Strategies

After completing the CHNA using a prioritization process aligned with our mission, resources and hospital strategic plan, St. Joseph Health, St. Mary will focus on the following areas for its FY18-FY20 Community Benefit efforts:

1. ***Access to Health Services and Resources*** – we will improve access to health services for residents living in low income and rural communities with the goal of providing equitable care to all persons. Services will include, but not be limited to:
 - Provide increasing levels of primary and specialty care and health promotion services promoting longer lives free of preventable disease, disability, injury and premature death. Services will be provided using fixed and mobile clinics in communities lacking health services. In addition, services will be provided at partner locations including local churches, schools, supermarkets and cities with an emphasis on preventing disease and improving health.

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

- Meet a greater percentage of patients’ socio-economic needs including legal, housing, education and mental health care and, where possible, integrate these resources into clinical programs.
 - Strengthen neighborhood systems offering low-cost transportation, affordable housing, healthy and affordable foods, crime free neighborhoods and workforce and economic development. This work supports San Bernardino County’s county-wide health improvement plan and the identification of neighborhoods having significant socioeconomic barriers impacting health.
2. *Mental Health and Substance Abuse* – we will improve access to mental health services for those living in low income communities and across the region:
- Hospital leadership will engage in county and state level system reform initiatives and the local mental health system will better address the mental health and addiction care of the community. Building partnerships to improve mental health care will continue. A set of coordinated strategies will be implemented regionally by the hospital and public health partners. The effort seeks to standardize mental health services for those needing acute care. These efforts include assessments of acute care resources including psychiatric beds, crisis clinics, and outpatient services.
 - Community clinics will increase mental health services with a focus on depression and addiction care. Partnerships with mental health providers will be improved and, where possible, integrated into clinic services. Hospital partners will work to improve access by offering outpatient mental health services. Hospital partnerships will support integrating mental health care at addiction and recovery programs.
 - Develop support groups and education in partnership with local faith communities, mental health associations and providers will continue. Efforts to establish a local National Alliance for Mental Illness (NAMI) chapter offering Peer to Peer and Family to Family classes will continue. The hospital will begin co-sponsoring a local Mental Health conference raising local awareness to resources treating those seriously impacted by disease and addiction. Offering Mental Health First Aid Adult and Youth trainings will continue in partnership with schools and faith communities.
 - Efforts to address crime and gun violence will begin. Early work will identify partners and strategies including promising programs directed toward crime prevention. Efforts to influence legislation and the funding of prevention

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

programs will occur in partnership with law enforcement, faith communities, schools, and city governments.

3. ***Obesity/Child Wellness*** – we will expand nutrition and fitness campaigns across the region including in neighborhoods identified as having high rates of obesity. Efforts will continue treating diabetes utilizing hospital, clinic and partner programs. The hospital will continue its annual Living Well with Diabetes Expo which brings together physicians, diabetes educators and the public to learn about type 1 and type 2 diabetes care including workshops in Spanish. Finally, the hospital will engage in regional efforts lead by the Hospital Association of Southern California including “Communities Lifting Communities” and “Bridging for Health”. Each initiative plans to target obesity and diabetes and one “hot spot” has been identified in the high desert.

- Hospital partnerships with faith communities will expand a new “Faith-Health Initiative” focused on improved congregation health through nutrition education and physical activity. This work includes training faith staff to develop various health initiatives including clinical screenings, health education and physical fitness programs.
- Expansion of adult nutrition education and fitness campaigns will increase free exercise programs along with residents losing weight and self-reporting improved health status. Efforts will expand local weight loss challenges with community supporters. Residents will continue assessing targeted neighborhoods and identify strategies increasing access to healthy foods and recreation. Residents will continue advocacy engaging city leaders on the need for safer streets and neighborhoods, parks and the availability of stores selling fruits and vegetables.
- Expansion of the hospital’s new “Wellness For Youth” initiative will occur at schools serving neighborhoods having high percentages of students on free and reduced lunch. A 5-year strategy will be developed with performance measures. The initiative will improve the health and wellness of 5th grade students while supporting the teaching of California Core requirements in English, Math and Science. An emphasis on fitness and movement will be tracked as seven dimensions of student wellness are promoted.

MISSION, VISION, AND VALUES

Our Mission

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

Our Vision

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

Our Values

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

INTRODUCTION – WHO WE ARE AND WHY WE EXIST

As a ministry sponsored by the Sisters of St. Joseph of Orange, St. Joseph Health, St. Mary lives out the tradition and vision of community engagement set out hundreds of years ago. The Sisters of St. Joseph of Orange trace their roots back to 17th century France and the unique vision of a Jesuit Priest named Jean-Pierre Medaille. Father Medaille sought to organize an order of religious women who, rather than remaining cloistered in a convent, ventured out into the community to seek out “the Dear Neighbor” and minister to their needs.

The congregation managed to survive the turbulence of the French Revolution and eventually expanded not only throughout France but throughout the world. In 1912, a small group of the Sisters of St. Joseph traveled to Eureka, California, at the invitation of the local Bishop, to establish a school. A few years later, the great influenza epidemic of 1918 caused the sisters to temporarily set aside their education efforts to care for the ill. They realized immediately that the small community desperately needed a hospital. Through bold faith, foresight and flexibility, in 1920, the Sisters opened the 28 bed St. Joseph Hospital Eureka and the first St. Joseph Health ministry.

ORGANIZATIONAL COMMITMENT

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

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

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

Each year St. Joseph Health, St. Mary allocates 10 percent of its net income (net unrealized gains and losses) to the St. Joseph Health Community Partnership Fund. 75 percent of these contributions are used to support local hospital Care for the Poor programs. 17.5 percent is used to support SJH Community Partnership Fund grant initiatives. The remaining 7.5 percent is designated toward reserves, which helps ensure the Fund's ability to sustain programs into the future that assist low-income and underserved populations.

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

Community Benefit Governance and Management Structure

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

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

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

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

Roles and Responsibilities

Senior Leadership

- CEO and VP of Mission are directly accountable for CB performance.

Community Benefit Committee (CBC)

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

Community Benefit (CB) Department

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

Local Community

- Partnership to implement and sustain collaborative activities.
- Formal links with community partners.
- Provide community input to identify community health issues.
- Engagement of local government officials in strategic planning and advocacy on health related issues on a city, county, or regional level.

PLANNING FOR THE UNINSURED AND UNDERINSURED

Our mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why St. Joseph Health, St. Mary has a **Patient Financial Assistance Program (FAP)** that provides free or discounted services to eligible patients.

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

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

For more information on SMMC’s Financial Assistance Program, please go to:
<http://www.stmaryapplevalley.com/Patients-Visitors/For-Patients/Billing-and-Payment/Patient-Financial-Assistance.aspx>

COMMUNITY

Definition of Community Served

St. Joseph Health, St. Mary provides San Bernardino County’s Victor Valley communities with access to advanced care and advanced caring. The hospital’s service area extends from Apple Valley in the north, Hesperia in the south, Lucerne Valley in the east and Adelanto in the west. Our Hospital Total Service Area includes the cities of Adelanto, Apple Valley, Hesperia and Victorville along with the rural communities of Lucerne Valley and Phelan. This includes a population of approximately 372,642 people, an increase of 13% from the prior assessment.

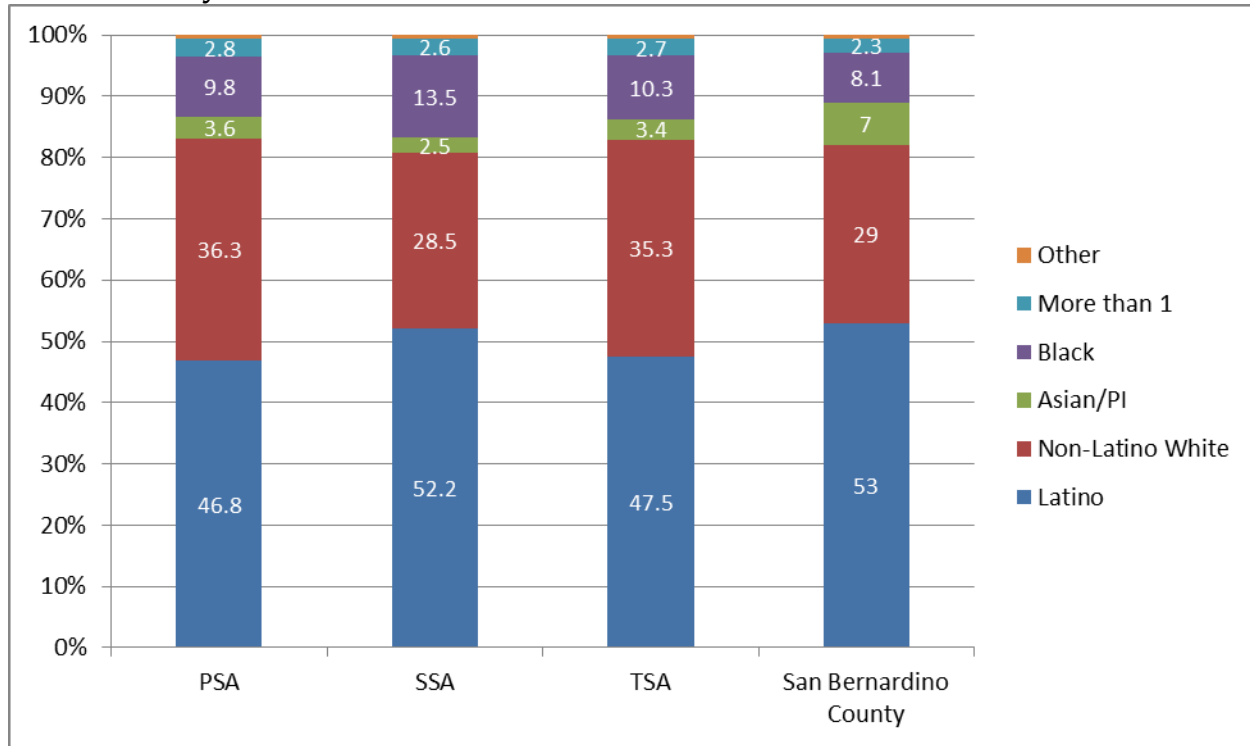
Community Profile

The table and graph below provide basic demographic and socioeconomic information about the St. Joseph Health, St. Mary Medical Center Service Area and how it compares to San Bernardino County and the state of California. The Total Service Area (TSA) of St. Mary Medical Center has almost 375,000 people, with a median household income of approximately \$50,000. Compared to California, the service area has more Latinos and African-Americans and fewer Asian/Asian-Americans. Compared to the county and, particularly, the state, the service area is less prosperous, with lower median incomes and greater poverty.

Service Area Demographic Overview

Indicator	PSA	SSA	TSA	San Bernardino County	California
Total Population	323,674	48,968	372,642	2,118,866	38,986,171
Under Age 18	28.1%	30.2%	28.4%	27.0%	23.6%
Age 65+	12.1%	10.5%	11.8%	10.5%	13.2%
Speak only English at home	71.9%	64.0%	70.9%	58.9%	56.2%
Do not speak English “very well”	9.7%	14.1%	10.3%	16.2%	19.1%
Median Household Income	\$51,555	\$41,253	\$50,500	\$55,726	\$62,554
Households below 100% of FPL	18.3%	27.8%	19.4%	15.3%	12.3%
Households below 200% FPL	39.5%	51.3%	40.9%	36.0%	29.8%
Children living below 100% FPL	30.7%	44.1%	32.5%	26.4%	22.7%
Older adults living below 100% FPL	12.0%	13.9%	12.2%	11.5%	10.2%

Race/Ethnicity



Race/Ethnicity data is based on self-reported responses in accordance with US Census categories.

Hospital Total Service Area

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

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

The Primary Service Area (“PSA”) is the geographic area from which the majority of the Hospital’s patients originate. The Secondary Service Area (“SSA”) is where an additional population of the Hospital’s inpatients resides. The PSA is comprised of Apple Valley, Hesperia and Victorville. The SSA is comprised of the city of Adelanto, and rural communities including Helendale, Lucerne Valley and Oro Grande.

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

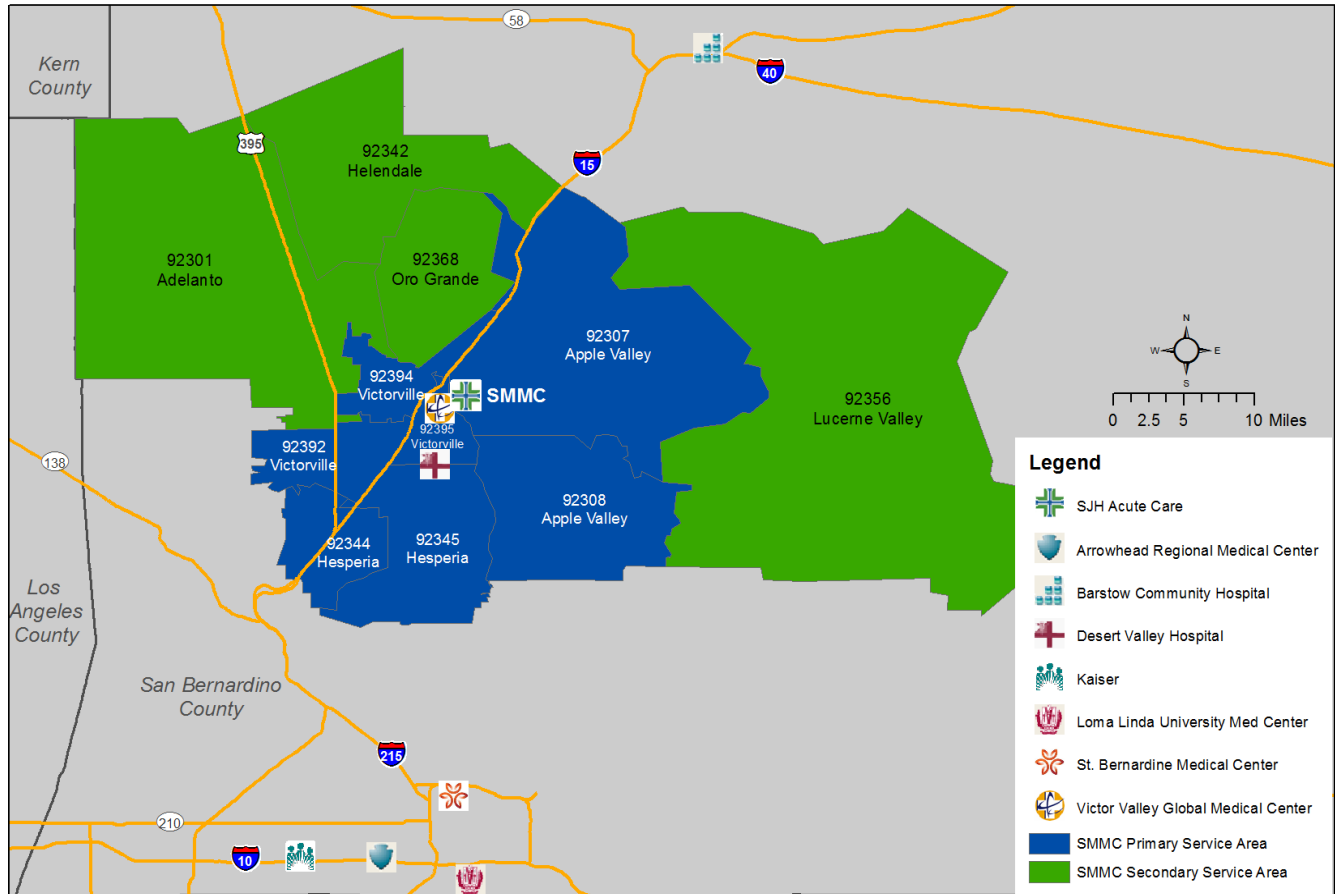
Table 1. Cities and ZIP codes

Cities/ Communities	ZIP Codes	PSA or SSA
Adelanto	92301	SSA
Apple Valley	93307, 92308	PSA
Helendale	92342	SSA
Hesperia	92344, 92345	PSA
Lucerne Valley	92356	SSA
Oro Grande	92368	SSA
Victorville	92392, 92394, 92395	PSA

Figure 1 (next page) depicts the Hospital’s PSA and SSA. It also shows the location of the Hospital as well as the other hospitals in the area that are a part of St. Joseph Health.

Figure 1. Hospital Total Service Area

St. Mary Medical Center (SMMC) Hospital Total Service Area



Map represents Hospital Total Service Area (HTSA). The Primary Service Area (PSA) comprises 70% of total discharges (excluding normal newborns). The Secondary Service Area (SSA) comprises 71% - 85% of total discharges (excluding normal newborns). The HTSA combines the PSA and the SSA. Includes zip codes for continuity. Cities are placed in either PSA or SSA, but not both.
 Prepared by the St. Joseph Health Strategic Services Department, April 2016.

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

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

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

- Income Barriers (Elder poverty, child poverty and single parent poverty)
- Culture Barriers (non-Caucasian limited English)
- Educational Barriers (% population without High School diploma)
- Insurance Barriers (Insurance, unemployed and uninsured)
- Housing Barriers (Housing, renting percentage)

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

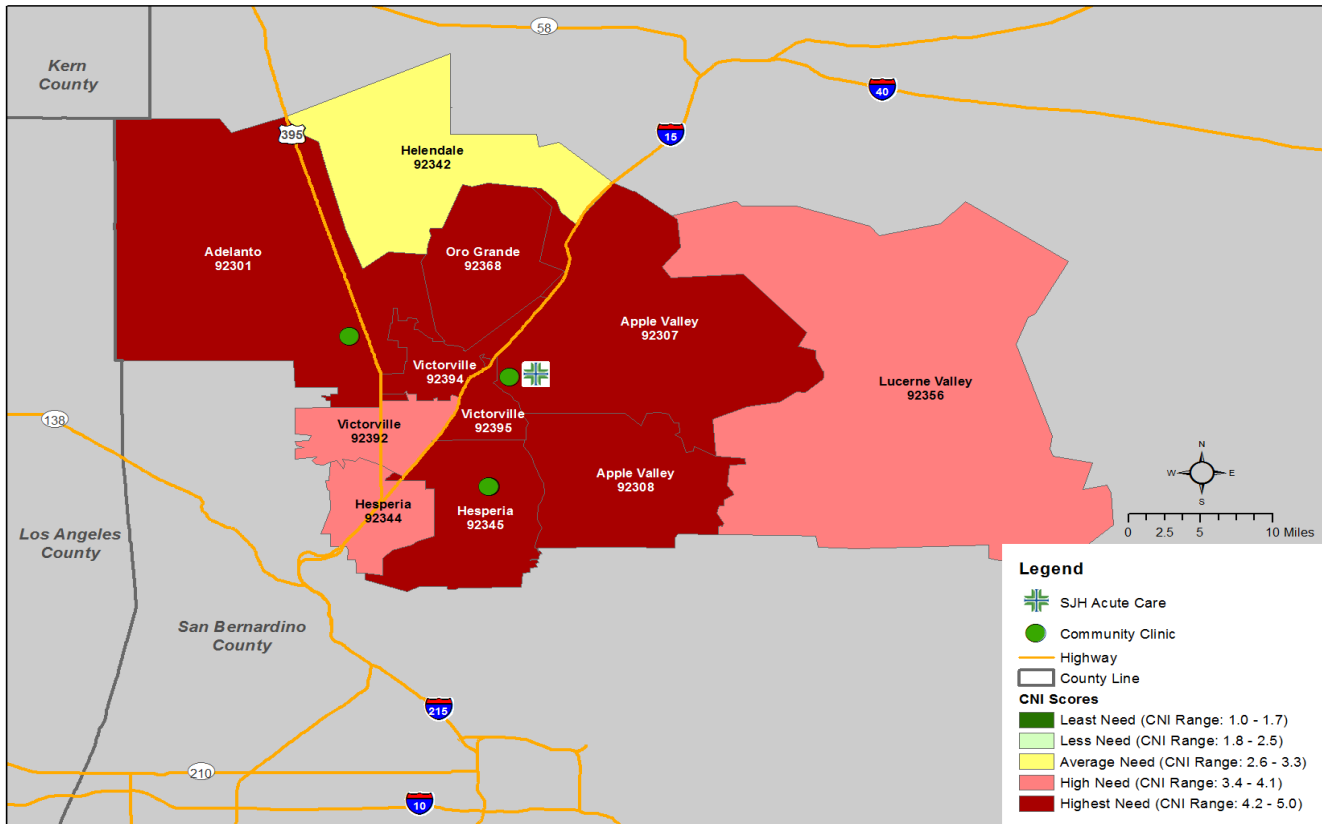
This objective measure is the combined effect of five socioeconomic barriers (income, culture, education, insurance and housing). A score of 1.0 indicates a zip code with the fewest socioeconomic barriers, while a score of 5.0 represents a zip code with the most socioeconomic barriers. Residents of communities with the highest CNI scores were shown to be twice as likely to experience preventable hospitalizations for manageable conditions such as ear infections, pneumonia or congestive heart failure compared to communities with the lowest CNI scores. (Ref ([Roth R, Barsi E., Health Prog. 2005 Jul-Aug; 86\(4\):32-8.](#)) The CNI is used to draw attention to areas that need additional investigation so that health policy and planning experts can more strategically allocate resources.

For example, the ZIP code 92301 on the CNI map is scored 5.0, making it a High Need community.

Figure 2 (below) depicts the Community Need Index for the *hospital's geographic service area based on national need*. It also shows the location of the Hospital as well as the other hospitals in the area that are a part of St. Joseph Health.

Figure 2. St. Joseph Health, St. Mary Community Need Index (Zip Code Level)

St. Mary Medical Center (SMMC) CNI Scores

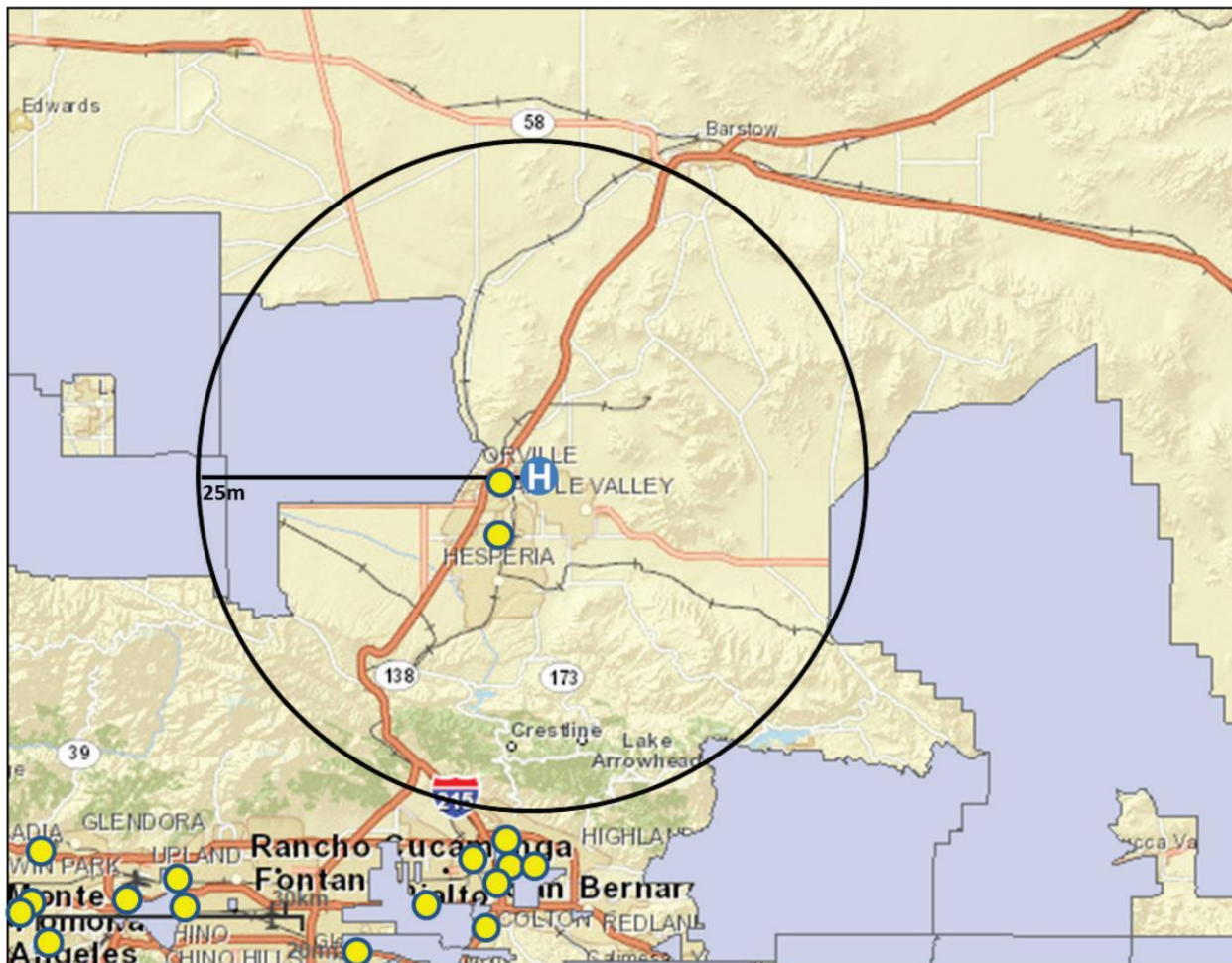


Source: Dignity Health Community Need Index (cni.chw-interactive.org), 2015; Accessed March 2016. Prepared by the St. Joseph Health Strategic Services Department, April 2016.

Medically Underserved Areas (MUA) and Health Professions Shortage Areas – Mental, Dental, Other

The Federal Health Resources and Services Administration designate Medically Underserved Areas (MUAs) and Health Professional Shortage Areas (HPSA) as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). The area west of the hospital including portions of Victorville and Adelanto are designed as MUAs and HPSA Populations. The entire service area of St. Joseph Health, St. Mary is located in a HPSA with large portions of the service area needing increased access to primary care and mental health.

Medically Underserved Areas/Medically Underserved Populations

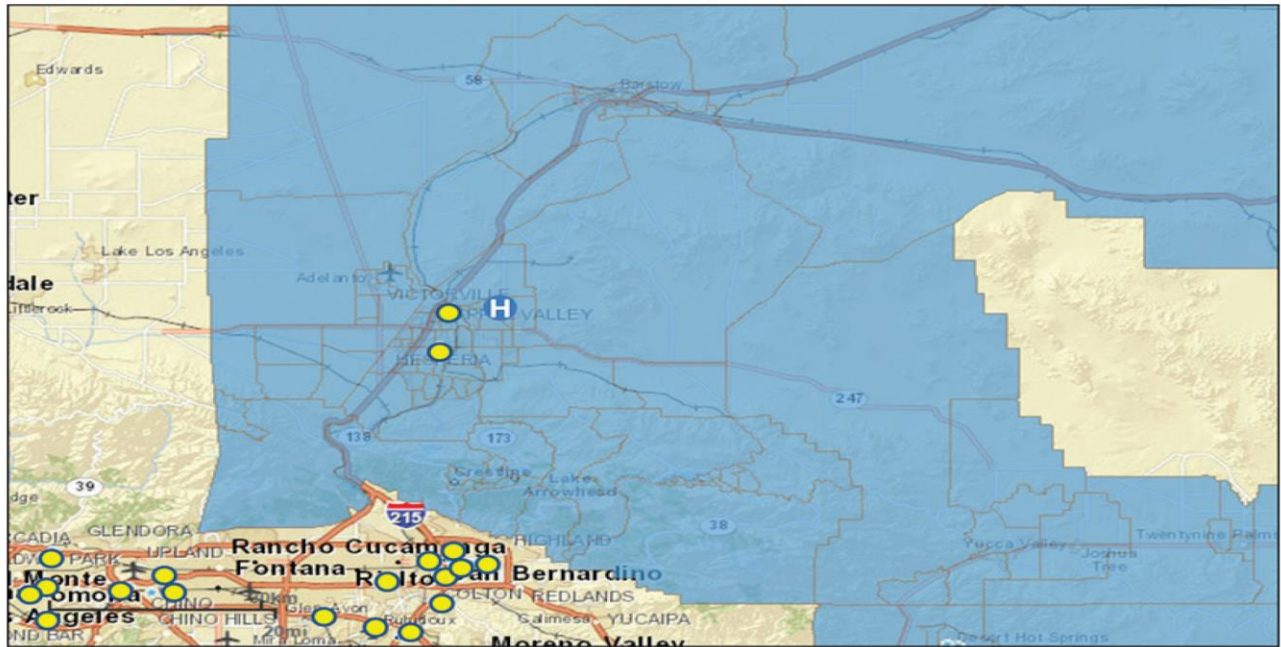


- H = St. Mary Medical Center
- = Federally Qualified Health Center

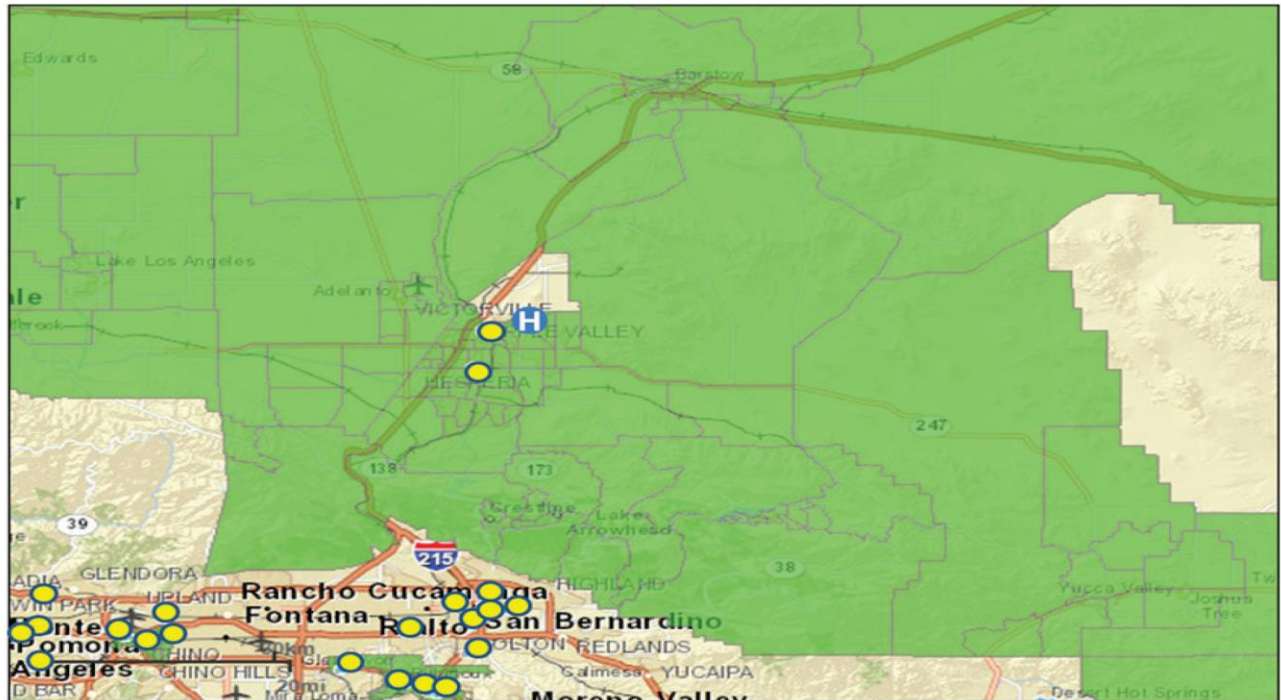
= MUA/MUP Designation

St. Joseph Health, St. Mary
 FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

Health Professional Shortage Areas



-  = St. Mary Medical Center
-  = Federally Qualified Health Center
-  = HPSA: Mental Care



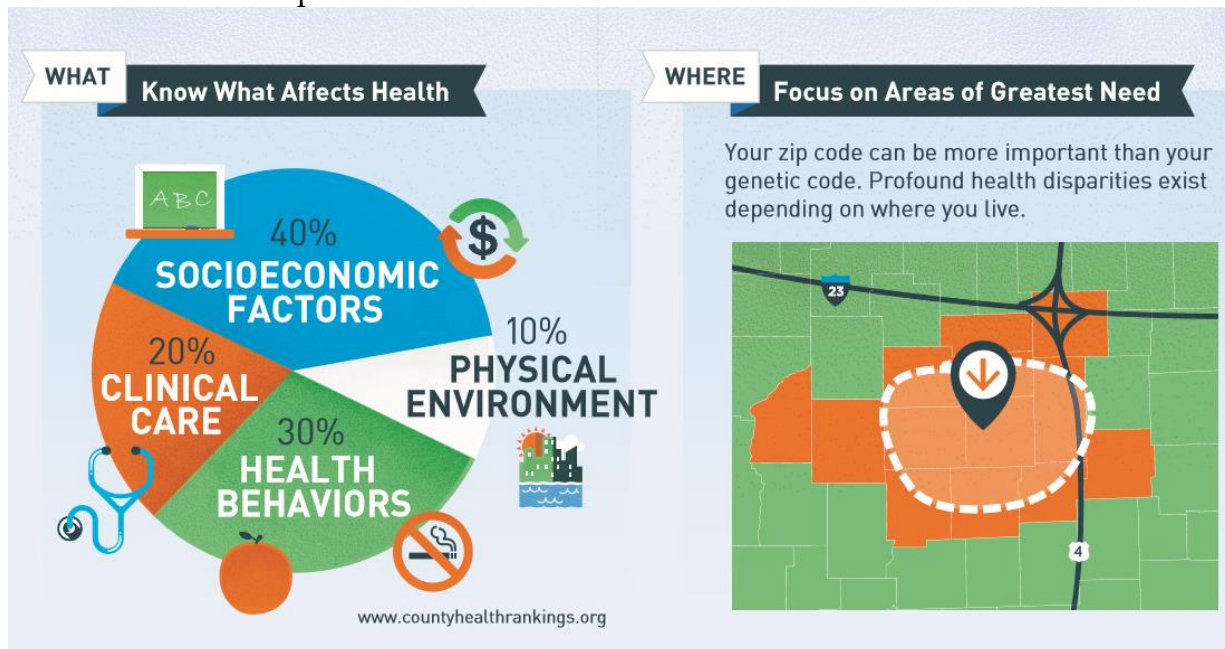
-  = St. Mary Medical Center
-  = Federally Qualified Health Center
-  = HPSA: Primary Care

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs, Assets, Assessment Process and Results

The CHNA process was guided by the fundamental understanding that much of a person and community’s health is determined by the conditions in which they “live, work, play and pray.” In gathering information on the communities served by the hospital, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, health behaviors, and the availability of clinical care. This framework, depicted in the graphic below from County Health Rankings and Roadmaps, focuses attention on the social determinants of health to learn more about opportunities for intervention that will help people become and stay healthy within their community.

In addition, we recognized that where people live tells us a lot about their health and health needs, and that there can be pockets within counties and cities where the conditions for supporting health are substantially worse. When data was publicly available, it was collected at the zip code level to show the disparities in health and the social determinants of health that occur within the hospital service area.



Examples of the types of information that was gathered, by health factor, are:

Socioeconomic Factors – income, poverty, education, and food insecurity

Physical Environment – crowded living situations, cost of rent relative to incomes, long commutes, and pollution burden

Health Behaviors – obesity¹, sugary drink consumption, physical exercise, smoking, and substance abuse

Clinical Care – uninsured, prenatal care, and the number of people per physician or mental health worker

In addition to these determinants of health, we also looked at the health outcomes of the people living in the service area, by zip code whenever possible. The health conditions that were examined included:

Health Outcomes – overall health condition, asthma, diabetes, heart disease, cancer, and mental health

METHODOLOGY

Collaborative Partners

The Olin Group is a socially conscious consulting firm working across nonprofit, public, private, and philanthropic sectors to bring about community transformation. Based in Santa Ana, California, The Olin Group has 15 years of experience working on evaluation, planning, assessment, fundraising, communication, and other services for nonprofit organizations, and had previously supported the CHNA process of multiple hospitals in the St. Joseph Health system. The Olin Group served as the lead consultant in the CHNA process, coordinating the quantitative and qualitative data collection processes and assisting in the prioritization and selection of health needs.

Other Collaborative Partners:

1. St. Joseph Health Community Partnerships Department and Strategic Services
2. Academy Go – strengthening non-profits to serve community need
3. Another Level for Women - helping women in crisis in Adelanto
4. Apple Valley Unified School District, Phoenix Academy Family Resource Center
5. Community Health Action Network- health education
6. San Bernardino County Department of Public Health
7. San Bernardino County Department of Behavioral Health
8. Stars Behavioral Health – crisis mental health services
9. United Way 211 – 24 hr. crisis call in center
10. Community Action Partnership of San Bernardino County – poverty programs
11. Faith Advisory Council for Community Transformation
12. City of Victorville – Helathy Victorville, old town redevelopment

¹ Per County Health Rankings obesity is listed under the health behavior category of diet and exercise.
<http://www.countyhealthrankings.org/our-approach/health-factors/diet-and-exercise>

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

13. Hesperia Unified School District, Hesperia Family Resource Center
14. Broken Hearts Ministry – food and faith to the poor
15. St. John of God Healthcare Services – addiction recovery programs
16. Adelanto Sheriff Department – crime and street safety
17. San Bernardino County Workforce development
18. Family Assist – domestic abuse and human trafficking
19. Congressman Paul Cook’s office – federal advocacy
20. Victorville Lutheran Church – food and health outreach
21. Victor Community College – career programs, youth in poverty assistance

Community Partners

St. Mary Medical Center partnered with the following community groups to recruit for and host the Focus Groups and Forums.

Academy for Grassroots Organizations, Victorville. Academy GO works to improve the quality of life in the High Desert Region by supporting and strengthening the social service sector. They provide a variety of resources and nonprofit learning opportunities throughout the region and serve a network of more than 1,000 nonprofit professionals and volunteers. Academy GO supported and hosted the stakeholder focus group held in Apple Valley.

Another Level for Women, Adelanto. Another Level for Women is a faith-based nonprofit organization dedicated to providing financial, emotional, and educational support services for women in the High Desert community, particularly extremely low-income women with children. Another Level for Women recruited for and hosted a resident focus group conducted in Spanish in Adelanto.

Hesperia Unified School District Family Resource Center, Hesperia. The Family Resource Center (FRC) serves families in Hesperia and beyond with such services as educational classes, a lending library, a technology center, and emergency food and clothing resources. The FRC recruited for and hosted a resident focus group.

Phoenix Academy, Apple Valley. Part of the Apple Valley Unified School District, Phoenix Academy serves approximately 1,500 Kindergarten through 8th grade students. Phoenix Academy recruited for and hosted a resident focus group for the Vista Loma and Yucca Loma neighborhoods of Apple Valley.

Trinity Lutheran Church, Victorville. Trinity Lutheran Church, part of the Evangelical Lutheran Church in America, serves the spiritual needs of the Victorville area and beyond. The Church hosted and supported the Community Forum located in the old town section of Victorville.

Secondary Data/Publicly Available Data

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

Within the guiding health framework for the CHNA, publicly-available data was sought that would provide information about the communities (at the city and zip code level when available) and people within our service area. In addition, comparison data was gathered to show how the service area communities are faring compared to the county or state. Indicators were chosen if they were widely accepted as valid and appropriate measures² and would readily communicate the health needs of the service area.

Preference was given to data that was obtained in the last 5 years and was available at the zip code level. The data sources used are highly regarded as reliable sources of data (e.g., ESRI Business Analyst Online, US Census Bureau American FactFinder, and California Health Interview Survey Neighborhood Edition). In total, 81 indicators were selected to describe the health needs in the hospital's service area.

If an indicator had zip code level data available, data was pooled to develop indicator values for the Total Service Area (TSA), Primary Service Area (PSA), and Secondary Service Area (SSA) of the hospital. This enabled comparisons of zip code level data to the hospital service area and comparisons of the hospital service area to county and state measures.

After the data was gathered, the zip code level data was compared to the Total Service area values and color coded light pink to dark red depending on how much worse a zip code area was compared to the TSA value. This made it easier to visualize the geographic areas with greater health needs.

Community Input

The process of collecting qualitative community input took three main forms: Community Resident Focus Groups, a Nonprofit and Government Stakeholder Focus Group, and a Community Forum. Each group was designed to capture the collected knowledge and opinions of people who live and work in the communities served by St. Mary Medical Center. We developed a protocol for each group to ensure consistency across individual focus groups, although the facilitators had some discretion on asking follow-up questions or probes as they saw fit. Invitation and recruitment procedures varied for each type of group.

Resident Focus Groups

For Community Resident Groups, Community Benefit staff, in collaboration with their committees and the system office, identified geographic areas where data suggested there were significant health, physical environment, and socioeconomic concerns. This process also identified the language needs of the community, which determined the language in which each focus group was conducted. Community Benefit staff then partnered with community-based organizations that serve those areas to recruit for and host the focus groups. The community-based organization developed an invitation list using their contacts and knowledge of the area.

² https://wwwn.cdc.gov/CommunityHealth/PDF/Final_CHAforPHI_508.pdf

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

Participants received a \$25 gift card for their time. Two consultants staffed each focus group, serving as facilitators and note takers. These consultants were not directly affiliated with the ministry to ensure candor from the participants.

Nonprofit and Government Stakeholder Focus Group

For the Nonprofit and Government Stakeholder Focus Group, Community Benefit staff developed a list of leaders from organizations that serve diverse constituencies within the hospital’s service area. Ministry staff sought to invite organizations with which they had existing relationships, but also used the focus group as an opportunity to build new relationships with stakeholders. Participants were not given a monetary incentive for attendance. As with the resident focus groups, this group was facilitated by outside consultants without a direct link to St. Joseph Health.

Resident Community Forum

Recruitment for the Community Resident Forum was much broader to encourage as many people as possible to attend the session. Community Benefit staff publicized the event through flyers and emails using their existing outreach networks, and also asked their partner organizations to invite and recruit participants. No formal invitation list was used for the forums and anyone who wished to attend was welcomed. The forum was conducted by an outside consultant in English, with simultaneous Spanish language translation for anyone who requested it.

While the focus groups followed a similar protocol to each other in which five to six questions were asked of the group, the forum followed a different process. The lead facilitator shared the health needs that had emerged from the CHNA process so far and asked the participants to comment on them and add any other concerns. Once the discussion was complete, the participants engaged in a cumulative voting process using dots to indicate their greatest concerns. Through this process, the forum served as something of a “capstone” to the community input process.

Process for gathering comments on previous CHNA

St. Joseph Health, St. Mary shared community health data and community feedback with San Bernardino County Public Health’s Community Vital Signs and Healthy Communities programs. Information was requested to assist in developing a 2015-2020 San Bernardino County Transformation Plan focused in four (4) areas: Economy, Education, Health and Wellness and Safety. The hospital is also a member of a health planning workgroup attempting to expand access to care county-wide. Finally, the hospital shared CHNA findings with local non-profit partners (to assist in grant writing) and regionally with member hospitals of a Community Benefit workgroup led by the Hospital Association of Southern California – Inland Empire region. In addition, on the St. Mary Medical Center website, the contact information of

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

the SMMC Community Benefit Lead was provided to enable the public to comment on the prior FY14 CHNA and FY15-FY17 CB Plan/Implementation Strategy Reports.

Identification and Selection of Significant Health Needs

Communities with Disproportionate Unmet Health Needs (DUHN) are communities defined by zip codes where there is a higher prevalence or severity for a particular health concern than the general population within St. Joseph Health, St. Mary Service Area.

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

The following table lists the DUHN communities/groups and identified significant health needs and community resources/assets.

Significant Health Need	Target Population	Geographic Area (City, Zip Code, County of San Bernardino)	Community Resources (Name of Organization(s))
<i>Access to Resources</i>	<i>Low income persons and broader community; residents of rural communities</i>	<ul style="list-style-type: none"> • <i>Adelanto, 92301</i> • <i>Lucerne Valley, 92356</i> • <i>Oro Grande, 92368</i> • <i>Old-Town Victorville, 92395</i> • <i>Phelan, 92371</i> 	<ul style="list-style-type: none"> •<i>Local school districts</i> •<i>San Bernardino County Public Health Dept.</i> •<i>San Bernardino County Department of Behavioral Health</i> •<i>Victor Valley Transit Authority</i>
<i>Mental Health</i>	<i>Low income and broader community</i>	<ul style="list-style-type: none"> • <i>Adelanto, 92301</i> • <i>Apple Valley, 92307& 92308</i> • <i>Lucerne Valley, 92356</i> • <i>Oro Grande, 92368</i> • <i>Old-Town Victorville, 92395</i> • <i>Phelan, 92371</i> 	<ul style="list-style-type: none"> •<i>Family Service Agency of San Bernardino</i> •<i>Mission Community Clinic</i> •<i>National Alliance for Mental Health, (NAMI)</i> •<i>San Bernardino County Department of Behavioral Health</i> •<i>Special Education counseling services (SELPA)</i> •<i>Stars Behavioral Health Walk-in Center</i> •<i>Sunset Hills Children’s Foundation</i>
<i>Obesity</i>	<i>Low income</i>	<ul style="list-style-type: none"> • <i>Adelanto, 92301</i> 	<ul style="list-style-type: none"> •<i>Healthy City campaigns of</i>

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

	<i>persons and broader community</i>	<ul style="list-style-type: none"> • <i>Apple Valley, 92307 & 92308</i> • <i>Hesperia, 92344 & 92345</i> • <i>Lucerne Valley, 92356</i> • <i>Old-Town Victorville, 92395</i> • <i>Oro Grande, 92368</i> • <i>Phelan, 92371</i> 	<i>Adelanto, Apple Valley, Hesperia, Snowline and Victorville</i> <ul style="list-style-type: none"> • <i>Heritage Victor Valley Medical Group</i> • <i>San Bernardino County’s Vision2Be Active and Nutrition Department’s Communities of Excellence, Health & Soul and Retail programs</i> • <i>Summer Meals Program</i>
<i>Diabetes</i>	<i>Low income persons and broader community</i>	<ul style="list-style-type: none"> • <i>Adelanto, 92301</i> • <i>Apple Valley, 92307&92308</i> • <i>Hesperia, 92344&92345</i> • <i>Lucerne Valley, 92356</i> • <i>Old-Town Victorville, 92395</i> • <i>Oro Grande, 92368</i> • <i>Phelan, 92371</i> 	<ul style="list-style-type: none"> • <i>Heritage Victor Valley Medical Group</i> • <i>St. Mary High Desert Medical Group</i>
<i>Food and Nutrition</i>	<i>Low income persons and broader community</i>	<ul style="list-style-type: none"> • <i>Adelanto, 92301</i> • <i>Apple Valley, 92307& 92308</i> • <i>Hesperia, 92344& 92345</i> • <i>Lucerne Valley, 92356</i> • <i>Old-Town Victorville, 92395</i> • <i>Oro Grande, 92368</i> • <i>Phelan, 92371</i> 	<ul style="list-style-type: none"> • <i>Another Level for Women</i> • <i>Broken Hearts Ministry</i> • <i>Community Action Partnership</i> • <i>Community Health Action Network</i> • <i>Food Forward</i> • <i>High Desert Food Collaborative</i> • <i>High Desert Outreach Center</i> • <i>Lords Table</i> • <i>Squash4Friends</i> • <i>Summer Meals program and schools hosting</i> • <i>Victor Valley Rescue Mission</i>
<i>Substance Abuse</i>	<i>Low income persons</i>	<ul style="list-style-type: none"> • <i>Adelanto, 92301</i> • <i>Lucerne Valley, 92356</i> • <i>Oro Grande, 92368</i> • <i>Old-Town Victorville, 92395</i> • <i>Phelan, 92371</i> 	<ul style="list-style-type: none"> • <i>AEGIS</i> • <i>Family Service Agency of San Bernardino County</i> • <i>Mission City Clinic</i> • <i>No Drugs America</i> • <i>San Bernardino County Department of Behavioral Health</i> • <i>St. John of God Healthcare Services</i>

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

			<ul style="list-style-type: none"> • Stars Health Walk-in Center
Lack of Exercise	Low income persons and broader community	<ul style="list-style-type: none"> • Adelanto, 92301 • Lucerne Valley, 92356 • Oro Grande, 92368 • Old-Town Victorville, 92395 • Phelan, 92371 	<ul style="list-style-type: none"> • Adelanto School District • City of Adelanto • City of Victorville and Town of Apple Valley • Free Zumba® initiatives in Adelanto and old-town Victorville • Healthy City recreation programs • Town of Apple Valley’s “Vantastic” mobile play program
Education	Low income persons and Broader Communities	<ul style="list-style-type: none"> • Adelanto, 92301 • Lucerne Valley, 92356 • Old-Town Victorville, 92395 • Phelan, 92371 	<ul style="list-style-type: none"> • Adelanto School District • Alliance For Education • California State University, San Bernardino • Don Ferrarese Charitable Foundation • Lucerne Valley School District • SELPA education programs • Millionaire Mind Kids • Snowline School District • Victor Community College
Economic Insecurity	Low income persons and Broader Communities	<ul style="list-style-type: none"> • Adelanto, 92301 • Apple Valley, 92307&92308 • Hesperia, 923444&92345 • Lucerne Valley, 92356 • Phelan, 92371 • Old-Town Victorville, 92395 	<ul style="list-style-type: none"> • Local city Economic Development Departments • San Bernardino County Department of Economic Development • Workforce Development
Walkability	Low income persons and Broader Communities	Parts of Primary Service Area (PSA) and Secondary Service Area (SSA)	<ul style="list-style-type: none"> • City planning and economic development departments • Southern California Association of Governments, • Mojave Air Quality Management District
Homelessness	Chronically ill homeless (e.g., severe brain disease, substance	<ul style="list-style-type: none"> • Old-Town Victorville, 92395 	<ul style="list-style-type: none"> • Azusa Pacific Nursing Program • City of Victorville • High Desert Homeless Services • Orinda Foundation • San Bernardino County Sheriff

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

	<i>abuse, criminal record, pedophilia), families in crisis (without housing), runaway youth, foster youth</i>		<i>(HOPE program)</i> <ul style="list-style-type: none"> • <i>San Bernardino County Department of Behavioral Health (office of homeless services)</i> • <i>Step Up</i>
<i>Insurance and Cost of Care</i>	<i>Low income persons</i>	<ul style="list-style-type: none"> • <i>Adelanto, 92301</i> • <i>Apple Valley, 92307&92308</i> • <i>Hesperia, 92344&92345</i> • <i>Lucerne Valley, 92356</i> • <i>Old-Town Victorville, 923495</i> • <i>Phelan, 92371</i> 	<ul style="list-style-type: none"> • <i>Azusa Pacific University Nursing Program</i> • <i>Clínica Médica Familiar</i> • <i>Covered California</i> • <i>Inland Empire Health Plan (IEHP)</i> • <i>Mission City Clinic</i> • <i>Molina</i> • <i>San Bernardino County Community Clinic Association</i> • <i>San Bernardino County Public Health and Department of Behavioral Health</i> • <i>St. John of God Healthcare Services</i>
<i>Housing Concerns</i>	<i>Low income persons and Broader Communities</i>	<ul style="list-style-type: none"> • <i>Adelanto, 92301</i> • <i>Apple Valley, 92307&92308</i> • <i>Hesperia, 92344&92345</i> • <i>Lucerne Valley, 92356</i> • <i>Phelan, 92371</i> • <i>Old-Town Victorville, 92395</i> 	<ul style="list-style-type: none"> • <i>Housing Authority of San Bernardino County and Transitional Assistance Department</i> • <i>Housing Partners Inc.</i> • <i>Low income housing stabilization programs of Adelanto, Apple Valley, Hesperia and Victorville</i>
<i>Pollution and Air Quality</i>	<i>Low income persons and Broader Communities</i>	<ul style="list-style-type: none"> • <i>Adelanto, 92301</i> • <i>Old-Town Victorville, 92395</i> 	<ul style="list-style-type: none"> • <i>Community Action Partnership (lead paint abatement of residential housing)</i> • <i>Mojave Air Quality Management District,</i> • <i>San Bernardino County Department of Environmental Health</i>

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

<i>Crime and Safety</i>	<i>Low income persons and Broader Communities</i>	<ul style="list-style-type: none"> • <i>North Adelanto, 92301</i> • <i>Old-Town Hesperia, 92345</i> • <i>Old-Town Victorville, 92395</i> • <i>Vista Loma and Yucca Loma neighborhoods of Apple Valley, 92307& 92308</i> 	<ul style="list-style-type: none"> • <i>Local school districts of Adelanto, Apple Valley, Hesperia and Victorville.</i> • <i>Sheriff departments of Adelanto, Apple Valley, Hesperia and Victorville</i>
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St. Joseph Health, St. Mary anticipates that implementation strategies may change and therefore, a flexible approach is best suited for the development of its response to the St. Joseph Health, St. Mary CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by St. Joseph Health, St. Mary in the enclosed 2018-2020 CB Plan/Implementation Strategy.

Community Health Needs Prioritized

List of Priority Health Needs

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

The matrix below shows the 15 health needs identified through the selection process, and their final prioritized scores. The check marks indicate each source of input and whether this issue was identified as a need by that input process.

Significant Health Need	Health Category	Total Rank Score	Community Data	Resident Focus Groups (FG)	Non-profit/ Govt. Stakeholder FG	Community Forum
Access to Resources	Clinical Care	42.2	✓	✓	✓	✓
Mental Health	Health Outcome	41.8	✓	✓	✓	✓
Obesity	Health Behavior	41.4	✓	✓	✓	
Diabetes	Health Outcome	38.8	✓			
Food and Nutrition	Health Behavior	38.5	✓	✓	✓	
Substance Abuse	Health Behavior	38.0	✓	✓	✓	
Lack of Exercise	Health Behavior	37.4	✓	✓	✓	✓
Education	Socioeconomic	37.0	✓	✓		✓
Economic Insecurity	Socioeconomic	35.1	✓	✓	✓	✓
Walkability	Physical Environment	33.6	✓	✓	✓	✓
Homelessness	Socioeconomic	32.9		✓	✓	✓
Insurance and Cost of Care	Clinical Care	32.6	✓	✓	✓	✓
Housing Concerns	Physical Environment	30.8	✓		✓	
Pollution and Air Quality	Physical Environment	29.6	✓			
Crime and Safety	Physical Environment	29.1	✓	✓	✓	

Based on the combined results of the assessment process, St. Joseph Health, St. Mary will address the following priority areas as part of its FY18-FY20 CB Plan/Implementation Strategy Report:

- Access to Resources (clinical care)
- Mental Health and Substance Abuse (health outcome)
- Obesity (health behavior)

Access to Resources emerged as a consistent priority throughout the CHNA process. It was a major discussion point in every focus group and received substantial support in the community forum. The indicator data shows that the county has relatively few physicians and dentists compared to California averages. The issue was identified as a top priority through steps 1 and 2 of the prioritization process, and was endorsed by the Community Benefit Committee. The

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

committee discussed how the hospital was in a unique position to expand services having made progress over the past three years expanding programs and clinic visits to the poor.

Mental Health and Substance Abuse were originally considered as separate issues but combined by the Community Benefit Committee. Committee members also discussed that mental health will be a priority focus of Providence St. Joseph Health over the next ten years. Mental Health was a frequent theme in the focus groups and forum, particularly focusing on the stresses caused by economic insecurity, the challenges faced by children and teens, and the lack of providers. The lack of providers is supported by county-wide data. It was the second highest priority through the first steps of the prioritization process. Substance Abuse was the sixth highest priority, and was also a strong theme across all focus groups.

Obesity was an issue initially highlighted by the indicator data, which shows an obesity rate in adults of 37%, compared to a state rate of 26%. In teens, the rate for the service area is 38%, compared to 33% for the state. Obesity was frequently discussed in the focus groups, particularly in conjunction with root causes such as nutrition and lack of exercise. Food and Nutrition was a major theme in all focus groups, and Lack of Exercise also emerged as an issue in the community process. Challenges with Walkability also were frequent themes in the process. Indicator data shows that only 28% of adults in the service area walk regularly, compared to 33% for California. Obesity was identified as the third highest priority after steps 1 and 2 of the process. The committee discussed the progress it has made with nutrition and exercise campaigns including efforts expanding student nutrition and fitness campaigns in local schools.

Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. We are committed to continue our Mission through Community Benefit Programs and by funding other non-profits through our Care for the Poor program managed by St. Joseph Health, St. Mary.

Furthermore, St. Joseph Health, St. Mary will endorse local non-profit organization partners to apply for funding through the St. Joseph Health Community Partnership Fund. Organizations that receive funding provide specific services and resources to meet the identified needs of underserved communities throughout St. Joseph Health, St. Mary's service areas.

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

Diabetes: Specifically focused on the health condition of diabetes, and awareness and prevention of it. This 2017 Community Health Needs Assessment ranked diabetes 4th in need

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

the expertise addressing this health outcome high. St. Joseph Health, St. Mary's Diabetes Program remains the only American Diabetes Association certified program in the hospital's Total Service Area. The program expands nutritional and certified diabetes trained staff from hospital-based diabetes and child obesity programs. Program staff began participating in a SJH regional diabetes workgroup sharing best practices. A referral relationship was established from physicians of St. Mary High Desert Medical Group. The targeting of diabetes education in neighborhoods with poor and uninsured persons and populations has increased through introduction to residents of Communities of Excellence program nutrition and physical activity campaign. Efforts to discuss diabetes screening during food pantry giveaways started. In addition, the hospital's Diabetes program is starting to implement a CDC Curriculum, "Diabetes Prevention Program," throughout the High Desert.

Food and Nutrition: Concerns about healthy eating habits, nutrition knowledge, and challenges of cost and availability of healthy options. An integrated approach to address issues of being a food desert are being tackled through a regional approach – the Community Action Partnership – High Desert Food Collaborative. Outside non-profits are being approached, for example, Food Forward. This Los Angeles based non-profit was recruited to provide donations of fresh fruits and vegetables to local food pantries operated in Adelanto, Apple Valley, Phelan and Victorville. The majority of food pantries are operated by churches: Broken Hearts Ministry, The Lord's Table, Another Level for Women, Victor Valley Rescue Mission. Other non-profits working around this need are the High Desert Outreach Center, Squash4Friends, and schools that are hosting Summer Meal Programs. Community Action Partnership received a planning grant to begin developing a timeline for opening a local High Desert office that would include a small food bank.

Substance Abuse: Pertains to the misuse of all drugs, including alcohol, marijuana, opiates, prescription medication, and other legal or illegal substances. It does not encompass cigarette smoking, which was considered separately and not identified as a significant health need. Our hospital's lack of expertise in this matter has placed us in contact with other non-profits. We gave, and foresee continuing giving, Care for the Poor restricted funds, to provide counseling for participants of St. John of God's Healthcare Services' 90-day drug and alcohol center. Prior to this grant, this extra level of service was not offered, and now participants on this substance abuse program can explore the underlying reasons behind their substance abuse, address that trauma, and can devise a plan to cope without the use of drugs and liquor.

Lack of Exercise: In addition to the behavior itself, it also includes issues around access to places to exercise and people not having enough time to exercise. This issue is tied very closely to Obesity (which was identified as a priority) and will be addressed through St. Joseph Health, St. Mary's Communities of Excellence work, with the Adelanto Senior Center and the Victorville Parks and Recreation Department, both host free weekly physical activity classes. We are actively seeking new faith based organizations and other Parks and Recreation Departments to

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

host free physical activity classes in low income neighborhoods. Also, through the healthy cities initiatives in Adelanto, Apple Valley, Hesperia and Victorville, we constantly advocate city leaders to create bike pathways, more parks and safety measures so that more families can enjoy the parks and their surrounding neighborhoods.

Economic Insecurity: Identified as a root cause of other health issues, this issue covers the effects of poverty and economic concerns as well as difficulties around finding jobs that pay livable salaries. St. Joseph Health, St. Mary will collaborate with local city Economic Development Departments, and the Workforce Development Force that address aforementioned community needs.

Education: Includes both formal education goals and attainment, including job training, and community-based education around issues such as exercise, nutrition, health access, and finances. Health education is tied very closely to Obesity (which was identified as a priority) and will be addressed through St. Joseph Health, St. Mary's Communities of Excellence work, which take place in Adelanto, Apple Valley, Hesperia, Piñon Hills and Victorville. In addition, our facility has formal understandings with several universities and colleges to provide "Health professions education" that result in a degree, certificate, or training necessary to be licensed to practice as a health professional, as required by state law, or continuing education necessary to retain state license or certification by a board in the individual's health profession specialty.

Walkability: The lack of walkable areas and streets, including the lack of sidewalks, crosswalks, street lights, as well as the long distances necessary to go places and the prevalence of high-speed busy streets. This issue is tied very closely to Obesity (which was identified as a priority) and will be addressed through St. Joseph Health, St. Mary's Communities of Excellence work. In November of 2017 city leaders of Adelanto, Apple Valley, Hesperia, Piñon Hills and Victorville will receive a "report card" on the state of walkability in low income neighborhoods, as well as the access of fresh produce for residents living in these neighborhoods. We will train residents to advocate for this issue through their elected officials, by voicing their concerns in City Planning and City Council Meetings.

Homelessness: Primarily focused on the condition of homelessness, including helping homeless individuals, prevention of homelessness, and mitigating its impact on communities. According to the 2017 San Bernardino County Homeless Count and Survey, the city of Victorville has the third highest homeless population in the County of San Bernardino. The First District Supervisor's office has focused on rapid re-housing, and the City of Victorville's Sheriff's office has the Homeless Outreach Proactive Enforcement (H.O.P.E.) Program aimed at addressing needs of the homeless population.

In addition, we have the Homeless Services Shelter, Victor Valley Rescue Mission and St. John of God providing housing to homeless individuals and families. There are also two Domestic Violence Shelters; Family Assistance Program and A Better Way.

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

Insurance and Cost of Care: Encompasses both those who do not have health insurance, but also those for whom the cost of services is a barrier even though they have insurance. St. Joseph Health, St. Mary offers primary care services through our Bright Futures Mobile Van for those that are uninsured in the communities of Adelanto, Apple Valley, Hesperia, Lucerne Valley and Victorville. We also partner with Covered California in insurance enrollment campaigns and are continue advocacy supporting Federally Qualified Health Clinics (FQHC) expansion. Three FQHC operators support the region: Borrego Health (Barstow and Adelanto) Mission City (Barstow and Victorville) and San Bernardino County Public Health (Adelanto and Hesperia).

Housing Concerns: Includes affordability, availability, overcrowding, and quality of housing. St. Joseph Health, St. Mary recognizes that other organizations have a greater expertise in this matter. Low income housing stabilization programs of Adelanto, Apple Valley, Hesperia and Victorville as well as the Housing Authority of San Bernardino County and Transitional Assistance Department, and Housing Partners I Inc., all address this relatively low priority issue.

Pollution and Air Quality: Includes industrial pollution but also vermin, trash, and dust due to dryness and a lack of paved roads. This issue was second to lowest priority issue identified through the 2017 Community Health Needs Assessment. Organizations working on this need are the Mojave Air Quality Management District, San Bernardino County Department of Environmental Health and the Community Action Partnership through their Lead paint abatement of residential housing.

Crime and Safety: Encompasses the incidence of crime and violence as well as the fear of it, which prevents people from using open space or enjoying their community. This issue finished last, with the lowest priority. By working with local law enforcement offices, school districts, and elected officials, our hope is that crime will go down and the image of the High Desert region will improve, attracting new employers to this region.

COMMUNITY BENEFIT PLAN

Summary of Community Benefit Planning Process

As the only non-profit hospital serving the high desert St. Mary has partnered with San Bernardino County Department of Public Health to assist in developing and implementing a Community Transformation Plan 2015-2020 encompassing a health improvement plan named "Access to Health & Wellness". The county looks to the hospital's expertise working in local communities to identify partners helping expand county health programs offering clinical and wellness programs.

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

Hospital staff joined formal county-led workgroups established to develop strategies and long-term and short-term targets in key health areas. The following county-wide strategies align with the hospital's 2018-2020 implementation plan:

- Improve the network of healthcare services available in the region
- Increase the number of adults with mental health or substance abuse disorders who receive treatment
- Begin a community wide effort addressing crime and its impact on mental health
- Increase the proportion of adults and youth who are at a healthy weight
- Begin research and advocacy improving the readiness of young children entering kindergarden

Source: <http://communityvitalsigns.org/>

Locally, the hospital continues obtaining input about improving access to health and social services. Operators of community clinics seek ways to increase public visibility to improve patient volume. Low income residents continue advocating that providers of health and social services offer culturally competent care with evening and weekend services. Finally, the poor continue advocacy to improve access to low cost services including transportation, medication and healthy foods, access to jobs and programs for youth.

Addressing the Needs of the Community: Access to Resources
FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan

1. Initiative/Community Need being Addressed: Access to Resources/Health Care

Goal (anticipated impact): Improve access to health services and socioeconomic resources to persons living in targeted communities throughout the High Desert.

Outcome Measure	Strategy Measure	FY17 Baseline	FY18 Target	FY19 Target	FY20 Target
Improve the network of health care services in the High Desert	# of unique patients served by community clinics	# of new services provided by hospital and/or partners 4	10% Improvement	10% improvement	10% Improvement
	# of new services provided by hospital and/or partners	Telepsychiatry TEST Program Lucerne Valley clinic St. Mary Urgent Care	6	8	10

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

Addressing the Needs of the Community: Access to Resources
FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan

1. Initiative/Community Need being Addressed: Access to Resources/Health Care (continued)

Goal (anticipated impact): Improve access to health services and socioeconomic resources to persons living in targeted communities throughout the High Desert.

Strategy(ies)	Strategy Measure	FY17 Baseline	FY18 Target	FY19 Target	FY20 Target
Increase the # of locations and clinic days available for care	# of clinic locations	7 locations	8 locations	8 locations	9 locations
	# of clinic days	TBD clinic days	10% improvement	10% improvement	10% improvement
Provide primary care home for uninsured (self pay) patients utilizing hospital ER for care	# of uninsured patients establishing community clinic as medical home	TBD	10% improvement	10% improvement	10% improvement
Increase the number of unique patients utilizing clinics for care	# unique patient encounters	TBD	10% improvement	10% improvement	10% improvement
	# of returning patients				
	# of total encounters				
Engage Faith Communities in health care ministries for their members	# of faith partners with health care ministry	2 United in Christ Baptist Church (AV) Gate Church (VV)	3	4	5

Addressing the Needs of the Community: Access to Resources
FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan

1. Initiative/Community Need being Addressed: Access to Resources/Health Care (continued)

Goal (anticipated impact): Improve access to health services and socioeconomic resources to persons living in targeted communities throughout the High Desert.

Evidence Based Sources: <https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services/objectives>

Key Community Partners: Faith Communities, Lucerne Valley Market and Hardware, Apple Valley Unified School District, San Bernardino County Department of Public Health, St. Mary High Desert Medical Group, First 5 Commission of San Bernardino, Center for Oral Health, Inland Counties Legal Services, St. John of God Healthcare Services, Shiloh Health/Specialty Health Partners

Resource Commitment:

- Hospital and Care For The Poor funding of community health programs
- Grant support
- Assistance of faith partners
- Ability to continue navigation and follow-up of self-pay patients using hospital Emergency Room
- Use of hospital interpreter to refer Limited English Proficient patients to community clinics
- Neighborhood marketing of community clinic services through community events and resident meetings
- Ongoing staff provided by San Bernardino Department of Behavioral Health (TEST Pilot)

**Addressing the Needs of the Community: Access to Resources
FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan**

2. Initiative/Community Need being Addressed: Mental Health/Addiction

Goal (anticipated impact): Improve the Mental Health of the most vulnerable adults in the High Desert

Outcome Measure	FY17 Baseline	FY18 Target	FY19 Target	FY20 Target
Increase network of care programs for adults with mental health and substance abuse disorders	2 St. Mary St. John of God	4 St. Mary Community Health St. John of God St. Mary High Desert Medical Group Shiloh Health	5	6

Strategy(ies)	Strategy Measure	FY17 Baseline	FY18 Target	FY19 Target	FY20 Target
Improve quality of care provided at community clinic settings for clients experiencing depression (SJHH Regional Initiative)	# of community clinic and family resource center clients who improve their depression by one level (as measured with PHQ9 assessment)	TBD	10% improvement	10% improvement	10% improvement
Improve quality of care provided at 90-day addiction and recovery program for clients experiencing depression	# of recovery patients who improve their depression by one level (as measured with PHQ9 assessment)	TBD	10% improvement	10% improvement	10% improvement

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

Addressing the Needs of the Community: Access to Resources
FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan

2. Initiative/Community Need being Addressed: Mental Health/Addiction (continued)

Goal (anticipated impact): Improve the Mental Health of the most vulnerable adults in the High Desert

Strategy(ies)	Strategy Measure	FY17 Baseline	FY18 Target	FY19 Target	FY20 Target
Collaborate with hospital and county partners to improve services to patients requiring acute care	Reduce # of days patients requiring acute care are held at hospital Emergency Rooms awaiting care	1 Crisis Walk-in Center	2 Crisis Walk-in Center Residential Treatment Center	3	4
Collaborate with medical groups, faith communities and schools to provide mental health education and support group services to adults and youth	# of faith partners and school districts enhancing mental health services with education and services for adolescent mental health care	3 Ascension Lutheran Church (AV) High Desert Church (VV) Life Church (VV)	4	5	6

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

Addressing the Needs of the Community: Access to Resources
FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan

2. Initiative/Community Need being Addressed: Mental Health/Addiction (continued)

Mental Health/Addiction – “upstream” initiative addressing crime and violence as causes of trauma and poor to fair ratings of self-reported mental health
note: St. Joseph Health Community Partnership funded project with Prevention Institute

Outcome Measure	FY17 Baseline	FY18 Target	FY19 Target	FY20 Target
TBD	TBD	TBD	TBD	TBD

Strategy(ies)	Strategy Measure	FY17 Baseline	FY18 Target	FY19 Target	FY20 Target
Engage community partners addressing upstream determinants of health across Spectrum of Prevention and the Adverse Community Experience and Resilience	# of partners engaged in coalition addressing and preventing community level trauma	0	10	20	30
Advocate for policies and system changes that improve community determinants of health	# of policies and system changes	0	3	4	5
Create guidelines for improved housing, neighborhood and school safety, economic investment, workforce development	# of guideline documents authored and disseminated	0	1	2	4
Implement economic and safety plans for community cohesion and wellbeing	# of plans developed	0	1	2	3

**Addressing the Needs of the Community: Access to Resources
FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan**

2. Initiative/Community Need being Addressed: Mental Health/Addiction (continued)

Mental Health/Addiction – “upstream” initiative addressing crime and violence as causes of trauma and poor to fair ratings of self-reported mental health
note: St. Joseph Health Community Partnership funded project with Prevention Institute

Evidence Based Sources: <https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Mental-Health>;
<https://www.preventioninstitute.org/publications/adverse-community-experiences-and-resilience-framework-addressing-and-preventing>; <https://www.healthypeople.gov/2020/topics-objectives/topic/Adolescent-Health>
<https://www.healthypeople.gov/2020/topics-objectives/topic/health-related-quality-of-life-well-being>

Key Community Partners: Ascension Lutheran Church (Apple Valley), High Desert Church (Apple Valley, Hesperia, Phelan and Victorville campuses), Life Church (Victorville), The Gate Church (Victorville), San Bernardino County Department of Behavioral Health, Hospital Association of San Bernardino County – Inland Region, Stars Behavioral Health-Crisis Walk-In Center (Victorville), Family Assist (Victorville), Adelanto School District, San Bernardino County School District, Apple Valley Unified School District, Hesperia Unified School District, Victorville Elementary School District, Victorville High School District, St. Mary High Desert Medical Group, Shiloh Medical/Specialty Health Partners, Family Service Agency of San Bernardino, Prevention Institute, San Bernardino County Sheriff, Adelanto, Apple Valley, Hesperia, Victorville city governments, Hospital Association of Southern California, San Bernardino County Workforce Development, County Supervisor Robert Lovingood, St. Joseph Health Community Partnership Fund, National Association of Mental Illness – Inland, San Bernardino and Pomona chapters.

Resource Commitments:

- Counseling staff at community health clinics and St. Mary High Desert Medical Group,
- Hospital staff continuing in HASC-IE/County hospital collaborative;
- Continuation of Faith Health initiative, staff supporting faith, school and community-led mental health education and support groups; continuation of Memorandum of Understanding between hospital and County Department of Behavioral Health for Triage Engagement and Support Teams (TEST) program,
- Grant funds to engage Prevention Institute in community coalition building over three years;
- Hospital engagement in Hospital Association’s Communities Lifting Communities initiative.

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

Addressing the Needs of the Community: Access to Resources
FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan

3. Initiative/Community Need being Addressed: Obesity/Child Wellness

Goal (anticipated impact): Promote health and reduce chronic risk through the consumption of healthy foods and maintenance of healthy body weight

Outcome Measure	FY17 Baseline	FY18 Target	FY19 Target	FY20 Target
Decrease the prevalence of adult obesity (ages 18+)	36.6%	TBD	TBD	35% San Bernardino County
Improve regular physical activity of youth (ages 5-17 years)	24.2%	TBD	TBD	23.9% San Bernardino County

Strategy(ies)	Strategy Measure	FY17 Baseline	FY18 Target	FY19 Target	FY20 Target
Implement Communities of Excellence Nutrition and Physical Activity campaigns in community and faith locations	# of adults reporting weight loss through fitness campaigns	69	200	300	300
Implement “Wellness for Youth” in elementary schools	# of students engaged in wellness and movement program	550	1,000	1,500	2,000
Participate in school district wellness committees	# of school district wellness committees	0	1	2	3

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

Addressing the Needs of the Community: Access to Resources
FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan

3. Initiative/Community Need being Addressed: Obesity/Child Wellness (continued)

Goal (anticipated impact): Promote health and reduce chronic risk through the consumption of healthy foods and maintenance of healthy body weight

Evidence Based Sources: <https://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status/objectives>
<https://www.cdc.gov/healthyschools/shi/index.htm>
<http://assessment.communitycommons.org/CHNA/ActionExample.aspx>

Key Community Partners: Adelanto, Apple Valley, Hesperia, Snowline and Victorville school districts, Principals, 5th grade teachers, parents and students, school wellness councils, Faith partners, SQORD, local fitness events, San Bernardino County Nutrition Action Partnership, Healthy City campaigns, High Desert Food Collaborative

Resource Commitment: Director of Community Wellness Innovation, Communities of Excellence staff and partners, staff at faith communities, school teachers.

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

Addressing the Needs of the Community: Access to Resources
FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan

4. Regional Initiative/Community Need being Addressed: Youth readiness entering school

Goal (anticipated impact): “upstream” effort supporting education partners leading to improved child readiness in one low income community

note: SJHH regional initiative addressing education as social determinant of health

Outcome Measure	FY17 Baseline	FY18 Target	FY19 Target	FY20 Target
use of Early Development Instrument (EDI) in High Desert to improve child development (SJHH regional work addressing social disparity)	0	TBD		TBD

Strategy(ies)	Strategy Measure	FY17 Baseline	FY18 Target	FY19 Target	FY20 Target
Begin research to identify use of EDI for children entering school	#of entities using tool	0	TBD	TBD	TBD
	# of best practice strategies being used to identify high need children				
Develop network of early child health advocates	#of partners	2 (First 5) San Bernardino County Pre-schools Department	3	5	7

Note: above initiative supports SJH-Hoag Affiliation agreement to address social disparity - education

Evidence Based Sources: <http://www.healthychild.ucla.edu/ourwork/edi/>

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

Key Community Partners: UCLA Center for Healthier Children, Families and Communities, St. Joseph Health – St. Jude, Children & Families Commission of Orange County, San Bernardino County First 5 Commission, local school districts, Hospital President & CEO, Children’s Fund of San Bernardino, San Bernardino County Public Health, San Bernardino County Pre-School Services, San Bernardino County Superintendent of Schools, physician partners, Family Assist, Inland Empire Health Plan.

Resource Commitment: Advocacy of Hospital President & CEO, Director of Advocacy and Healthy Communities, staff of Community Health Department, staff of Community Health department.

*St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report*

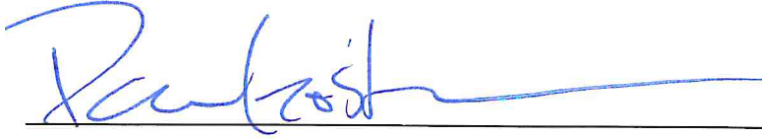
Other Community Benefit Programs and Evaluation Plan

Initiative/Community Need Being Addressed:	Program Name	Description	Target Population (Low Income or Broader Community)
1. Access to Resources	Health Insurance Enrollment	Enrollment of uninsured persons	Low Income
2. Access to Resources	Board Memberships	Strengthen partners addressing social determinant of health issues including homelessness, food insecurity	Low Income
3. Access to Resources	Healthy Beginnings	Prenatal Services	Low Income
4. Access to Resources	Transportation	Transportation of patients	Low Income
5. Access to Resources	Post-Acute Care	Access to specialty care	Low-Income
6. Access to Resources	Health Careers	Expand Health Professions	Broader Community
7. Access to Resources	Diabetes	Diabetes self-management	Low Income
8. Obesity	Healthy City campaigns	Expand neighborhood access to healthy food, fitness, safe recreation	Low-Income and Broader Community
9. Mental Health	The Fam Spot	Counseling to at-risk youth at drop in center	Low-Income
10. Mental Health	St. John of God	Mental health care to persons recovering from alcohol and drug addiction	Low-Income
11. Health Disparities (a)	Revive Our Old Town (ROOT)	Revitalization of old-town Victorville – community safety, economy, housing, education	Low Income
12. Health Disparities (b)	Communities Lifting Communities	Reduce Health disparities across southern, CA	Low Income

(a) Funded by SJH Community Partnership Fund ; (b) Funded by Hospital Association of Southern California

Governance Approval

This FY18-FY20 CB Plan/Implementation Strategy Report was approved at the meeting of the St. Joseph Health, St. Mary Community Benefit Committee of the Board of Trustees.



Chair's Signature confirming approval of the FY18-FY20 CB Plan/Implementation Strategy Report

9/19/2017

Date

Appendix

Definition of Terms

Community Benefit: An initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives:

- a. Improves access to health services;
- b. Enhances public health;
- c. Advances increased general knowledge; and/or
- d. Relieves government burden to improve health.

Community benefit includes both services to the poor and broader community.

To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following:

- a. Community health needs assessment developed by the ministry or in partnership with other community organizations;
- b. Documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; or
- c. The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

Health Equity: Healthy People 2020 defines *health equity* as the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”

Social Determinants of Health: Powerful, complex relationships exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies. These factors, which influence an individual’s or population’s health, are known as *determinants of health*. *Social determinants of health* are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Initiative: An initiative is an umbrella category under which a ministry organizes its key priority efforts.

Program: A program is defined as a program or service provided to benefit the community (in alignment with guidelines).

St. Joseph Health, St. Mary
FY18 – FY20 Community Benefit Plan/ Implementation Strategy Report

Goal (Anticipated Impact): The goal is the desired ultimate result for the initiative's or program's efforts. This result may take years to achieve and may require other interventions as well as this program. (E.g. increase immunization rates; reduce obesity prevalence.).

Scope (Target Population): Definition of group being addressed in this initiative: specific description of group or population included (or not included, if relevant) for whom outcomes will be measured and work is focused. Identify if this initiative is primarily for persons living in poverty or primarily for the broader community.

Outcome measure: An outcome measure is a quantitative statement of the goal and should answer the following question: "How will you know if you're making progress on goal?" It should be quantitative, objective, meaningful, and not yet a "target" level.