Adelanto residents and city leaders advocate for health in their neighborhoods

ST. JOSEPH HEALTH, ST. MARY
2014 Community Health Assessment Report

St. Joseph Health
St. Mary

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EXECUTIVE SUMMARY
OVERVIEW OF COMMUNITY HEALTH NEEDS ASSESSMENT

In 2012 and 2013 St. Joseph Health, St. Mary (SJH, St. Mary) conducted a Community Health Needs Assessment (CHNA) following processes developed by St. Joseph Health. These processes comply with new Internal Revenue System regulations addressing non-profit hospitals conducting and reporting community health assessments and the development of community benefit plans addressing unmet needs. SJH, St. Mary is the only non-profit hospital serving the community. For 60 years the hospital has been privileged to serve residents of the Barstow and Victor Valleys. The region's population growth has increased to 430,000 residents. In response, SJH, St. Mary is constructing a second hospital that will open in 2017. The new hospital will be located in the city of Victorville. This second hospital enables SJH, St. Mary to serve communities currently without a hospital including Adelanto, Hesperia, Oak Hills, Phelan and Wrightwood.

Local health data identified (16) significant health conditions prioritized to four

In 2011 SJH contracted with Professional Research Consultants (PRC) a national health firm with expertise conducting comprehensive community health surveys. PRC worked with SJH to design, conduct and assess a comprehensive health survey for the communities located within SJH. St. Mary's Primary and Secondary service areas. The 156 question survey instrument was based largely on the Centers For Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS) and other national health sources including indicator data relative to national health promotion and disease prevention objectives targeted by Healthy People 2020. Collection of primary health data from the survey were based on responses from a sampling of 750 residents living in the hospital's Primary and Secondary Service areas. Survey results were cross referenced with a baseline of local health data (established using a PRC survey conducted in 2007) and the latest available state and national data including Healthy People 2020 targets. The assessment of 2012 with 2007 health data identified 16 health conditions of concern. In turn, this list was prioritized to seven (7) and finally to four (4) priorities. Three priorities address chronic health conditions identified at prevalence levels significantly higher than reported for the state. The fourth priority is access to care which will address barriers preventing persons from accessing health services. This selection is based on community feedback, the difficult economy, the cutbacks in programs serving the poor, the implementation of Covered California and recognition that access issues are worsening. Providing input during priority setting was a variety of local and county-wide partners including San Bernardino County Public Health, leaders of local non-profits, homeless persons and residents living in the

poorest community as identified from community mapping. The table below lists significant issues identified by the PRC health survey for the Barstow and Victor Valleys. The table includes results from a similar 2007 health assessment as well as disease benchmarks reported at the state and national levels. The health survey was conducted prior to the county publishing its community vital signs health assessment. The county report reports county-wide health measures to 2009 while the PRC survey findings are specific to the communities of the Barstow and Victor region and current to 2012.

16 health/social conditions of significance identified from PRC assessment

Condition	2012 Prevalence	% increase (over 2007 baseline)	Hospital Response	Benchmarks
1.Asthma Child	13.1%	.9%		Decreased to 14.2% in CA
2. Cancer Cancer (skin)	5.2% 5.6%	.2% .4%		5.5% national 5.8% national
3. Diabetes	15.3%	3.9%	Priority	CA 8.6% Elderly, minorities, low income
4. Stroke	3.3%	.4%		
5. Hypertension High Cholesterol	35.2% 34.0%	3.4% 6.8%		36.5% in CA Lower in S. CA
6. Depression	13.5%	.7%		11.7% national
7. Low self –rated Mental Health	18.4%	3.9%	Priority	11.7% national
8.Arthritis/Activity Limitations	26%	4.0%		21% national
9. Self-Rated Health	23%	4.7%		18% CA 17% national
10. Adult Overweight/ Obese	37% 33%	6.6% 6.1%	Priority	CA 36% CA 24%
11. Accessing Grocery Stores	18.5%	3.4%		14.4% S. Cal
12. Alcohol	18.9%	3.3%		15.8% national
13. Tobacco	20%	1%		12.2% in CA
14. Adult Dental Care	57%	N/A		70% national
15. Uninsured	21.6%	2.1%		
16. Health Access	41.5%	3.1%	Priority	37.3% national

A discussion of the 16 significant health conditions and how the hospital and its partners are responding is provided below.

1. Child Asthma – rose slightly to 13.9% but is still below the 14.2% reported for California. A hospital partner, San Bernardino County Public Health provides asthma care via a mobile medical service visiting local schools on a regular schedule. Services are provided for free. Hospital staff partner who work with schools and families regularly refer families to the asthma service. Additionally, the county's largest health insurance provider (Inland Empire Health Plan) has staff (named Health Navigators) assisting families who have been identified as frequent users of hospital Emergency Rooms for asthma care. These programs are supported with grant funds from First 5 San Bernardino.

2. Cancer - levels of cancer and skin cancer rose slightly from 2007 but are still below the state level of 5.5% and 5.8% respectively. The hospital will continue to monitor cancer levels in the event programs need developing. The region is noted for extremely hot weather and the hospital recognizes that cancer rates may increase as a result of climate change and the aging population. The region currently provides limited oncology services with advanced care provided by two out of the region hospitals: Loma Linda University Medical Center and the City of Hope hospital.

3. Diabetes – levels of diabetes rose 3.9% to 15.3% which is significantly higher than the 8.6% reported for the state. The hospital recognizes that diabetes is increasing at the state and national levels. The hospital has again selected diabetes as a priority community benefit program. The hospital will look to expand diabetes programs currently run by the hospital's Diabetes Education department and Community Health departments. The programs have successfully helped teach patients self-care including annual eye and foot exams. Additionally, the hospital will stress the preventative benefits of healthy eating and regular exercise. The hospital has developed community partners teaching nutrition and diabetes care in the community.

4. Stroke – the prevalence of stroke has risen .4% to 3.3%. The hospital has been working to achieve County designation as a Stroke receiving center to add to its designation as a STEMI receiving center. The hospital is currently expanding its line of heart and vascular services, education and outreach including free screening services. A second local hospital (Desert Valley Hospital) opened its new Heart Care Center in 2012. Both hospitals offer Cardio rehab care and free education on controlling the

modifiable risk factors including but not limited to: high blood pressure, high cholesterol, cigarette smoking, poor diet and inactivity and overweight and obesity.

5. Hypertension & High Cholesterol - has increased in the region to levels equal to what is reported at the state level with cholesterol increasing 6.8% from 2007. The hospital believes its efforts addressing obesity and diabetes support reducing these health conditions as well as county-wide efforts to promote healthy eating and exercise.

6. and 7. Depression & Poor Mental Health (self-reported) – levels of both health conditions (13.5% and 18.4%) have increased from 2007 and are above those reported at for the state. The hospital has selected mental health as a priority community benefit program. Limited behavioral health services are currently provided at the hospital's community clinics (pregnant women and families with children 5 years and younger). Additionally, the hospital successfully recruited a clinic partner (Mission City) providing low cost psychiatry care. The hospital refers patients to the clinic. The hospital will look to improve upon a local collaborative addressing mental health with the hope of filling gaps and improving services. Two current gaps include: (1) no local inpatient psychiatric center and (2) the need for more psychiatry services to low income persons.

8. Arthritis & Activity Limitations – levels are reported increasing 4% points to 26% above the 21% prevalence reported nationally. The hospital is working with partners to engage seniors in a variety of wellness and health promotion programs. SJH, St. Mary and Desert Valley Hospital run large senior programs including walking and exercise programs. The hospital will monitor the prevalence of these conditions understanding that programs offering earlier diagnosis may be required above the traditional diagnosis by primary care physicians.

9. Poor/Fair self-rated health – the percentage of persons self-reporting that their health status is either fair or poor increased 4.7% to 23% above both the state (18%) and national (17%) benchmarks. Lack of health insurance, no medical home and low income are typically strongly correlated with poor health. The hospital will continue to assist with enrollment of Covered California in an effort to establish health insurance to the estimated 67,000 uninsured of the Victor Valley. Although the hospital has physician partners providing pro-bono clinics to the poor, the hospital recognizes that low cost and/or free specialty care services are in high demand. The hospital anticipates that the uninsured obtaining health insurance and access to more physician care, will increase the number of persons self-reporting: good, very good or excellent health.

10. Adult Overweight & Obesity - since 2007 the prevalence of adults with weight risks has increased 6.6% and 6.1% respectively above the state benchmarks of 36% and 24%. The hospital has identified adult weight as a priority program and is responding by adapting a successful child obesity program it runs across the region. Additionally, the hospital has been urged by San Bernardino County public health to continue a partnership involving local communities adopting healthy lifestyles. PRC health findings report a decrease in local levels of child obesity from 20.9% to 16.7%.

11. Accessing Grocery Stores – the percentage of persons self-reporting barriers accessing grocery stores increased 3.4% to 18.5% which is higher than the 14.4% reported for southern California. The hospital and county public health are well aware that the region has multiple "food deserts" and that the physical environment of many communities provides too little access to fresh fruit and vegetables. The county is ranked in the lower quartile (46th out of 57 California Counties) in its physical environment promoting health (limited access to healthy foods) as reported in the 2013 County Health Rankings and Roadmaps. The county health department continues to provide grant support to the hospital to assist in efforts to bring healthy foods to the region. Access to fresh produce has been requested by residents of north Adelanto.

12. Alcohol Use – increased consumption (chronic and binge) of alcohol has increased 3.3% to 18.9% which is above the 15.9% reported nationally. The hospital will continue supporting a local partner (Institute for Public Strategies) working to pass local ordinances addressing alcohol use and the sale of alcohol. The hospital has asked IPS to address this public health risk in the local Healthy City campaigns. City leaders have resisted health advocacy on using alcohol license moratoriums.

13. Tobacco Use – health data reports a 1% increase in tobacco use to 20% in 2012 which is significantly higher than the 12.2% level reported at the state level. The hospital is working with each local Healthy City campaign in an effort to increase ordinances that further ban public smoking and/or remove the sale of tobacco. Additionally, the hospital will be designated smoke-free in 2014 and the hope is that other local health facilities follow suit. The hospital provides grant support to St. John of God Health Care services that are tobacco addition as part of their work with substance abuse.

14. Adult Dental Care – it is reported that 57% of High Desert adults make annual visits to a dentist whereas the national level is reported at 70%. The hospital operates no dental programs however the hospital has funded a local dental clinic which provides

low cost dental services to the poor. The clinic's board includes hospital leaders who are working to secure additional grants and a partnership with a local Federally Qualified Health Clinic recently operated by San Bernardino County Public Health.

15. Uninsured – the number of uninsured has increased 2.1% to 21.6% slightly above the state level of 20%. The hospital will continue its campaign enrolling the uninsured into Covered California. Estimates from IEHP and UCLA report 67,000 uninsured persons in the High Desert. Covered California reports the region is the 5th largest uninsured population in the Inland Empire region of southern California. The hospital is the region's only representative of a two-county Health Insurance Initiative. The hospital enrolls the uninsured at its hospital, through its community clinics and with staff working in schools, churches and family resource centers.

16. Health Access Issues – health survey data reports a 3.7% increase (to 41.5%) in persons reporting barriers to accessing the health services whereas the national level is reported at 37.3%. The hospital is working to develop an outpatient system of care to address some of these barriers to include recruiting specialists to the region. Additionally, the hospital has successfully recruited four (4) community clinics to the community. The hospital now schedules patients to the clinics for follow-up care. Improving access has been selected as a key local and regional priority to improve.

Of the 16 significant health conditions identified in the PRC health assessment, the hospital has selected four: Access to Care, Diabetes, Mental Health and Obesity. By addressing obesity the hospital plans to prevent diabetes and lower the percentage of persons reporting high levels of cholesterol and high blood pressure. The hospital's work in obesity will also address residents reporting problems assessing healthy foods. The hospital will continue to implement the region's only comprehensive diabetes program caring for low income and uninsured persons. Additionally, the hospital has identified diabetes care as a key quality standard with its primary care physician partners. The hospital's selection of mental health is in response to the significant increase reported by the assessment. The hospital has also been approached by public health on efforts addressing access to both primary and specialty care. On the next page the CHNA will discuss how community level mapping has identified local neighborhoods facing significant economic, health and social disparities. This mapping process enables the targeting of hospital and partner resources to the most vulnerable.

Conducted socioeconomic mapping that identified communities with greatest needs

A second feature of the hospital's CHNA process included mapping community need to rank order local populations facing the greatest disparities accessing care. The first mapping process identified nine (9) "Highest Need" communities with 271,388 residents experiencing disparities in care. A second mapping process, conducted at the "Block Group level", identified thirty-five (35) neighborhoods with 87,439 residents impacted by severe hardships accessing care. Residents living in these communities will continue to be priority populations in the hospital's community benefit interventions. This includes operating clinics serving the poor, providing mobile health services in smaller neighborhoods and leading extensive health education and health insurance enrollment campaigns that include improving the physical environment. To this end the hospital will continue its partnership recruiting grant funders to develop community assets including residents accessing fresh produce, safe streets and parks and recreation. Finally, the hospital will partner to help bring additional health services to the region.

Joined hospital-public health collaborative to improve regional health planning

To assist San Bernardino County in moving toward a collaborative health planning process, the hospital joined a county-wide committee, including non-profit hospitals and representatives of San Bernardino County's Public Health and Healthy Communities programs. The collaborative assists hospitals to implement their respective CHNAs with input from San Bernardino County government. In 2011 San Bernardino County leaders officially adopted health and wellness as part of its county strategic plan http://cms.sbcounty.gov/cao-vision/Elements/Wellness.aspx. The county completed a county-wide health assessment titled *Community Vital Signs* released in 2013. The first of its kind, the comprehensive report aggregates health and economic data over a five year period (2007-2011). Additionally, the health collaborative allows Community Benefit and Public Health experts to collaborate on health interventions. The hospital submitted its processes using the PRC health survey and the mapping methodology used by SJH which objectively identifies "high need neighborhoods". The health forecasting work of UCLA was conducted for all of San Bernardino County as well as the local catchment area of SJH, St. Mary. The hospital will continue its advocacy to other hospitals and county public health that the SJH mapping processes should be considered on a wider scale in an effort to better target limited health and social resources to neighborhoods facing the greatest disparities in care.

Received community feedback from public health and persons in poverty
SJH, St. Mary conducted local community focus groups to obtain feedback on the significant health issues and which quality of life issues the hospital could support. The hospital collected community feedback by conducting focus group meetings with local non profits serving the community's poor, interviewing homeless persons at Food Banks and meeting with residents living in communities identified as having significant barriers to care. Additionally, health findings from the homeless surveys, along with agency and resident feedback, were provided to the hospital's Community Benefit Committee. The Committee assessed this feedback to finalize a list of significant health findings. The committee's decision , like that of residents, looked at prioritizing health issues by severity, the impact over time on the population and by what resources could make a difference meeting the needs. This list of prioritized health issues has been provided to San Bernardino County Public Health. A member of the county health department serves on the hospital's Community Benefit committee.

SJH, St. Mary engaged the expertise of Professional Research Consultants (PRC) to conduct a randomized telephone survey using a 156 question health questionnaire to 750 households located within the hospitals Primary and Secondary Service Areas. The purpose of this large survey was to collect a statistically reliable quantity of local health data that enabled comparison with disease prevalence rates reported at the San Bernardino County, California and national levels including health goals established in Healthy People 2020. Health data was collected and analyzed by PRC producing a list of significant health issues. The list of significant health issues was then used in community focus groups and shared with San Bernardino County public health for feedback. Additionally, the list of health issues was shared with a collaborative of San Bernardino County hospitals working to improve Community Benefit planning and implementation. Finally, the health issues were provided to the Health Forecasting team at UCLA. This team of public health experts developed a process forecasting health issues to identify future prevalence rates. The forecasting process allows modeling how differing interventions impact health improvement. The forecasting work has been completed in late 2013 with forecasts developed to 2020.

COLLABORATING ORGANIZATIONS

SJH, St. Mary completed the CHNA with input from a network of health partners. Since SJH, St. Mary is the only non-profit hospital serving the region, no local hospitals assisted in underwriting the production of health survey data. A listing or partners

who provided health data from their CHNA or supported the hospital with community feedback is listed below.

PARTNERS ASSISTING HOSPITAL WITH FEEDBACK AND PRIORITIES

Organization Name	Organization Location	Type(s) of Support
Academy For Grassroots Development	Phelan, CA Apple Valley, CA	Hosted focus group of 52 Victor Valley non-profits to discuss and help prioritize significant health issues impacting Victor Valley residents
Azusa Pacific University High Desert Campus	Victorville, CA	Hosted nursing students to discuss and prioritize chronic disease levels and public health issues impacting Victor Valley
Barstow non profit council	Barstow, CA	Hosted 5 local non-profits feedback on health issues impacting Barstow Valley
Hospital Association of Southern California	Riverside, CA	Hosts CHNA & Community Benefit collaborative
High Desert Outreach	Adelanto, CA	Hosted focus group of 18 residents, city non-profits and city leaders

PARTNERS ASSISTING HOSPITAL WITH FEEDBACK AND PRIORITIES

Organization Name	Organization Location	Type(s) of Support
Institute for Public Strategies	Victorville, CA	Hosted resident meeting of 8 to help prioritize health findings and advocate local policy change
Loma Linda University Medical Center	Redlands, CA	Provided feedback to local health data including advocacy on interventions and policy, hosted UCLA
Lords Table & Feed My Sheep Ministries	Victorville, CA	Hosted homeless surveys of 128 low income residents on health and social needs
Kaiser Permanente	Fontana, CA	Provided health findings from its CHNA for Fontana Hospital
San Bernardino County Public Health & Healthy Community Programs	San Bernardino, CA	Provided county level health data and feedback on local health findings and interventions
St. Joseph Health	Irvine, CA	Provided technical assistance conducting CHNA including health survey design and community mapping
UCLA Fielding School of Public Health – Health Forecasting Project	Los Angeles, CA	Provided forecasting and modeling data for local health conditions to develop long-term perspective on population health, resource needs and identification of which policies and interventions have greatest impact
Victor Valley Transit Authority	Hesperia, CA	Provided technical input on public transit of poor

COMMUNITY INPUT

The hospital conducted a series of five (5) focus groups and an additional survey to gather community input and perspective with solutions and partners. One hundred and twenty-eight (128) *low income and homeless persons* identified pressing health and social needs including access to more food, and housing, employment and the need of eye care. The survey was designed by the hospital and conducted in the community of Victorville with assistance of *Feed My Sheep Ministries* and *The Lords Table* hot meal program. The survey was conducted in the area of Victorville where the homeless reside. Community level mapping identifies the neighborhood has having "highest needs". The hospital selected surveying the homeless after supporting *San Bernardino County's Department of Behavioral Health's Office of Homeless Services* collaborative effort to count the county's homeless. A homeless report produced from the survey count identified the Victor Valley as having the second highest population of chronically homeless in San Bernardino County. Access to health services for homeless includes eye, oral and mental health.

Findings from the PRC health survey were studied and a list of 16 priority health and lifestyle issues developed. These findings were reviewed by the hospital's Community Benefit Committee which initially ranked seven (7) issues as significant. The Committee asked the hospital to seek community input asking that focus groups prioritize health findings from the list of 16 conditions. Additionally, committee members urged community feedback to also include quality of life concerns. Focus group meetings were then held with *leaders* from *San Bernardino County's Departments of Public and Behavioral Health*, resident leaders making up the *Institute for Public Strategies*, *residents and city leaders* of *the City of Adelanto and Barstow.* Focus group meetings in Adelanto and Barstow were both located in neighborhoods mapped by the hospital has having "highest needs". Both African American and Spanish speaking residents were engaged in feedback sessions hosted by IPS in Victorville and High Desert Outreach in Adelanto. Finally, the communities of Adelanto have been designated by the U.S. Department of Health and Human Services as a Medically Underserved Area with Barstow designated as being a Primary Care Health Professional Shortage Area and a Mental Health Professional Shortage Area. The hospital continues to operate a clinic serving Adelanto and in 2012 recruited Molina to open a primary care clinic there. Feedback representing the broader community was obtained by hosting a large focus

group of 52 local non-profits serving the population in the hospital's primary and secondary service areas.

COMMUNITY NEED

Community Needs Prioritized

The hospital's community benefit committee considered community feedback which aligned with the committee's previous ranking of seven (7) significant issues from an original list of 16 provided by the PRC health survey. The hospital prioritized to four (4) issues that will be developed into a three (3) year Community Benefit Report for fiscal years 2015-2017. Addressing these priorities enables the hospital to leverage its expertise and collaborative strength with obesity and diabetes, two disease conditions the hospital is already achieving success with. Mental health and addressing care for the homeless will be collaborative efforts. The hospital's limited resources in each area will require extensive collaboration to develop programs meeting these needs. In the case of Adelanto and Barstow their feedback urges hospital advocacy recruiting actual healthcare providers or clinics locate to their respective communities. Listed below are the conditions selected by the hospital and for comparison how they were ranked in the 2013 CHNA completed for Kaiser Foundation - Fontana. The Kaiser Foundation Hospital- Fontana is the second non-profit serving the Victor Valley. Community Benefit staff from each hospital work closely on programs and grants.

Four Significant Health Issues/Conditions Selected

Significant Health Issue	2012 % increase over 2007 baseline within Hospital's service area	Ranking by SJH, St. Mary CHNA	Ranking By Kaiser Fontana CHNA
Obesity	6.6% increase to 35%	1*	7
Diabetes	3.9% increase to 15.3%	2	4
Mental Health	3.9% increase to 16.4%	3 **	2
Access to Care	3.1% increase to 41%	4	3

Notes:

* Addresses hypertension and high cholesterol which also increased from 2007

** Addresses depression and community requests for more mental health providers

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. St. Mary is also guided by a fifth value of Hospitality provided by the Brothers of St. John of God who co-sponsor the hospital.

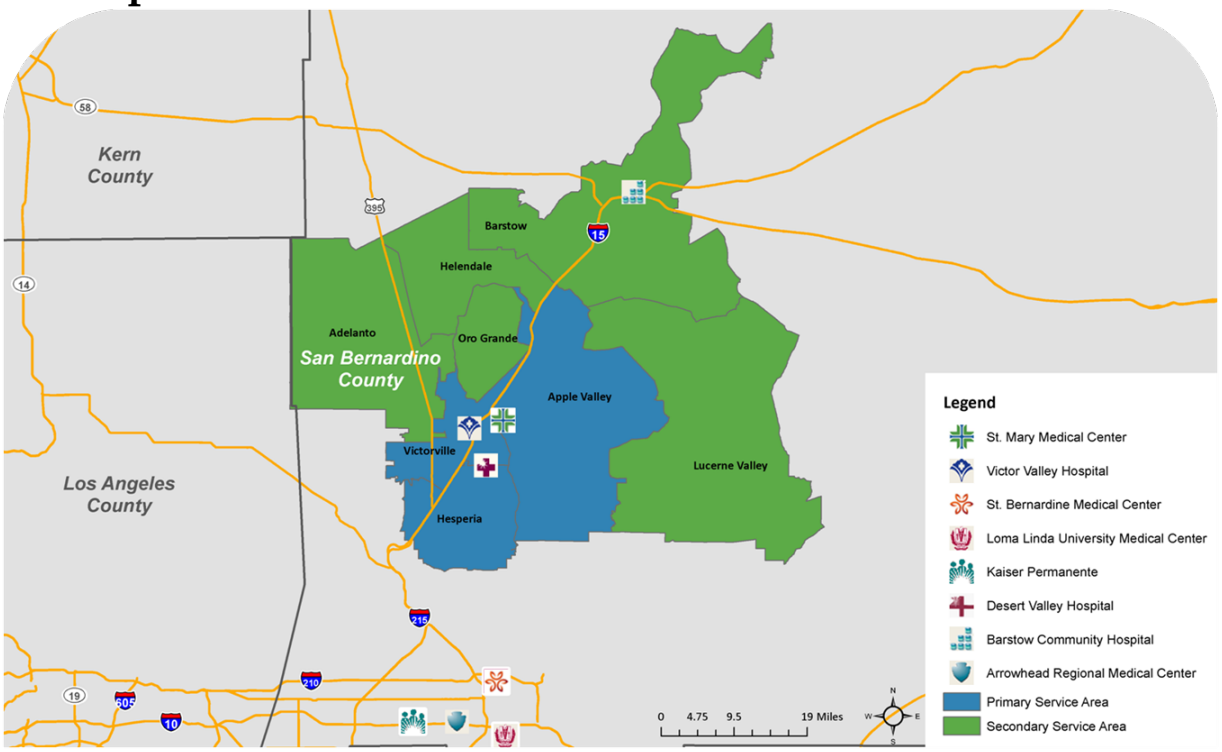
INTRODUCTION – WHO WE ARE AND WHY WE EXIST

For 60 years SJH. St. Mary has been privileged to serve the residents of the Barstow and Victor Valley regions in the tradition of the Brothers of St. John of God and the Sisters of St. Joseph of Orange. Today, the 201 bed hospital is the region's largest provider of acute care services. The hospital is also known for its extensive community engagement serving the poor, helping improve the health of the region and partnering to improve the region's quality of life. The hospital supports a community health department operating three fixed community clinics serving the poor and a mobile medical service reaching rural neighborhoods and multiple local health fairs. The clinic programs are providing maternal mother/baby and diabetes care to high risk populations and their work has routinely surpassed Healthy People 2020 targets. The department has received multiple awards for patient satisfaction and took a leadership role in the hospital obtaining its designation as a *Baby Friendly* hospital. Additionally, the hospital supports a Healthy Community department with programs working to enroll the uninsured, make local neighborhoods healthier through increased access to fresh foods and recreation, and leading advocacy campaigns on policies promoting and protecting health.

ORGANIZATIONAL COMMITMENT
Community Benefit Governance and Management Structure

The SJH St. Mary's Community Benefit (CB) Committee is a formal committee of the hospital's Board of Trustees (BOT) which oversees the direction of programs serving community needs. The hospital's Mission encompasses the direction of the hospital's community benefit programs "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." The CB Committee meets quarterly to review and discuss progress implementing community benefit programs as well as programs exclusively serving the needs of the poor. Additionally, the committee reviews data collected by the hospital's CHNA process to establish priorities. A board member chairs the CB Committee with additional board members appointed terms. Hospital representatives include the President and Chief Executive Officer and the Vice President for Mission Integration as well as the Director of Community Health and Healthy Communities. Additionally, members include representatives from public health, community leaders with local knowledge of health and social needs and disparities in care. Committee activities include, but are not limited to (1) reviewing health data and community needs, (2) providing feedback on the effectiveness of hospital and community interventions, (3) discussions expanding partnerships and providing input developing interventions and (4) serving as advocates for program support and resources. The CB Committee reports to the hospital's BOT recommendations on how CB priorities address community needs, updates on programs assisting the poor, awards of grants and expanded collaboration at local and county levels. Findings from the CHNA were used by the hospital in development of a strategic plan. The hospital's new strategic plan will develop a network of outpatient services to best serve the health needs of the population. For example, CHNA findings reporting elevated levels of tobacco supported the hospital moving to a smoke-free campus. Similarly, the community's high prevalence of diabetes has the hospital and primary care physicians partnering on strategies helping patients care for their condition. Finally, the hospital and physician partners have started a Coumadin Clinic serving the uninsured with no access to the required physician follow-up care they need.

Community
Description and Profile of Communities Served



SJH St. Mary's Community Benefit Service Area is roughly defined as serving the Victor Valley region of San Bernardino County with a total population of 430,795 as reported by 2010 U.S Census Data. The larger communities of Apple Valley, Hesperia and Victorville comprise the hospital's primary service area and the smaller communities of Adelanto, Barstow, Helendale, Lucerne Valley, Oro Grande, Phelan and Oak Hills and Wrightwood make-up the hospital's secondary service area. The hospital's primary and secondary service areas currently serve residents of three (3) of San Bernardino county's five (5) supervisory districts. The region experiences out-migration for trauma and specialty care provided by Arrowhead Regional Medical Center and Loma Linda University Medical Center.

The region is 90% desert and the largest nearest metropolitan area - the City of San Bernardino is 40 miles away. The service area is noted as having significantly higher percentages of indigent and uninsured populations when compared with both state and national levels. Additionally, residents suffer from heart disease, diabetes, adult obesity and stroke at levels well above California and national benchmarks. Over 90% of the hospital's community benefit area has been identified as "High Need" from scoring and

aggregating socioeconomic indicators (e.g., income, race, family size) contributing to health disparities. With some exceptions, these health and social conditions are largely homogenous across San Bernardino County. For this reason nonprofit hospitals in San Bernardino are reporting similar increases in chronic diseases and overwhelmed safety net providers. These common challenges coupled with less funding is fostering greater collaboration between hospitals, county health agencies, universities and local governments. An example includes hospital collaboration with the UCLA Fielding School of Public Health. Medical researchers will model and forecast the prevalence of significant diseases to the year 2035 for the county and the hospital's specific service area. The project's aim is providing evidence-based data to hospitals for short and long-term strategic community benefit planning.

The hospital's service area is comprised of four (4) major communities with some unique demographic, economic and health characteristics. The total population of the hospital's primary and secondary service area (430,000) is approximately equivalent to that in the city of Oakland. These communities have recently begun economic collaboration in response to the difficult economy and loss of redevelopment funds. Retail development has picked up for Apple Valley, Hesperia and Victorville with Adelanto lagging with little new activity. Very few new housing developments are in progress and most construction projects are commercial rehabilitation. The region is undergoing major highway and overpass improvement which improves traffic flow and provides additional economic opportunity to Apple Valley, Hesperia and Victorville. The hospital serves a number of smaller communities including: Helendale (zip code: 92342), Lucerne Valley (zip code: 92356) Oro Grande (zip code: 92368), Phelan (zip codes: 92329, 92371) and Wrightwood (zip code: 92397) A detailed look at the larger population centers the hospital serves follows below.

Victorville (Zip Codes: 92392, 92394, 92395) - The 50th largest city in California has a 2010 US Census reported population of 115,903. The city is approximately 74 square miles in size at an elevation of 2,726 ft. Demographic data reports 47.8% of residents are Hispanic with White 28.3% followed by Blacks at 16%. Over 30% of residents are between the ages of 0 to 19 years of age which as a percentage is larger than reported at the county level. Economic data reports the median income in Victorville is $52, 983 (among African American families just $44,767) with poverty highest (30%) in African American families followed by Hispanic (16%) and White (9%). City government addressed budget deficits with program consolidation and staff reductions. City tax revenue is returning as a result of increases in retail sales with some new housing starts. Home prices are increasing however 40% of sales are identified as "distressed" the

result of bank foreclosure. The city is home to the area's major community college Victor Valley Community College and several for profit colleges including Azusa Pacific and Chapman. The city continues developing an intermodal transportation hub named Southern California Logistics Airbase (SCLA) from the former George Air Force Base. The SCLA economic hub seeks major investors and employers from the aviation and manufacturing sectors. The city has formed a "Healthy Victorville" campaign in partnership with county public health, SJH, St. Mary, Desert Valley Hospital, Kaiser and Victor Global Medical Center. The campaign is urging increased city investments in policy, parks and non-motorized transportation, to improve health. The hospital partners with food pantries including The Lords Table, Samaritan Helping Hands, Victor Rescue Mission, and shelters including Family Assist, A Better Way Domestic Violence and Victor Homeless shelter to help those in crisis. Each year SJH St. Mary awards grants to several of these partners including Catholic Charities for its immigration expertise. Additionally, the hospital partners with local community clinics offering low cost health services. This includes St. John of God offering substance abuse care and Mission City clinic offering behavioral health. Health data obtained from surveying residents identifies a 3% increase to 18.9% in alcohol (binge drinking) a 1% increase to 20% in tobacco use and a 4% increase to 18.9% of residents self-reporting poor mental health. The hospital's Community Health department has its mobile medical service providing weekly care to the area's uninsured which is now estimated at 21.7% of the population. Services of the mobile program include: primary care, immunizations, cancer screenings, diabetes care and health insurance enrollment. The hospital partners with Victor Community Dental Program with grants enabling them to provide dental care to adults in children. The hospital partners with local schools to implement family obesity programs. In April 2013 the hospital partnered with county health to assist the area's homeless. The hospital's support included a survey of what health and social services the homeless needed more of. Their response was employment, greater access to donated food, and access to vision care. The feedback is being used by the hospital and food pantry partners to secure grant funds expanding food access. Four large pantry programs are coordinating resources to expand donated food. Additionally, one pantry has acquired property with plans of creating a comprehensive homeless care center.

Hesperia (Zip Codes: 92344, 92345) - has 90, 173 residents as reported by the 2010 Census. The city is 73 square miles at an elevation of 3,186 feet. The city has no hospital and residents are dependent on accessing acute care at Victorville and Apple Valley hospitals 10 to 15 miles away. There are a reported 26, 431 households with 21.9% of black families living in poverty followed by 20.9% for Hispanic and 9.6% for

White families. These poverty rates are higher than county and state levels. Household income is $51,676, (lower than county and state levels) with Hispanic family income reported at $42,897, Black at $49,185 and White at $61,795. An estimated 35.8% of residents are between the ages of 0-19 years of age a higher percentage than reported at the county and state level. The percentage of students who are reported as overweight/obese is 41% slightly higher than the county and state ratings of 39.3% and 38% respectively. Hesperia is in the early stages of a "Healthy Hesperia" campaign that includes city representatives, public health, SJH St. Mary and representatives from the school and park and recreation districts. The city has started a weekly farmers market, invested in additional miles of bicycle lanes and is the only city supporting breastfeeding with a designated room in its City Hall. The hospital works closely with Hesperia school district to enroll uninsured children and to run obesity programs. The school district has one of the most engaged Spanish speaking parent groups which partners with the hospital to promote health literacy, nutrition and health insurance enrollment campaigns. The hospital partners with the Victor Valley Transportation Authority (VVTA) with regard to public transportation and health care access. VVTA has a dedicated bus route enabling residents of Barstow to access St. Mary for health services not provided at its community hospital. Additionally, VVTA is piloting a twice weekly bus route to Arrowhead County Hospital a distance of approximately 40 miles. This service is intended to enable low income patients (enrolled in the county's "Arrow Care" health insurance program) to access health services at the county hospital. The hospital is partnering with public health to increase the volume of uninsured patients cared for at its Hesperia Federally Qualified Health Center. The hospital schedules uninsured patients requiring a physician's follow-up care at the clinic. The hospital's Community Health department operates a clinic providing uninsured persons primary care, immunizations, well baby visits, cancer screening services, counseling and education and diabetes self-care. The hospital has also begun assisting a faith based program operated from Holy Family church to conduct resident organizing on immigration reform. The hospital has advocated to city leaders its concern about approving liquor and tobacco licenses on streets where availability is prevalent. The hospital provides grant support to a community garden that donates its produce to local food pantries. The hospital partners with a Hesperia physician who provides pro-bono care to uninsured patients at a monthly clinic. The physician has been nominated with the hospital's 2013 Justice Award for this work.

Apple Valley (Zip Codes: 92307, 92308) - has 69,135 residents as reported by the 2010 Census. The Town is 73.5 square miles at an elevation of 2,946 feet with 23,598 households with 69% White, 29.2% Hispanic and 9.1% Black and 2.9% Asian.

Approximately 31% of residents are between the ages of 0-19 years just higher than the county average and residents aged 50 to 85 years (a total of 35%) make up a higher percentage of residents than reported at the county and state level. The senior community has a high prevalence of adult obesity, problems accessing specialty care, diabetes and physical limitations. Asian household income is reported at $86,719 higher than county and state levels. Median household income is $56,547 higher than the county but lower than the state level. Hispanics and Blacks suffer unemployment rates of 17.0% and 20.9% respectively, nearly double the 9% rate for White residents. The Town of Apple Valley was the first community to begin a Healthy City campaign. As a key partner the Town has received grant funds to expand park and recreation programs, develop health promotion policies and install exercise equipment in neighborhood parks. The hospital sponsors several fitness events each year. SJH St. Mary works closely with the school district and two school-based family resource centers to enroll the uninsured and jointly run obesity programs. The hospital hosts Catholic Charities on its campus enabling patients and residents in crisis to receive food, utility and housing vouchers. The hospital supports the town's Police Activity League with grants. The PAL program serves at-risk youth with mentoring and physical activity resources and provides parenting education. The hospital operates a community clinic serving uninsured residents with primary care, education and counseling, immunizations, health insurance enrollment, diabetes self-care, well baby visits, breastfeeding support and cancer screening services. The hospital has provided senior residents a free care center catering to their health, education and social needs. This "Senior Select" program reports the largest membership in the region offering weekly educational programs. The hospital works with United Way in support of local nonprofit programs and to implement health insurance enrollment campaigns at schools and health fairs. The hospital partners in a senior health fair with Apple Valley Fire District and a family disaster education program with the LDS church. The hospital is on the board of the Chamber of Commerce.

Adelanto (Zip Code: 92301) – has 31,765 residents as reported by the 2010 Census. The city is 56 square miles and at an elevation of 2,871 feet with 58.3% Hispanic, 43% White 20% Black. There are 7, 809 households. Over 40% of residents are between the ages of 0 to 19 years several percentage points higher than county and state levels and conversely, fewer residents are aged 50 years and older than what is reported at county and state levels. Median household income is $41,475 with Black families earning the lowest - only $28,310, almost half the county and state rate for Black households. Unemployment is 15.75% and as high as 28.8% for households of two or more races. The city has few employers, no high school or college, very few retailers generating

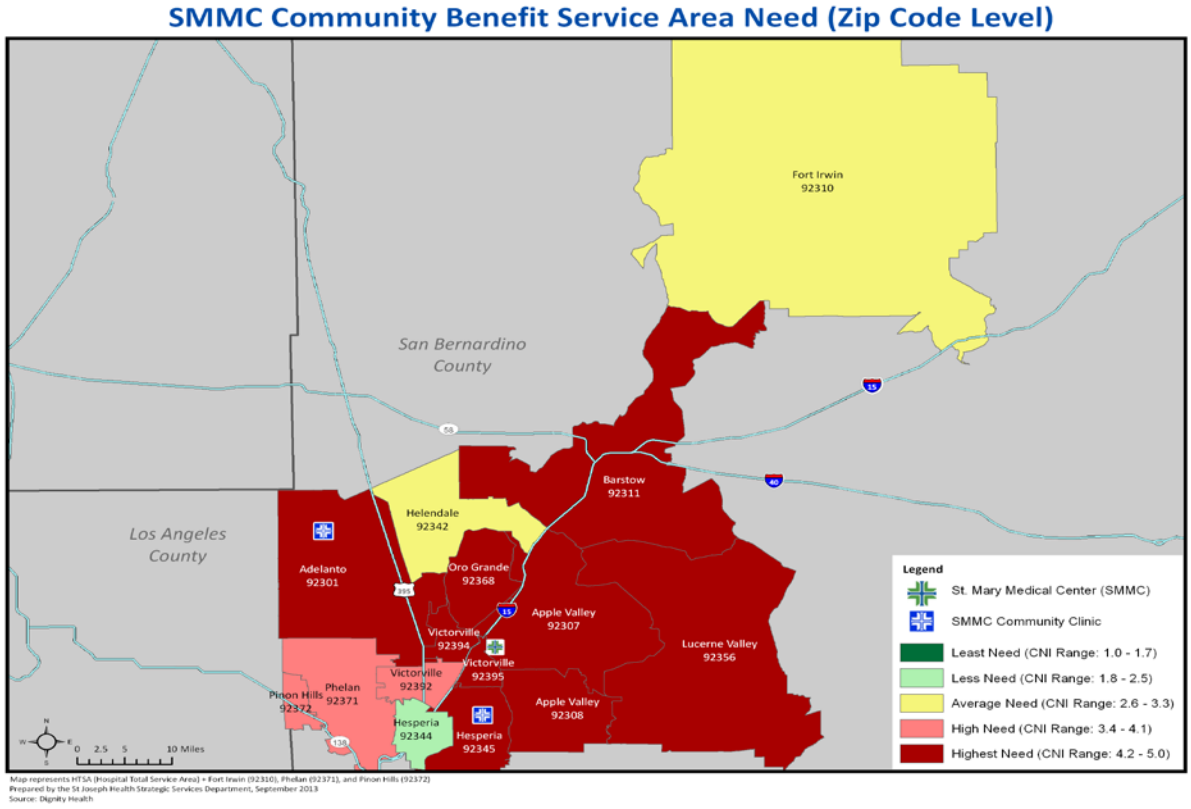
sales tax revenue and several prisons. Only 11.5% of residents are reported to have attained college degrees significantly less than the county and state levels. The hospital works closely with City leaders who recently formed a Healthy City campaign. This campaign includes city, hospital and nonprofit representatives as well as school leaders. Projects have included the expansion of a local park with new playground equipment and the region's only SPICE and Bath Salt ordinance. This city regulation prohibits the local sale of "Synthetic Marijuana" subject to the loss of one's business license. The hospital operates a community clinic serving low residents and partners with schools with family obesity programs. The hospital also provides grant funds allowing a food pantry to acquire and distribute donated fruits and vegetables. The hospital provides grant support to programs serving youth including a Boys and Girls Club. Additionally, the hospital helps fund a summer swim program at the only public pool in the community. The hospital's influence in the community is significant given its smaller size and the high needs residents face. The hospital successfully partnered with Molina to open a community health clinic and Catholic Charities to open a field office. The Catholic Charities staff is providing services to persons who have family members detained in a local Immigration and Custom's Enforcement Center (ICE) operated by the US Department for Homeland Security. The hospital is working with city leaders on the expansion of fresh produce as a Healthy City project. The hospital is an executive member of its Chamber of Commerce.

Barstow (Zip Code: 92311) - has 22,639 residents as reported by the 2010 Census. The city is located midway between Los Angeles and Las Vegas and is 41 square miles in size at an elevation of 2,178 feet. There are 8,085 households with 52% White, 42% Hispanic and 14% Black. Economic data indicates 27% of families live below the federal poverty level with the highest levels reported in households with young children. Black families have the highest rates of poverty at 29.2% followed by Hispanic at 23% and Whites at 16.9%. The city is 31 miles east of SJH St. Mary. Barstow has a 30 bed hospital providing its residents 24 hour Emergency Room services, as well as OB and respiratory care. Patients with specialty care needs travel to SJH St. Mary for treatment. The community is supported with a public health clinic offering some primary and behavioral health services, immunizations and health education. The county continues to work to obtain federal funding to operate as a Federally Qualified Health Center. The hospital partners with Desert Manna Homeless and Food Pantry program the lead agency serving the homeless and hungry of several smaller desert communities including: Baker, Hinckley and Landers. The hospital has been developing grant opportunities to expand the delivery of donated food to households in need. This desert region supports virtually no local produce so transportation of donated food is

essential to programming. Desert Manna was recently awarded a refrigerated truck enabling it to travel consistently to the county's Food Bank, a roundtrip distance of 110 miles. The hospital has also worked with leaders at Barstow Community Hospital and County Public Health to designate the area Medically Underserved Area for purposes of obtaining grants, starting a FQHC clinic, assisting with physician recruitment.

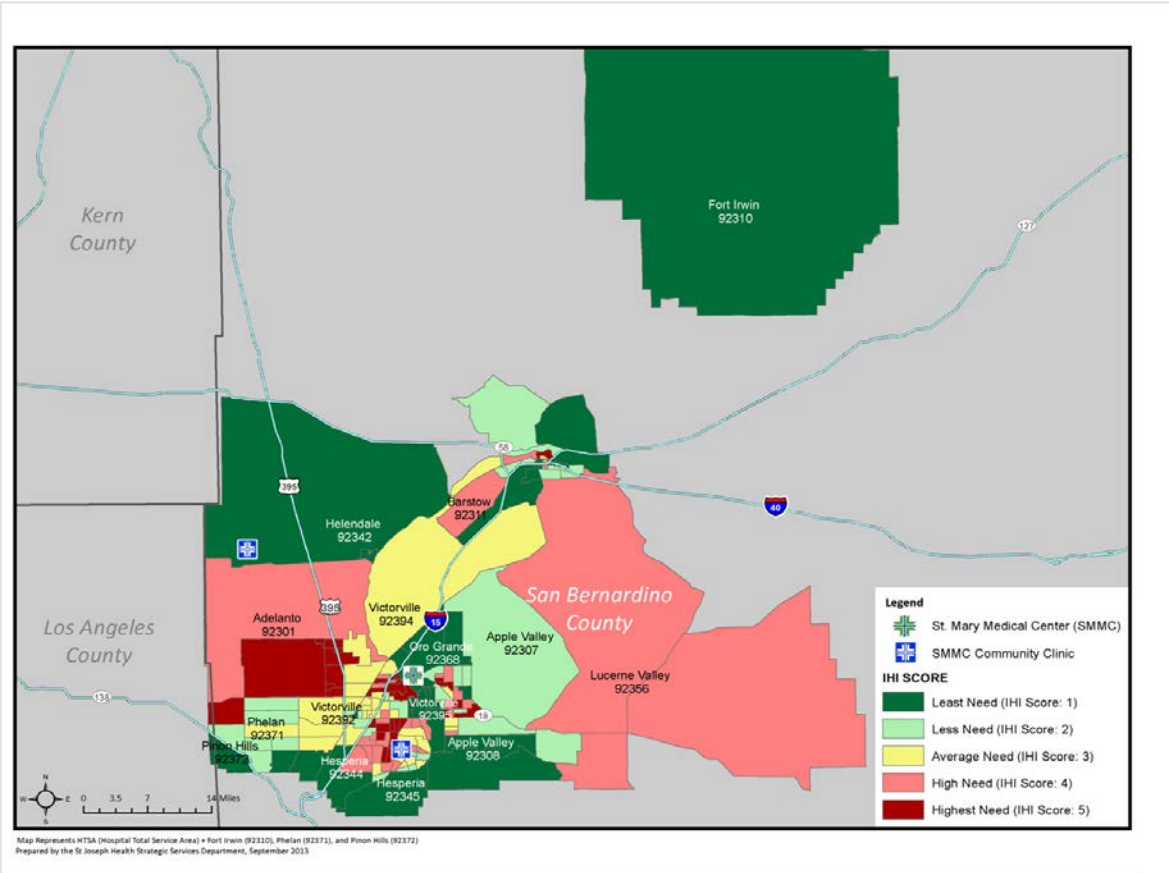
Community Need Index (CNI)

Illustrated on the following page is a color-coded map identifying communities in the hospital's Primary and Secondary Service Areas on their assessed need. The color scheme denotes need as follows: Red is highest need, Pink is high need, Yellow is average need, light Green is less need and dark Green is least need. Development of need was determined using a process developed by Dignity Health which aggregates five (5) socioeconomic indicators that contribute to health disparity as follows: Income (poverty), Culture (i.e., Hispanic origin or percentage not speaking English), Education (percentage over 25 years old without a High School diploma) and Housing (percentage renting). Each Zip Code is assigned a score of 1 to 5 for each of the five barriers with an average score calculated to yield a CNI value range. This need is determined by comparison with the national level. The map below illustrates that 80%-90% of the hospital's Primary and Secondary Service are ranked Highest Need or High Need. Research has shown a strong correlation between High Need and Hospital Admission rates and health disparities.



Intercity Hardship Index (IHI)

A second level of mapping was conducted to objectively assess neighborhoods with the highest needs or barriers to care. The map depicted below illustrates a process developed by the Urban & Metropolitan Studies Program at the Nelson A. Rockefeller Institute of Government. The process named Intercity Hardship Index (IHI) aggregates six socioeconomic indicators that contribute to health disparities including: Income, Crowded Housing, Unemployment, Education, Poverty and Dependency (the percentage of population under 18 years and over 64 years of age). The IHI process assigns a score of 1 to 5 with color coding used to illustrate need. Again, local neighborhoods in dark red are those with the highest needs or disparities in care. As in the past the hospital uses these maps to target community benefit investments including operation of community clinics and mobile medical services and healthy community programs addressing community building, health insurance and health promotion and protection. The map below identifies at least one (1) dark red neighborhood per city. Focus group meetings were held in two of these areas.



***Source**: System Office, Community Health Dept.*

METHODOLOGY

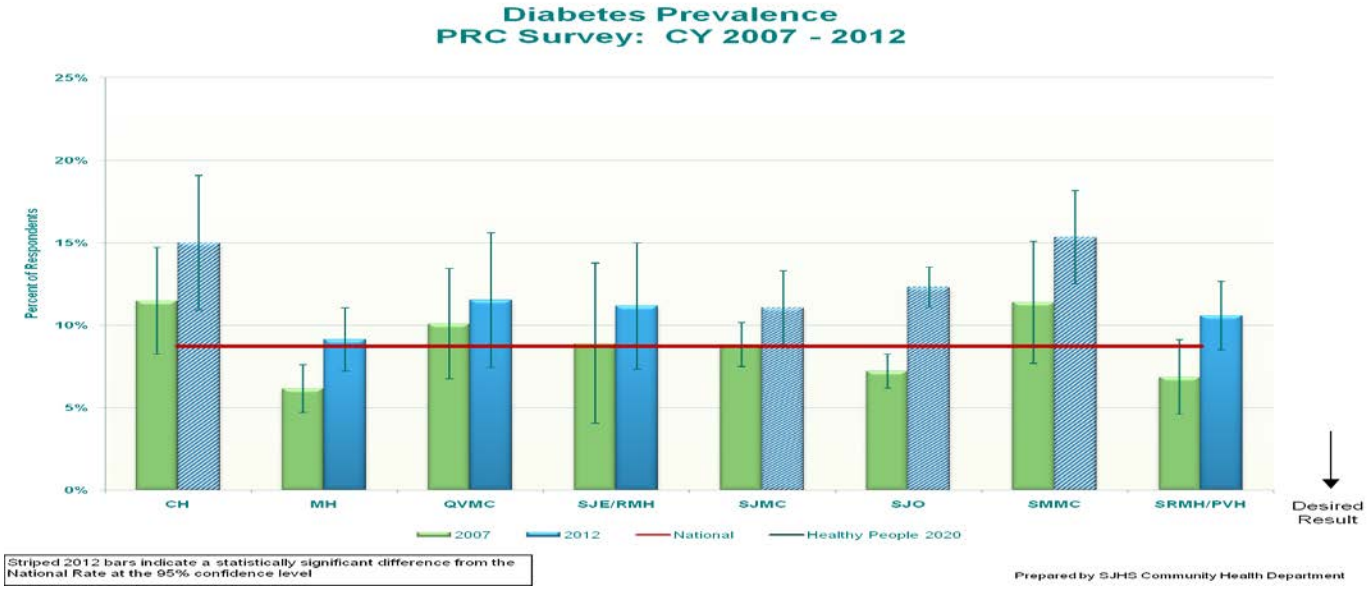
The Hospital's CHNA involved the collection of multiple sources of health and social data including secondary data, the collection of primary data through the survey and community feedback using meetings and focus groups. As previously discussed the hospital used community mapping to identify residents living in communities with the greatest barriers to accessing care and health forecasting to determine the best mix of policy and programs to improve public health. A discussion of how PRC collected and integrated several health data sources is explained on the following page.

PRC developed a sampling plan where 750 local households responded with household members 18 years and older and data on children via proxy by the person most responsible for that child's healthcare needs. Raw sample results were "weighted" in an effort to make representative demographic characteristics of the population sampled. This is accomplished in a way called "post stratification".

The hospital's methodology for conducting focus groups was determined by (1) identification of communities with greatest need and (2) partnering with an agency serving that community to host focus group sessions. Groups were provided a listing of the 16 significant health issues determined from the PRC health assessment. The Adelanto focus group was conducted in Spanish. City leaders and representatives from Healthy City campaigns were invited. The hospital asked all attendees to individually review and prioritize the list of significant health issues. Attendees were then asked to share their rankings in a public discussion. This discussion included a conversation about the severity and trending of diseases and which community assets could be used or were needed to address the issues. The hospital tallied group priorities for further discussion. The hospital provided attendees with the rankings developed by the hospital's Community Benefit committee for further discussion.

ANALYTIC METHODS – PRC Health Survey Results

The PRC survey results met a 95% confidence interval indicating that, for a given sample size, the statistical estimate would fall within the expected error range on 95 out of 100 trails. Additionally, unstable estimate sizes were determined in that any sample size 40 and less. Illustrated below is the format from the PRC health survey.



Green and Blue bar graphs depict 2007 and 2012 results. Hospital is (SMMC) above.

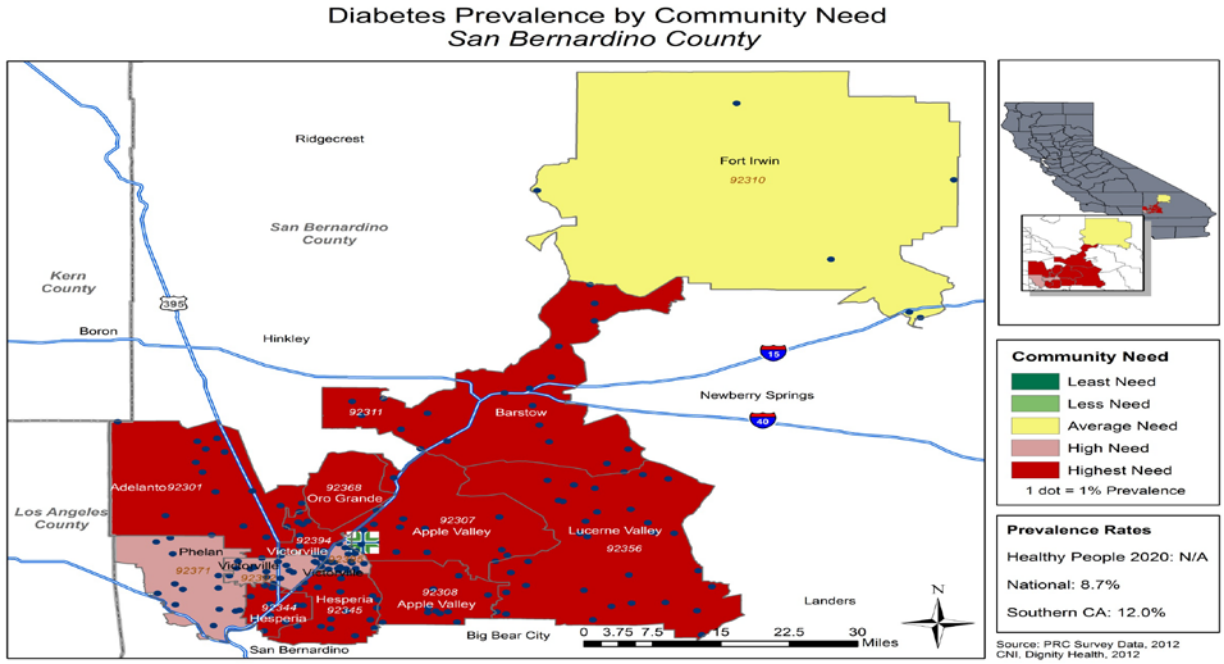
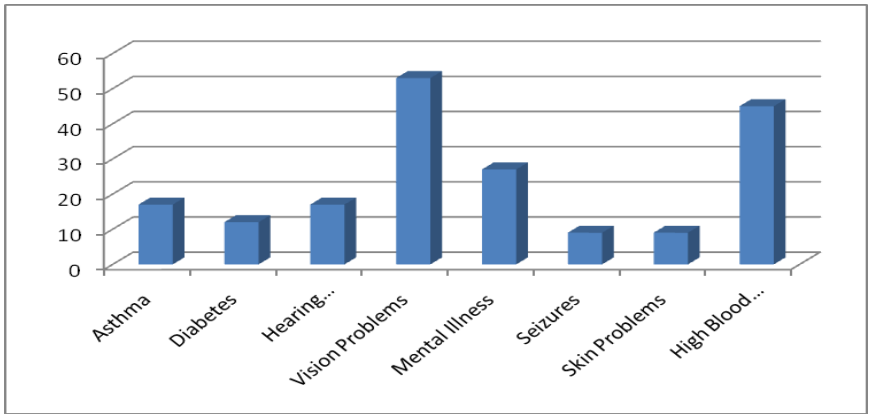


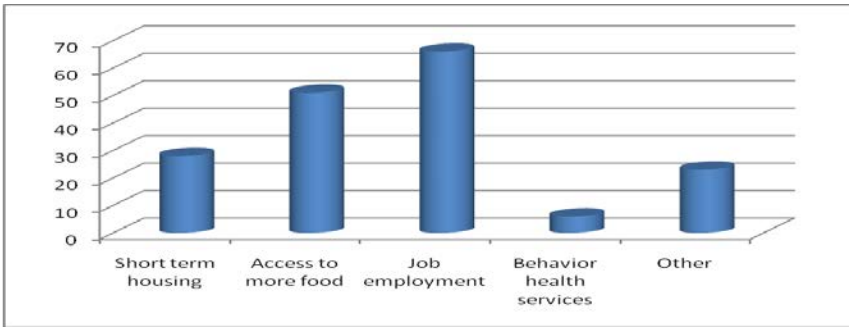
Illustration of diabetes prevalence across hospital's primary and secondary areas

The illustrations on the previous page depict how health outcomes are displayed in the PRC survey. The two bar graphs labeled "SMMC" report the prevalence of Diabetes with the green bar reporting a 2007 incidence (which serves as a disease baseline) along with a blue bar representing the 2012 incidence. The red line represents the reporting of diabetes at the national level. Striped bars are used when the 2012 level is reported at a statistically significant difference from the national rate at the 95% confidence level.

ANALYTIC METHODS – Homeless Surveys conducted by interviews



Homeless persons prioritize their health needs



Homeless persons prioritize their social needs

A small paper survey was administered to 128 homeless persons living in and along the riverbed region of old town Victorville. The survey was conducted at local food programs run by hospital partners: The Lords Table and Feed My Sheep Ministries.

ANALYTIC METHODS – Mapping Community Need/Hardship

Sample of format used to report community need by ranking and indicator score

Zip Code	Block Group	City	Total Population	Intercity Hardship Index (IHI) Score	SMMC Total Service Area Position Based on IHI Score	IHI Need by Block Group	Indicators					
							% of Housing Units with 7+ People	% of Households Living Below Federal Poverty Level	% of Those Over the Age of 25 with Less than a High School Education	% of the Population Under the Age of 18 or Over the Age of 64	Per Capita Income	% of the Unemployed Civilian Population Over the Age of 16
92301	060710091161	Adelanto	1,065	76.89	1	5.00	71.06	96.18	74.06	53.28	100.00	66.73
92301	060710091171	Adelanto	6,430	70.75	2	5.00	100.00	72.31	83.37	39.76	73.06	56.01
92301	060710091163	Adelanto	2,099	69.10	3	5.00	66.06	78.10	74.01	62.63	91.19	42.60
92345	060710100143	Hesperia	2,077	68.28	4	5.00	69.44	54.13	85.56	57.29	89.23	54.02
92395	060710098002	Victorville	1,037	65.31	5	5.00	61.75	65.43	59.65	52.70	87.78	64.56
92395	060710098003	Victorville	1,519	64.83	6	5.00	80.96	44.65	93.35	56.28	81.02	32.70
92395	060710098001	Victorville	1,174	64.25	7	5.00	58.34	100.00	57.04	49.50	84.35	36.25
92301	060710091164	Adelanto	2,404	63.55	8	5.00	71.04	61.06	53.91	57.54	85.09	52.65
92301	060710091162	Adelanto	1,430	60.93	9	5.00	29.58	61.10	100.00	60.49	88.24	26.15
92395	060710099132	Victorville	3,490	60.01	10	5.00	54.63	57.06	78.41	57.00	82.86	30.08
92345	060710100104	Hesperia	2,103	59.47	11	5.00	85.34	36.21	55.83	47.59	65.47	66.36
92345	060710100111	Hesperia	1,671	58.59	12	5.00	64.66	36.62	68.03	52.33	77.06	52.84
92345	060710100141	Hesperia	1,037	57.98	13	5.00	71.06	28.12	60.08	52.05	71.91	64.63
92395	060710099121	Victorville	2,002	57.64	14	5.00	49.25	71.06	35.49	52.99	79.80	57.27
92308	060710097121	Apple Valley	1,093	57.62	15	5.00	27.41	62.63	71.94	56.66	78.63	48.44
92345	060710100142	Hesperia	1,959	56.96	16	5.00	77.67	41.93	33.52	56.06	87.68	44.91
92395	060710099131	Victorville	2,939	56.91	17	5.00	71.39	34.74	50.55	56.65	78.56	49.56
92301	060710091173	Adelanto	1,041	56.82	18	5.00	62.84	28.35	56.20	58.31	85.15	50.06
92394	060710099043	Victorville	5,751	56.31	19	5.00	45.91	54.75	55.23	55.02	81.19	45.77
92307	060710097163	Apple Valley	2,281	55.17	20	5.00	33.96	72.32	32.75	52.85	92.86	46.27

Mapping results on the previous page illustrate how SJH aggregated, ranked and reported community/neighborhood hardships in the hospital's service area. The illustration is only a partial representation of the 35 block groups identified. The hospital typically uses the ranking provided from this process to target programs, collaborative relationships and grant making.

PRIORITIZATION PROCESS AND CRITERIA

~~~~~~~~~~~~~~~~~Sample focus group survey used by hospital~~~~~~~~~

Feedback from High Desert Not-for Profit Organizations and Leaders
August 1, 2013 ~ Academy for Grassroots Organizations Workshop
(Please print clearly)

A. Name_____
B. Name of organization you represent_____
C. Telephone_____Email_____
D. Does your agency serve low income persons? Yes or No (Circle one)
E. What is the biggest unmet need people you serve request help with? _____
F. Your agency is located in which community? _____
G. List the top 3 services your agency provides low income persons
1. 2. 3.
H. Does your agency address the health needs of people you serve? Yes or No (Circle one)
I. Can/Does your agency refer persons who have health needs? Yes or No (please circle one)
J. Would your agency like to educate or enroll people who are uninsured in 2014? Yes or No (Circle one)
K. Would your agency be able to teach persons about health? Yes or No (Circle one)
L. Circle items you would like to teach: Eating Healthy Benefits of Exercise Living with Diabetes Wellness

Please rank the following diseases and health behaviors as the most urgent in addressing

Health Condition of Significance	2012 percent increase over 2007 baseline	Rank 1 thru 7 in order of importance (1 = most)
Adult Obesity	6.6% increase to 35%	1
Diabetes	3.9% increase to 15.3%	2
Mental Health and Depression	3.9% increase to 18.4%	3
Health Access	3.1% increase to 41%	4
Alcohol use (binge drinking 5+) Tobacco use	3.3% increase to 18.9% 1% increase to 20%	
Problems accessing grocery stores	3.4% increase to 18.5%	
Hypertension High Cholesterol	3.4% increase to 35.2% 6.8% increase to 34.0%	
Child Asthma	.9% increase to 13.1%	
Cancer	.4% increase to 5.6%	
Stroke	.4% increase to 3.3%	
Arthritis/Activity Limitations	4.0% increase to 26%	
Self-rated health rated as fair or poor	3.9% increase to 23%	
Adults receiving annual oral care	57% (no 2007baseline)	

In your opinion what are the biggest needs the High Desert must address better or is not addressing at all (print)

The hospital use of focus group surveys enabled attendees to individually prioritize health conditions. Afterwards, the hospitals used group facilitation and voting to
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determine a group consensus on a list of health priorities and a quality of life issue. The hospital collected as many completed surveys as possible and asked attendees to take with them a copy of the survey they returned to the hospital.

~~~~~~~~Sample Form provided to San Bernardino County Public Health Leaders~~~~~~~~~~

Snapshot of Significant Health Findings
2012 Community Health Needs Assessment
Conducted by SJH/PRC for Primary and Secondary Service Areas
St. Joseph Health, St. Mary Apple Valley

Condition	2012 Prevalence	% increase (over 2007 baseline)	Expert Feedback	Notes
Asthma Child	13.1%	.9%		Decreased to 14.2% in CA
Cancer Cancer (skin)	5.2% 5.6%	.2% .4%		5.5% national 5.8% national
Diabetes	15.3%	3.9%		CA 8.6% Elderly, minorities, low income
Stroke	3.3%	.4%		
Hypertension High Cholesterol	35.2% 34.0%	3.4% 6.8%		 36.5% in CA Lower in S. CA
Depression	13.5%	.7%		11.7% national
Low self –rated Mental Health	18.4%	3.9%		11.7% national
Arthritis/Activity Limitations	26%	4.0%		21% national
Self-Rated Health	23%	4.7%		18% CA 17% national
Adult Overweight/ Obese	37% 33%	6.6% 6.1%		CA 36% CA 24%
Accessing Grocery Stores	18.5%	3.4%		14.4% S. Cal
Alcohol	18.9%	3.3%		15.8% national
Tobacco	20%	1%		12.2% in CA
Adult Dental Care	57%	N/A		70% national
Uninsured	21.6%	2.1%		
Health Access Issues	41.5%	3.1%		37.3% national
~~~~~~~~

COLLABORATING ORGANIZATIONS

The organizations listed below played a significant role and contribution assisting the hospital to gather community input from a range of residents and community leaders. The hospital is grateful for their assistance in conducting health assessments and developing efforts to improve the health and quality of life in the region.

Organization Name	Organization Location	Type(s) of Support
Academy For Grassroots Development	Phelan, CA Apple Valley, CA	Hosted focus group of 52 Victor Valley non-profits to discuss and help prioritize significant health issues impacting Victor Valley residents
Azusa Pacific University High Desert Campus	Victorville, CA	Hosted nursing students to discuss and prioritize chronic disease levels and public health issues impacting Victor Valley
Barstow non profit council	Barstow, CA	Hosted 5 local non-profits to discuss significant health issues impacting Barstow Valley
Hospital Association of Southern California	Riverside, CA	Hosts CHNA & Community Benefit collaborative with county's 6 non profit hospital's and leaders of Public Health
High Desert Outreach	Adelanto, CA	Hosted focus group of 18 residents, city non-profits and city leaders

COLLABORATING ORGANIZATIONS (cont'd)

Organization Name	Organization Location	Type(s) of Support
Institute for Public Strategies	Victorville, CA	Hosted resident meeting of 8 to help prioritize health findings and advocate local policy change
Loma Linda University Medical Center	Redlands, CA	Provided feedback to local health data including advocacy on interventions and policy, hosted UCLA
Lords Table & Feed My Sheep Ministries	Victorville, CA	Hosted homeless surveys of 128 low income residents on health and social needs
Kaiser Permanente	Fontana, CA	Provided health findings from its county-wide CHNA
San Bernardino County Public Health & Healthy Community Programs	San Bernardino, CA	Provided county level health data and feedback on local health findings and interventions
St. Joseph Health	Irvine, CA	Provided technical assistance conducting CHNA including health survey with PRC and neighborhood mapping of health disparities
UCLA Fielding School of Public Health – Health Forecasting Project	Los Angeles, CA	Provided forecasting and modeling data for local health conditions to develop long-term perspective on population health, resource needs and identification of which policies and interventions have greatest impact
Victor Valley Transit Authority	Hesperia, CA	Provided technical input on public transit of poor

COMMUNITY NEED

Community Needs Prioritized

Community Focus groups provide feedback on health and social needs
Identified in hospital's 2012 Community Health Needs Assessment

Focus Group	Type of Attendees	Leading Health	Leading Social
Academy for Grassroots Development	52 leaders of Victor Valley non profits	Adult obesity (44) Diabetes (42) Mental Health (29)	Transportation (18) Health Literacy (16) Jobs (14)
Adelanto residents	21 leaders of Adelanto	Diabetes (18) Adult Obesity (14) Hypertension (10)	Grocery store Access to Park/Exercise Mental and dental providers
San Bernardino County Public Health	Public Health Leaders	Obesity Mental Health Access to Care	Keep partnering with us on Healthy City; consider using navigators for chronic conditions; partner to expand access to care
Barstow Leaders	8 leaders of Barstow non profits	Diabetes (5) Hypertension (4) Access (3) Adult obesity (3)	A community health clinic – perhaps a FQHC clinic
Homeless persons	137 very low income Homeless	Uninsured (54) Vision Issues (53) High Blood Pressure (45)	Employment (66) Food (51) Housing (28)
Healthy Victorville	7 city and health reps. from Molina, Victor Global and Desert Valley hospitals	Diabetes (7) Adult Obesity (6) Hypertension (3) Access (3)	Street Safety, local policy on tobacco and Spice and Bath Salts
Behavioral Health Collaborative of Victor Valley	9 Mental Health professionals	Improve 5150 system (2) Stress Reduction Education Health Navigators	Hospital join local mental health collaborative

Quality of Life considerations advocated by community

1. Grocery Store/Healthy Foods available in North Adelanto
2. Recruit more health providers to Adelanto (dental, mental health)
3. Continue Healthy High Desert/Healthy City campaigns across the region
4. Housing for Homeless persons, employment, more donated food
5. Transportation serving the poor to improve access to services
6. Food Hub/Bank

Community Benefit Committee develops a list of seven (7) health issues

Health Condition of Significance	2012 percent increase over 2007 baseline	Notes
1. Adult Obesity	6.6% increase to 35%	Hospital expertise; partnerships available
2. Diabetes	3.9% increase to 15.3%	Hospital expertise; partnerships available
3. Mental Health and Depression	3.9% increase to 18.4%	Hospital addresses with partners
4. Health Access	3.1% increase to 41%	Continue Covered CA; developing system of care
5. Alcohol and Tobacco	3.3% increase to 18.9% 1% increase to 20%	Hospital partners
6. Problems accessing grocery stores	3.4% increase to 18.5%	Hospital partners
7. Hypertension High Cholesterol	3.4% increase to 35.2% 6.8% increase to 34.0%	Hospital addresses with diabetes and obesity and health prevention campaign

The hospital's Community Benefit Committee used community feedback and its initial list of seven (7) significant health conditions to develop its final list of four priorities: Access Issues, Diabetes, Mental Health, and Obesity.

Disproportionate Unmet Health Need Group (DUHN), Key Community Needs, and Assets Summary

Communities with Disproportionate Unmet Health Needs (DUHN) are communities defined by zip codes and census tracts where there is a higher prevalence or severity for a particular health concern than the general population within SJH, St. Mary's Service Area. The Community Needs Index (CNI) mapping identified (9) Highest Need communities in the hospital's service area. The use of Intercity Hardship Index (IHI) mapping identified 35 neighborhoods ranked 5 as highest needs. A short list of the most vulnerable neighborhoods is highlighted below.

DUHN Population Group or Community	Key Community Needs	Key Community Assets
Adelanto *3 block groups* *9,594 persons* *82% poverty*	*Health Services* *High School and College* *Economic Development* *Employers* *Stable City Budget* *Park and Recreation* *Retail Development*	*City Government* *Adelanto School District* *Adelanto Chamber* *Adelanto Rotary* *High Desert Outreach* *County Public Health* *County Government* *Healthy Adelanto Campaign* *Resident leaders of Cx3* *Molina Health* *Community Health Action Network*

Disproportionate Unmet Health Need Group (DUHN), Key Community Needs, and Assets Summary (cont'd)

DUHN Population Group or Community	Key Community Needs	Key Community Assets
Hesperia *1 block group* *2,077 persons* *54% poverty*	*Health Services* *Economic Development* *Employers* *Improved Access to Services* *Health Insurance*	*City Government* *Hesperia School District* *Hesperia Chamber* *Healthy Hesperia campaign* *CHAN* *County Public Health* *County Government*

DUHN Population Group or Community	Key Community Needs	Key Community Assets
Victorville (old-town) *3 block groups* *3,730 persons* *69% poverty*	*Economic Redevelopment* *Employment* *Coordinated Health Services* *Coordinated* *College Education* *Health Insurance* *Mental Health* *Substance Abuse* *Job Training*	*City Government* *Victor Global Medical Center* *Desert Valley Hospital* *Victor School Districts* *Victor Valley Chamber* *Victor Rotary* *Victor Valley College* *County Public Health* *County Government* *Mission City Clinic* *Lords Table* *Victor Rescue Mission* *Healthy Victorville*

Disproportionate Unmet Health Need Group (DUHN), Key Community Needs, and Assets Summary (cont'd)

DUHN Population Group or Community	Key Community Needs	Key Community Assets
Apple Valley *1 block group* *1,093 persons* *62% poverty*	*Economic Redevelopment* *Employment* *Coordinated Health Services* *GED, ESL* *College Education* *Health Insurance* *Mental Health* *Substance Abuse* *Job Training*	*Apple Valley Town Government* *SJH, St. Mary* *Choice Medical Group* *St. Mary High Desert Medical* *Healthy Apple Valley* *Apple Valley School District* *Paul Swick Center* *County Government* *CX3 Project* *Phoenix Resource Center* *Apple Valley Head Start*

Primary Data - Community Input -Focus Groups and Paper survey

The hospital conducted seven (7) focus groups as number below Additionally, the hospital implemented a paper survey conducted in one-on-one interviews with homeless persons in the old town area of Victorville. The table below highlights feedback including voting results on significant health issues and suggested quality of life indicators.

Focus Group/Survey	Type of Attendees	Leading Health	Leading Social
1. Academy for Grassroots Development	52 leaders of Victor Valley non profits	Adult obesity (44) Diabetes (42) Mental Health (29)	Transportation (18) Health Literacy (16) Jobs (14)
2. Adelanto residents	21 leaders of Adelanto	Diabetes (18) Adult Obesity (14) Hypertension (10)	Grocery store Access to Park/Exercise Mental and dental providers
3. San Bernardino County Public Health	Public Health Leaders	Obesity Mental Health Access to Care	Keep partnering with us on Healthy City; consider using navigators for chronic conditions; partner to expand access to care
4. Barstow Leaders	8 leaders of Barstow non profits	Diabetes (5) Hypertension (4) Access (3) Adult obesity (3)	A community health clinic – perhaps a FQHC clinic
Homeless persons	137 very low income Homeless	Uninsured (54) Vision Issues (53) High Blood Pressure (45)	Employment (66) Food (51) Housing (28)
6. Healthy Victorville	7 city and health reps. from Molina, Victor Global and Desert Valley hospitals	Diabetes (7) Adult Obesity (6) Hypertension (3) Access (3)	Street Safety, local policy on tobacco and Spice and Bath Salts
7. Behavioral Health Collaborative of Victor Valley	9 Mental Health professionals	Improve 5150 system (2) Stress Reduction Education, Navigators	Hospital join local mental health collaborative

SECONDARY DATA

CHNA Core Health Indicators

Health Condition of Significance	2012 percent increase over 2007 baseline	Notes
1. Adult Obesity	6.6% increase to 35%	Hospital expertise; partnerships available
2. Diabetes	3.9% increase to 15.3%	Hospital expertise; partnerships available
3. Mental Health and Depression	3.9% increase to 18.4%	Hospital addresses with partners
4. Health Access	3.1% increase to 41%	Continue Covered CA; developing system of care
5. Alcohol and Tobacco	3.3% increase to 18.9% 1% increase to 20%	Hospital partners
6. Problems accessing grocery stores	3.4% increase to 18.5%	Hospital partners
7. Hypertension High Cholesterol	3.4% increase to 35.2% 6.8% increase to 34.0%	Hospital addresses with diabetes and obesity and health prevention campaign

County Health Rankings

San Bernardino County Health Rankings 2013

Condition	Ranking (out of 57 CA Counties)
Health Outcomes	44th
Mortality	32nd
Morbidity	51st
Health Factors	46th
Clinical Care	52nd
Social & Economic Factors	39th
Physical Environment	46th

Data source: http://www.countyhealthrankings.org/app#/california/2013/san-bernardino/county/outcomes/overall/snapshot/by-ran

PRC Survey – Executive Summary of Findings – Good News and Bad

SMMC's CBSA fares much better in several health indicators since 2007. In terms of health outcomes, CBSA residents report *improvements in chronic heart disease.* Findings also suggest that *over the last five years, area residents are engaging in healthier behaviors, which is evidenced by lower rates of childhood obesity, increases in cancer screening, fruits and vegetables consumption, physical activity, immunization, and lower chronic drinking rates. Furthermore, fewer individuals report visiting the ED two or more times in the past year.*

In spite of these successes, residents continue to experience poor outcomes *relative to asthma, cancer, diabetes, stroke, hypertension, high cholesterol, major depression, as well as low ratings of overall and mental health. In terms of health behaviors more adults are obese, more individuals are engaging in binge drinking, and a higher proportion of residents report difficulty in accessing grocery stores with affordable and fresh produce. In addition, rates of uninsured increased as did the proportion of individuals with difficulty accessing healthcare while fewer report that they have an ongoing source of medical care.*

Consistent across health indicators are the disparities that persist among minorities, individuals with lower levels of education and higher levels of poverty. These results suggest the need for continued efforts that aim to reduce health disparities and increase the opportunities for healthy living in the community

Summary of Results

Focus Groups
Focus group feedback closely aligned with the hospital's initial prioritization of the seven (7) significant health conditions. All focus groups were provided the list of 16 health conditions from which to prioritize and discuss. All focus groups were able to list quality of life indicators they felt impacted the community and the hospital should consider addressing. These are listed above and range from continuing the Healthy City campaigns (County Public Health) to addressing education and health literacy (local nonprofits) to recruiting additional health providers to the community (resident leaders in Adelanto.)

One-on-One interviews with Homeless
One-on-one surveys were conducted with the homeless living in the old-town section of Victorville. Survey results prioritized employment, food and housing in addition to

stressing the need to access Covered California and vision care. The hospital will include assisting the homeless to better access care in its Access to Care effort.

The hospital's community benefit committee prioritized four issues to address in a FY15-FY17 Community Benefit Plan. To address the significant increases reported for Diabetes and Obesity, the hospital will be expanding programs to meet these chronic health needs. The hospital can build upon existing diabetes and obesity programs recognized as the only ones available. Additionally, the collaborative nature that the county is pursing health improvement provides the hospital with opportunities to expand partnerships and obtain resources. Efforts to develop community partners assisting the hospital to teach the public on the benefits of better self-care issues will continue to be important.

The hospital's selection of mental health and access to care challenges the hospital to expand its limited resources/expertise to meet these significant health and social issues. The hospital will again look for support from community partners to address both these issues in effective ways. The hospital will continue to develop its network of care to expand outpatient services. This enables the hospital to improve its focus on community care and improved outcomes with patient care. Both areas are critical to the strategy of improving the population's health.

SOURCES

Core Health Indicators Report

http://assessment.communitycommons.org/CHNA/SelectArea.aspx?reporttype=keyaction

***Source**: System office, Community Health Dept.*

County Health Rankings

http://www.countyhealthrankings.org/app/#/california/2013/compare-counties/071+041

***Source**: System office, Community Health Dept.*

PRC Survey data

***Source**: System office, Community Health Dept.*

The SJH, St. Mary Community Health Assessment is a follow-up to the study conducted in 2007. It is a systematic, data-driven approach to determining the health status, behaviors and lifestyles of residents in the Community Benefit Service Areas (CBSA) of St. Joseph Health. Subsequently, this information will be used to formulate strategies to improve community health and wellbeing.

A Community Health Assessment provides information used by communities to identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Assessment will serve as a tool toward reaching three basic goals:

1. To improve community residents' self-reported health status, functional health and their overall quality of life.
2. To reduce the health disparities among residents.
3. To increase accessibility to preventive services for all community residents.

In addition to these goals, data from this report will assist in completing the Community Health Needs Assessment (CHNA) report as part of the Federal 501(r) requirements.

Appendix 1: Community Input

Public Health or Other Departments or Agencies

Organization	Nature of Community Input
San Bernardino County Department of Public Health	Shared secondary data from county's 2013 Community Vital Signs Report; provided feedback on hospital's health assessment
San Bernardino County Department of Behavioral Health	Provided feedback on results of hospital's health assessment
First 5 San Bernardino	Shared data on development of a Healthy People 2020 Scorecard for San Bernardino county children
Inland Empire Health Plan	Shared data on uninsured in hospital's region
Victor Valley High School District	Feedback on behavioral health issues impacting youth
UCLA Center for Health Forecasting	Provided health forecasts on prioritized health conditions provided by hospital
Hospital Association of Southern California	Hosted collaborative to draw together hospital and public health efforts improving population health
Loma Linda University Medical Center	Facilitated UCLA offering health forecasting services to hospital
Phelan/Pinon Hills Community Services District	Provided feedback to health survey results

Community Leaders and Representatives

Organization	Nature of Community Input
Academy For Grassroots Organizations	Hosted non-profit forum enabling feedback on hospital's health assessment
High Desert Outreach	Hosted resident forum in Adelanto; provided feedback on hospital's health assessment
Boys & Girls Club of the Victor Valley	Provided input on hospital's health assessment for Adelanto's low income families
Institute For Public Strategies	Hosted Victorville resident leader forum; feedback on hospital's health assessment; advocated policy assistance with tobacco, alcohol and sale of Spice
Victor Community Support Services	Provided feedback on survey findings
Azusa Pacific University High Desert campus	Provided survey feedback; students assisted in completing homeless surveys
San Bernardino County Land Use Services	Provided survey feedback; students assisted in completing homeless surveys
33rd district Assemblyman Tim Donnelly's office	Provided survey feedback; students assisted in completing homeless surveys
Energy Healing Therapies	Provided survey feedback
Mojave District Air Quality Management District	Provided survey feedback
San Bernardino County Office of Homeless Svs.	Provided health survey feedback

Community Leaders and Representatives (cont'd)

Organization	Nature of Community Input
Global Communications 2000	Provided health survey feedback
Moving Forward Coaching & Consulting	Provided health survey feedback
Town of Apple Valley	Provided health survey feedback
Girl Scouts	Provided health survey feedback
HICAP	Provided health survey feedback
Dept. of Aging and Adult Services	Provided health survey feedback
High Desert Transitional Living Connection	Provided health survey feedback
National Association of Blacks in Criminal Justice	Provided health survey feedback
MLK/Joy/Center of Hope	Provided health survey feedback
County of San Bernardino Economic Development	Provided health survey feedback
Lewis Center for Educational Research	Provided health survey feedback
Molina Health	Provided health survey feedback
SB County Public Health Family Health Services	Provided health survey feedback
C.O.P.E	Provided health survey feedback
Soaring High Academy	Provided health survey feedback
Moses House Ministries	Provided health survey feedback
United Way	Provided health survey feedback
Gentiva Hospice	Provided health survey feedback
Victor Valley Rescue Mission	Provided health survey feedback
St. John of God Health Care Services	Provided health survey feedback
Well Being Connections	Provided health survey feedback
AV Partners for Health	Provided health survey feedback

Appendix 1: Community Input (continued)

Contracted Third Party

The hospital worked with the UCLA Health Forecasting project to model and trend the prevalence of chronic diseases to the year 2020. UCLA provided these services under a grant provided by the Unihealth Foundation

Name	Title	Organization
Peggy Vadillo, MPP	Research Associate	UCLA Fielding School of Public Health – Health Forecasting Project – San Bernardino County
Dr. Lu Shi	Simulator Modeler	

Appendix 2: Healthcare Facilities within Service Area - clinics

Name	Address	Description of Services Provided
County of San Bernardino Department of Public Health – FQHC Clinic	16453 Bear Valley Rd Hesperia, CA 92345	Primary medical care services
Molina Medical Clinic	11965 Cactus Rd. Adelanto, CA 92301	Primary medical care services
Molina Medical Clinic	14544 7th Street Victorville, CA 92395	Primary medical care services
Mission City Clinic	15201 11th Street Victorville, CA 92395	Primary medical care services, psychiatry care
St. Mary Community Health Clinic	11424 Bartlett Way #9 Adelanto, CA 92301	Primary medical care services, prenatal care, mental health, diabetes, breastfeeding, cancer screening
St. Mary Community Health Clinic	18077 Outer Highway 18 Apple Valley, CA	Primary medical care services, prenatal care, mental health, diabetes, breastfeeding, cancer screening
St. Mary Community Health Clinic	17071 Main Street Hesperia, CA 92345	Primary medical care services, prenatal care, mental health, diabetes, breastfeeding, cancer screening
Dr. Mike's Walk-in Clinic	15791 Bear Valley Rd Hesperia, CA	Primary medical care services
Dr. Mike's Walk-in Clinic	12143 Navajo Rd Apple Valley, CA	Primary medical care services
Dr. Mike's Walk-in Clinic	716 E Main Street Barstow, CA	Primary medical care services
Victor Dental Svs.	14357 7th St. Victorville, CA	Dental care for the poor

Appendix 3: Healthcare Facilities within Service Area – acute care

Name	Address	Description of Services Provided
Barstow Community Hospital	555 South 7th Street Barstow, CA 92311	30 bed facility offering inpatient and outpatient services including medical, surgical and emergency care
Desert Valley Hospital	16850 Bear Valley Rd Victorville, CA 92395	148 bed acute care hospital offering inpatient and outpatient services including medical, surgical and emergency care
St. Joseph Health St. Mary	18300 Highway 18 Apple Valley, CA 92307	212 bed facility offering inpatient and outpatient services including medical, surgical and emergency care; operates community clinics and mobile medical program
Victor Valley Global Medical Center	11th Street Victorville, CA 92395	101 bed facility offering inpatient and outpatient services including medical, surgical and emergency care
*Kaiser Foundation Hospital – Fontana Medical Center	9961 Sierra Ave. Fontana, CA 92335	420 bed facility offering inpatient and outpatient services including medical, surgical and emergency care
*Arrowhead Regional Medical Center	400 N Pepper Ave. Colton, CA 92324	456 bed teaching facility offering inpatient and outpatient services including medical, surgical and emergency care
*Loma Linda University Medical Center	11234 Anderson St. Loma Linda, CA 92354	900 bed four hospital teaching facility offering inpatient and outpatient services including medical, surgical and emergency care

*** These hospitals serve persons in service areas of SJH, St. Mary**

Appendix 4: Medically Underserved Area

***Source**: System office, Community Health Dept.*

If applicable:

"HRSA has calculated an Index of Medical Underservice (IMU) score for communities across the U.S. The IMU score calculation includes the ratio of primary medical care physicians per 1,000 persons, the infant mortality rate, the percentage of the population with incomes below the poverty level, and the percentage of the population greater than age 64. IMU scores range from zero to 100 where 100 represents the least underserved and zero represents the most underserved.[1]

Any area or population receiving an IMU score of 62.0 or less qualifies for Medically Underserved Area (MUA) or Medically Underserved Population (MUP) designation. "

Appendix 4: Health Professions Shortage Area

***Source**: System office, Community Health Dept.*

If applicable:

Health Professions Shortage Areas (HPSAs) can be: "(1) An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services); (2) a population group; or (3) a public or nonprofit private medical facility."[1]

Appendix 5: Ministry Community Benefit Committee

Name	Title	Affiliation or Organization
Ms. Rosella Bernal	Hospital Board Member	Union Bank, Branch Manager
Ms. Glenda Bates	Member, Public Health Dept.	Lactation Specialist, Women, Infants and Children Program
Ms. Margaret Cooker	Community Member	Retired nurse, Victorville Rotary/Health Advocate Victorville resident
Sister Claudette Des Forges	Hospital Board Member	Sisters of St. Joseph of Orange
Ms. Meaghan Ellis	Member, Public Health Dept.	Director, San Bernardino County Public Health Clinics
Mr. Bruce Fay	Hospital Board Member	Retired Business Executive
Mr. Alan Garrett	Hospital Board Member	Hospital President & CEO
Mr. Charlie Glasper	Community Member	Retired, Former Adelanto Mayor Adelanto resident
Mr. Jack Hamilton	Community Member	Executive Pastor, High Desert Church Phelan resident
Sister Theresa LaMetterey	Hospital Board Member	Sisters of St. Joseph of Orange
Mr. Eric Moreno	Hospital Board Member and Committee Chair	Retired, Pastor Oasis HD Church Apple Valley resident
Mary O'Toole	Community Member	Senior Analyst, County Executive Office Hesperia resident
Brother Ignatius Sudol	Hospital Board Member	St. John of God Healthcare Services
Rob Turner	Hospital Board Member	Retired Education, Apple Valley Rotary Apple Valley resident

Appendix 6: Core Health Indicators Report for San Bernardino County

County Health Rankings

San Bernardino County Health Rankings 2013

Condition	Ranking (out of 57 CA Counties)
Health Outcomes	44th
Mortality	32nd
Morbidity	51st
Health Factors	46th
Clinical Care	52nd
Social & Economic Factors	39th
Physical Environment	46th

Data source: http://www.countyhealthrankings.org/app#/california/2013/san-bernardino/county/outcomes/overall/snapshot/by-ran

Appendix 7: County Health Rankings

Below you will find link to San Bernardino County 2013 Data Report

http://communityvitalsigns.org/Portals/41/Meetings/2013Stakeholder/CVS_data_report.pdf

Appendix 8: PRC CHNA Data