



*2014 New Vision Mobile Clinic- a gift from a generous donor*

**ST. JOSEPH HOSPITAL**  
*FY15 – 17 Community Benefit Plan/ Implementation Strategy Report*

**St. Joseph Health**   
St. Joseph Hospital

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## **EXECUTIVE SUMMARY**

St. Joseph Health, St. Joseph Hospital of Orange (SJO) is an acute-care hospital founded in 1929, located in Orange, California. The facility has 491 licensed beds, 442 of which are currently active, and a campus that is approximately 33 acres in size. SJO has a staff of 2,840 and professional relationships with more than 971 local physicians. At SJO, we are proud to provide our patients with a broad range of services on our modern campus that allow for us to more accurately treat complex medical conditions. From bariatric surgery to cardiac care, cancer treatment and our cutting-edge maternity center, we are proud to offer a wide variety of services to meet the specific medical needs of our community.

In response to identified unmet health-related needs in the community needs assessment, during FY15-17 SJO will focus on three key priorities for the broader and underserved disadvantaged members of the surrounding community.

*Access to Health Care* was selected as a priority to address the overwhelming need for health care services seen in the underserved communities residing in central Orange County. Providing access to health care means the timely use of high quality health services to achieve optimal health outcomes.

*Chronic Disease Management* will address management of those diseases, primarily diabetes, that have a major impact on quality of life and the cost of the care provided. The goal is to prevent further complications, to empower persons served to assume responsibility for their health, and to educate them about various medical conditions associated with chronic disease and the ability they have to make wise choices. Medical care coupled with health education will include comprehensive care coordination and support to optimize well-being.

*Mental Health* efforts will include providing the emotional framework necessary to support the goals needed for the comprehensive approach to chronic disease management. We will focus on partnering with service providers and community-based organizations to improve understanding of and address mental health needs, gaps, and resources.

Due to the fast pace at which the community and health care industry change, SJO anticipates that implementation strategies may evolve and therefore, a flexible approach is best suited for the development of its response to the SJO Community Health Needs Assessment (CHNA). On an annual basis SJO evaluates its Community Benefit Plan, specifically its strategies and resources; and makes adjustments as needed to achieve its goals/outcome measures, and to adapt to changes in resource availability.

### **Organizational Commitment**

In 1986, St. Joseph Health created a plan and began an effort to further its commitment to neighbors in need. With a vision of reaching beyond the walls of health care facilities and transcending traditional efforts of providing financial assistance for those in need of acute care services, St. Joseph Health created the St. Joseph Health Community Partnership Fund (formerly known as the St. Joseph Health System Foundation) to improve the health of low-income individuals residing in local communities.

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

Furthermore, SJO 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.

## **INTRODUCTION – WHO WE ARE AND WHY WE EXIST**

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

### **Mission, Vision and Values and Strategic Direction**

#### ***Our Mission***

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

#### ***Our Vision***

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

#### ***Our Values***

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

St. Joseph Hospital has been meeting the health and quality of life needs of the local community for over 85 years. Serving the communities of Anaheim, Garden Grove, Huntington Beach, Orange, Santa Ana, Tustin and Westminster, St. Joseph Hospital is an acute care hospital that provides quality care in the areas of bariatric surgery, behavioral health, cardiac care, cancer treatment, nasal and sinus center, kidney dialysis center, orthopedic services and our cutting-edge maternity center. With 2,840 employees committed to realizing the mission, St. Joseph Hospital is one of the largest employers in the region.

### **Strategic Direction**

As we move into the future, St. Joseph Hospital is committed to furthering our mission and vision while transforming healthcare to a system that is health-promoting and preventive, accountable in its inevitable rationing decisions, integrated across a balanced network of care and financed according to its ability to pay. To make this a reality, over the next five years (FY14-18) St. Joseph Health and St. Joseph Hospital are strategically focused on two key areas to which the Community Benefit (CB) Plan strongly align: population health management and network of care. Population-based care includes the recognition that social determinants of health such as poverty, education, crime, geography and pollution drive a significant part of society’s health outcomes. A network of care will be a systems change approach to providing comprehensive and holistic care to the communities we serve.

## ORGANIZATIONAL COMMITMENT

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

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

Each year St. Joseph Hospital allocates 10% of its net income (net realized gains and losses) to the St. Joseph Health Community Partnership Fund. (See Figure 1). 7.5% of the contributions are used to support local hospital Care for the Poor programs. 1.75% is used to support SJH Community Partnership Fund grant initiatives. The remaining .75% is

designated toward reserves, which helps ensure the Fund's ability to sustain programs into the future that assist low-income and underserved populations.

Furthermore, St. Joseph Hospital 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.

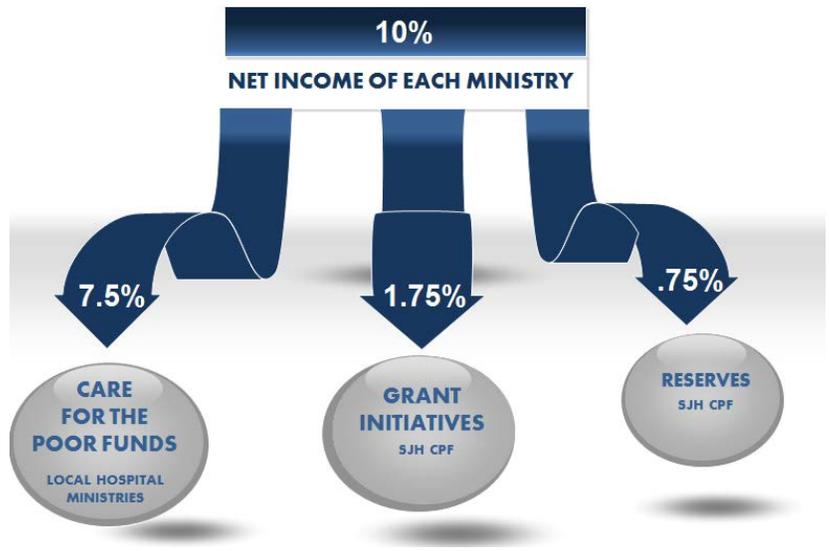
### Community Benefit Governance and Management Structure

St. Joseph Hospital 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 the Director of Community Outreach 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 Hospital 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

Figure 1. Fund distribution



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 5 members of the Board of Trustees and 7 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 bimonthly.

### **Roles and Responsibilities**

#### ***Senior Leadership***

- CEO and other senior leaders are directly accountable for Community Benefit 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’.
- CBC 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.

## **COMMUNITY**

### **Community Served**

SJO provides central Orange County communities with access to advanced care and advanced caring. The hospital's service area extends from the 91 Freeway - North boundary, Pacific Coast Hwy - South boundary, 15 Freeway – East boundary, and 605 Freeway – West. Our Hospital Total Service Area includes the cities of Anaheim, Garden Grove, Midway City, Orange, Santa Ana, Tustin, Villa Park, Westminster, Buena Park, Costa Mesa, Fountain Valley, Fullerton, Huntington Beach, Irvine, Lake Forest, and Stanton. This includes a population of approximately 2,490,784 people, an increase of 7% from the prior assessment. For a complete copy of St. Joseph Hospital's FY14 CHNA click here: <http://www.sjo.org/>

In central Orange County, an urban metropolis, the region's economically poor residents face significant challenges and barriers as it relates to achieving optimal health outcomes. In 1993, central Santa Ana was federally designated as a Medically Underserved Area (MUA). South Garden Grove and West Santa Ana were designated as Medically Underserved Populations (MUP). And there were 4 population groups designated as Health Professional Shortage Areas (HPSAs) for primary medical care in East and West Anaheim, South Santa Ana, Garden Grove and North Stanton. According to the Intercity Hardship Index, IHI (see page 12 for more detail on the IHI), 364 out of approximately 400 neighborhood block groups in Orange County with the highest need are within the SJO primary service area. The average annual income per person in the highest need areas within the SJO primary service area ranges from \$5,777 to \$25,549. The cities of Santa Ana, Anaheim and Placentia have top 4 block groups with 74% to 89% of the population over the age of 25 with less than a high school education. These same cities have top 19 block groups within 22% to 40.7% of households below the Federal Poverty Level. The cities of Anaheim, Huntington Beach, Orange, Placentia, Santa Ana and Stanton have top 42 block groups with 30% to 43% of housing units with 7+ people.

Another helpful tool that quantifies need in communities is the Community Need Index (CNI). The CNI demonstrates need at the Zip Code level. Research indicates a strong correlation between high CNI scores and hospital admission rates. Residents who live in areas with the highest need were twice as likely to experience preventable hospitalization for manageable conditions (i.e. ear infections, pneumonia, etc.). Eight cities (18 zip codes) in central Orange County had a score of "highest need" (see page 12 for more detail on the CNI).

### **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 reside. The PSA is comprised of Anaheim, Garden Grove, Midway City, Orange, Santa Ana, Tustin, Villa Park and Westminster. The SSA is comprised of Buena Park, Corona, Costa Mesa, Cypress, Foothill Ranch, Fountain Valley, Fullerton, Huntington Beach, Irvine, and Lake Forest.

**Table1. Cities and ZIP codes**

Cities	ZIP codes
Anaheim	92801, 92802, 92804, 92805, 92806, 92807, 92808
Garden Grove	92840, 92841, 92843, 92844, 92845
Midway City	92655
Orange	92865, 92866, 92867, 92868, 92869
Santa Ana	92701, 92703, 92704, 92705, 92706, 92707
Tustin	92780, 92782
Villa Park	92861
Westminster	92683
Buena Park	90620, 90621
Corona	92879, 92880, 92882, 92883
Costa Mesa	92626, 92627
Cypress	90630
Foothill Ranch	92610
Fountain Valley	92708
Fullerton	92831, 92833
Huntington Beach	92646, 92647, 92648, 92649
Irvine	92602, 92603, 92604, 92605, 92606, 92612, 92614, 9267, 92618, 92620
Lake Forest	92630

Figure 1 (below) 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. St. Joseph Hospital Total Service Area**



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

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

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

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

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



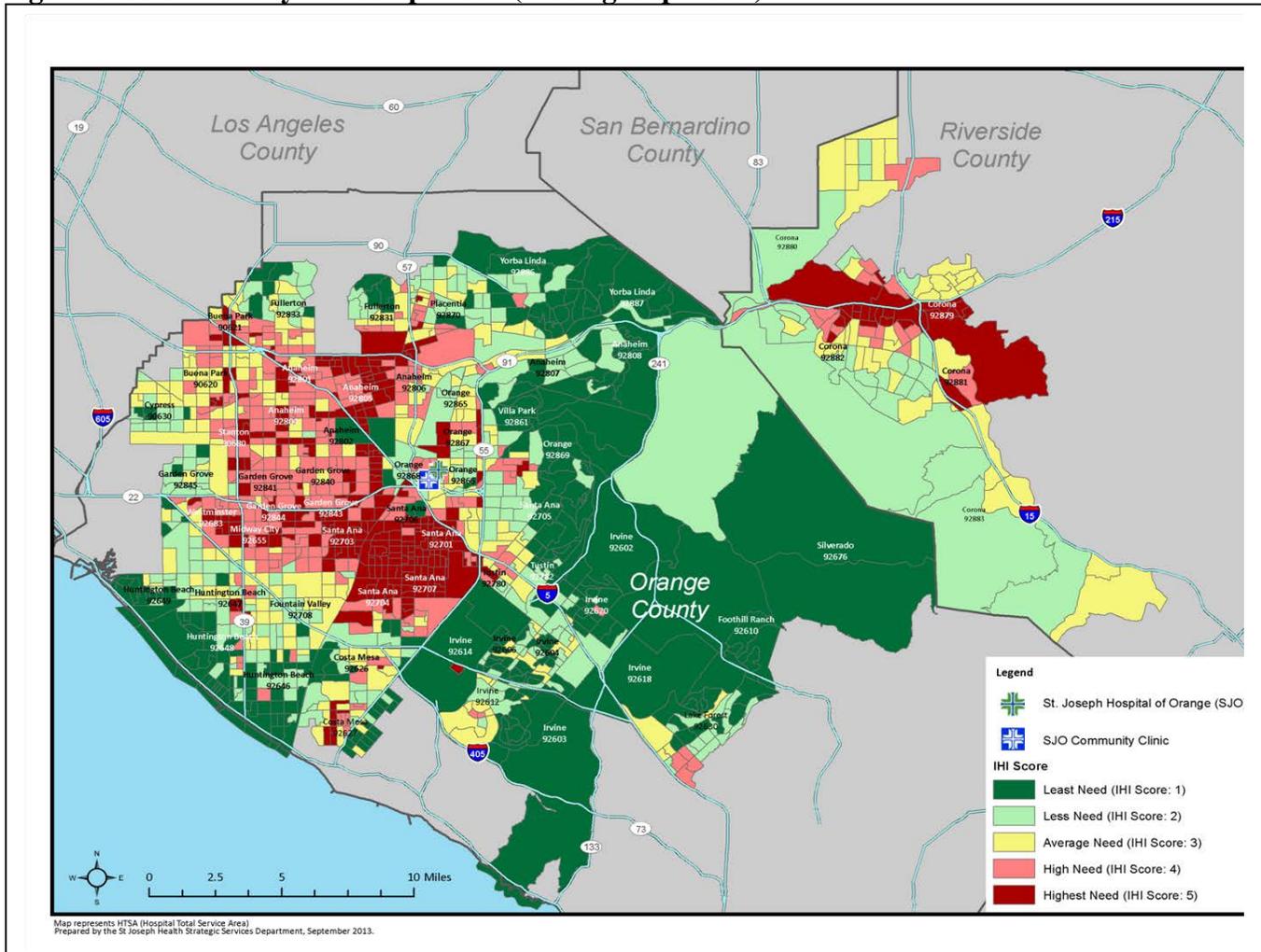
The IHI combines six key social determinants that are often associated with health outcomes:

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

Based on the IHI, each block group was assigned a score from 1 (lowest IHI, lowest level of hardship/need) to 5 (highest IHI, highest level of hardship/need). The IHI is based on *relative need within a geographic area*, allowing for comparison across areas. Similar to what is seen with the Community Need Index; the highest need areas are in the cities of Santa Ana, Anaheim, Garden Grove, Westminster, Midway City, and Buena Park.

Figure 3 (below) depicts the **Intercity Hardship Index** for the hospital’s geographic service area and demonstrates *relative need*.

**Figure 3. SJO Intercity Hardship Index (Block group Level)**



## **COMMUNITY NEEDS AND ASSESSMENT PROCESS**

### **Summary of Community Needs Assessment Process**

SJO completed a needs assessment in 2014. In 2012 and 2013, SJO gathered information to complete its needs assessment. Community input was obtained through a phone survey, five focus groups, and interviews with five leaders in the community. Information about the community also was pulled from the Office of Statewide Health Planning and Development (OSHPD), the 2010 Census and the American Community Survey (ACS).

In preparing the Community Health Needs Assessment, SJH worked with Professional Research Consultants, Inc. (PRC) to conduct and analyze the community survey, and The Olin Group, Inc. to conduct interviews and focus groups and to summarize all the community input.

Community organizations that participated in this process included The Cambodian Family, Delhi Center, Healthy Smiles for Kids - Orange County, Lestonnac Free Clinic, Orange County Health Care Agency, and Valley High School. Interviewees represented organizations that serve low-income, medically underserved residents of SJH's community benefits service area. Focus group participants were all community members and/or patients of the hospital or its clinics as well as Spanish or Khmer speaking individuals.

A variety of methods and sources were used to gather primary and secondary data for this needs assessment in order to ensure input from across the community.

### **Primary Data**

Survey – Professional Research Consultants, Inc. conducted a survey in 2012 of 1,250 residents in the SJO service area. The survey instrument was based largely on the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System, as well as various other public health surveys and customized questions addressing gaps in indicator data relative to national health promotion and disease prevention objectives targeted by Healthy People 2020. The responses were weighted to match the demographic characteristics of the population and thereby improve the representativeness of the results.

Interviews – The Olin Group, interviewed five community and health care leaders who are knowledgeable about the health needs of local residents were interviewed in the fall of 2013. One of those interviewed was a representative of the Orange County Health Care Agency (Orange County's public health department). Each interviewee was provided key findings from the survey and then asked to provide their own insights on the needs of the community. A summary report was prepared that presents the main points from all five interviews.

Focus Groups – A total of 54 community members participated in five focus groups about health needs and quality of life issues in the St. Joseph Hospital service area. The transcripts of four focus groups (40 participants) that were conducted in May 2012 for The Cambodian Family, a local nonprofit organization, were analyzed for this assessment. Two of the focus groups were conducted in Spanish, and two in Khmer. All four asked about health and quality of life challenges in the Santa Ana area. A fifth focus group was conducted in October 2013. This focus group consisted of 14 clients of the St. Joseph Hospital Diabetes Management Program and was conducted in Spanish.

### **Secondary Data**

Office of Statewide Health Planning and Development (OSHPD) data from 2009 was used in defining the SJO service area.

Data from the 2010 US Census and estimates from the 2006-2010 American Community Survey (ACS) and 2005-2009 ACS were used to develop the Community Needs Indices and Intercity Hardship Indices.

Data from the 2012 American Community Survey / Demographic and Housing Estimates, was used to show the race/ethnic breakouts of the SJO service area. The 2013 Orange County Health Profile, Public Health Services, Orange County Health Care Agency, was used to show health differences among the three primary racial/ethnic groups of the SJH service area. Information on the API community was provided in a personal communication from the Executive Director of OCAPICA. An unpublished report prepared for MOMS Orange County by The Olin Group provided information about births in the SJO service area.

**Identification and Selection of DUHN Communities**

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

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

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

DUHN Population Group or Community ZIP code or block group	Community Needs	Community Assets
Garden Grove – 92843, 92844	<ul style="list-style-type: none"> <li>• Higher rates of families where Spanish is the primary language at home</li> <li>• Higher rates of families with someone age 25+ not having a HS diploma</li> <li>• Higher number of Households with more than 7 people</li> <li>• Higher number of Households living below the poverty level</li> <li>• Higher number of female heads of household</li> </ul> <p>Utilizing IHI and CNI to identify areas with disproportionate unmet health needs, the zip codes listed reflect areas with</p>	<ul style="list-style-type: none"> <li>• County of Orange Health Care Agency</li> <li>• Community-based Organizations               <ul style="list-style-type: none"> <li>○ Healthy Smiles</li> <li>○ Orange County Asian and Pacific Islander Community Alliance (OCAPICA)</li> <li>○ Orange County Korean American Health Information Education Center (OCKAHIEC)</li> <li>○ MOMS Orange County</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>• Higher rates unemployment</li> <li>• Higher rates of dependency</li> <li>• Lower rates of education attainment</li> <li>• Lower per capita income levels</li> <li>• Higher rates of crowded housing (&gt; 7 persons per household)</li> <li>• Higher rates of poverty</li> <li>• Higher rates of limited English proficient individuals</li> <li>• Higher rates of unemployed and uninsured</li> </ul>	
<p>Santa Ana – 92701, 92704, 92707</p>	<ul style="list-style-type: none"> <li>• Higher rates of families where Spanish is the primary language at home</li> <li>• Higher rates of families with someone age 25+ not having a HS diploma</li> <li>• Higher number of households with more than 7 people</li> <li>• Higher number of households living below the poverty level</li> <li>• Higher number of female heads of household</li> </ul> <p>Utilizing IHI and CNI to identify areas with disproportionate unmet health needs, the zip codes listed reflect areas with</p> <ul style="list-style-type: none"> <li>• Higher rates Unemployment</li> <li>• Higher rates of dependency</li> <li>• Lower rates of education attainment</li> <li>• Lower per capita Income levels</li> <li>• Higher rates of crowded housing (&gt; 7 persons per household)</li> <li>• Higher rates of poverty</li> <li>• Higher rates of limited English proficient individuals</li> </ul> <p>Higher rates of unemployed and uninsured</p>	<ul style="list-style-type: none"> <li>• County of Orange Health Care Agency</li> <li>• Community-based Organizations                         <ul style="list-style-type: none"> <li>○ Latino Health Access</li> <li>○ Kidworks</li> <li>○ MOMS Orange County</li> <li>○ The Cambodian Family</li> <li>○ Delhi Center</li> <li>○ Corbin Family Resource Center</li> <li>○ Taller San Jose</li> </ul> </li> <li>• Community Clinics/Health Centers                         <ul style="list-style-type: none"> <li>○ AltaMed (3 clinics)</li> <li>○ Birth Choice Health Center</li> <li>○ Clinica CHOC Para Ninos</li> <li>○ Kaiser Permanente Harbor MacArthur Clinic</li> <li>○ Puente a la Salud Mobile Community Clinics</li> <li>○ Serve the People Health Center</li> <li>○ SOS-El Sol Wellness Center</li> <li>○ UCI Santa Ana</li> </ul> </li> </ul>
<p>Midway City - 92655</p>	<ul style="list-style-type: none"> <li>• Higher rates of families where Spanish is the primary</li> </ul>	<ul style="list-style-type: none"> <li>• County of Orange Health Care Agency</li> </ul>

	<p>language at home</p> <ul style="list-style-type: none"> <li>• Higher rates of families with someone age 25+ not having a HS diploma</li> <li>• Higher number of households with more than 7 people</li> <li>• Higher number of households living below the poverty level</li> <li>• Higher number of Female heads of household</li> </ul> <p>Utilizing IHI and CNI to identify areas with disproportionate unmet health needs, the zip codes listed reflect areas with</p> <ul style="list-style-type: none"> <li>• Higher rates unemployment</li> <li>• Higher rates of dependency</li> <li>• Lower rates of education attainment</li> <li>• Lower per capita income levels</li> <li>• Higher rates of crowded housing (&gt; 7 persons per household)</li> <li>• Higher rates of poverty</li> <li>• Higher rates of limited English proficient individuals</li> </ul> <p>Higher rates of unemployed and uninsured</p>	<ul style="list-style-type: none"> <li>• Community-based Organizations           <ul style="list-style-type: none"> <li>○ MOMS Orange County</li> </ul> </li> </ul>
<p>Anaheim – 92801, 92805</p>	<p>Utilizing IHI and CNI to identify areas with disproportionate unmet health needs, the zip codes listed reflect areas with</p> <ul style="list-style-type: none"> <li>• Higher rates unemployment</li> <li>• Higher rates of dependency</li> <li>• Lower rates of education attainment</li> <li>• Lower per capita income levels</li> <li>• Higher rates of crowded housing (&gt; 7 persons per household)</li> <li>• Higher rates of poverty</li> <li>• Higher rates of limited English proficient individuals</li> </ul> <p>Higher rates of unemployed and uninsured</p>	<ul style="list-style-type: none"> <li>• County of Orange Health Care Agency</li> <li>• Community-based Organizations           <ul style="list-style-type: none"> <li>○ Boys and Girls Club</li> <li>○ Anaheim Harbor Family Resource Center</li> <li>○ MOMS Orange County</li> </ul> </li> <li>• Community Clinics/ Health Centers           <ul style="list-style-type: none"> <li>○ Alta Med (2 clinics)</li> <li>○ Puente a la Salud Mobile Community Clinics</li> <li>○ UCI Family Health Center-Anaheim</li> </ul> </li> </ul>

## **PRIORITIZED COMMUNITY HEALTH NEEDS**

The list below summarizes the prioritized community health needs identified through the FY14 Community Health Needs Assessment Process. Through the CHNA process, fifteen areas of concern were identified. The top eight concerns arose consistently across all avenues for community input - interviews, focus groups and community survey (note – the survey did not ask about access to green space and parks, but it was a high concern among community members in interviews and focus groups). The second list includes seven concerns that were mentioned through just one or two of the data gathering methods and thus appeared less frequently. The top eight are presented here in alphabetical order followed by the additional seven, also in alphabetical order:

### **Top Eight Concerns**

1. Access to affordable, healthy food
2. Access to health care
3. Dental health
4. Diabetes
5. Lack of green space and parks
6. Mental health
7. Obesity
8. Substance abuse

### **Seven Additional Concerns:**

9. Affordable and accessible transportation
10. Asthma in adults
11. Chronic Heart Disease
12. Cultural competency
13. Depression
14. Stress
15. Stroke

## **COMMUNITY BENEFIT PLAN**

### **Summary of Community Benefit Planning Process**

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

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

In March 2014, the Community Benefit Committee, a sub-committee of the SJO Board of Trustees participated in a “study session” to identify and prioritize community needs. The Committee used a ranking method tool to prioritize needs based on specified criteria provided. They used the criteria as well as a number ranking system (each Committee member received three points each) to rank the priority needs identified through the CHNA. The table below demonstrates the summarized rankings from all Committee members and the top three priority areas that resulted from the rankings.

Criteria	Access to Health Care	Dental Health	Chronic Disease <small>(Obesity, Asthma, Heart Disease, Stroke)</small>	Mental Health <small>(Depression, Stress, Substance Abuse)</small>	Access to Affordable, Healthy Food	Lack of Green Space and Parks	Affordable and Accessible Transportation	Total
Relevancy to mission	10	5	9	8	1			33
Scope of problem	10	5	7	9	2			33
Seriousness of problem	9	4	9	10	1			33
Health Disparities	7	3	8	12	2	1		33
Effectiveness of interventions	7	9	9	6	1	1		33
Economic feasibility	9	8	9	6	1			33
Importance to community	12	3	6	5	3	3	1	33
Time commitment	10	4	9	10				33
Existing efforts on problem	7	5	13	6	2			33
Implications for not proceeding	12	2	6	12	1			33
Sustainability likely	8	7	8	9	1			33
<b>Total</b>	<b>101</b>	<b>55</b>	<b>93</b>	<b>93</b>	<b>15</b>	<b>5</b>	<b>1</b>	

Based on review of prioritized significant health needs and a thoughtful priority setting process, SJO will address the following priority areas as part of its FY15-17 CB Plan:

- Access to Health Care
- Chronic Disease
- Mental Health

**Addressing the Needs of the Community:  
FY15 –17 Key Community Benefit Plan**

**Evaluation**

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

**Initiative (community need being addressed):** According to the Inner City Hardship Index, 364 of approximately 400 highest needs block groups are in the St. Joseph Hospital primary service area.

**Goal (anticipated impact):** Increase Access to Care for number of persons at 200% of Federal Poverty Level in central OC who lack appropriate health services.

Outcome Measure	<i>Baseline</i>	<i>FY15 Target</i>	<i>FY17 Target</i>
Number of new patients who select SJO Community Clinics as their medical home.	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>

Strategy(ies)	<i>Strategy Measure</i>	<i>Baseline</i>	<i>FY15 Target</i>
1. Increase # of patients served by 20%.	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>
2. Increase availability of Specialty Care providers.			
3. Implement performance improvement plan throughout clinic departments.	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>

**Key Community Partners:** Coalition of Orange County Health Centers

Family Resource Centers  
 CalOptima

**Initiative (community need being addressed):** Orange County Health Profile 2013 shows the following percentage of people reporting chronic disease diagnosis: 7.4% of adults with diabetes, 25.4% of adults with hypertension, 23.8% of adults are obese; 17% of deaths in the county were caused by heart disease, 6% of deaths in the county were caused by stroke.

**Goal (anticipated impact):** Improve Chronic Disease Management to optimize health outcomes for patients at La Amistad Family Health Center.

Outcome Measure	<i>Baseline</i>	<i>FY15 Target</i>	<i>FY17 Target</i>
Number of chronic disease patients with improved clinical values.	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>

Strategy(ies)	<i>Strategy Measure</i>	<i>Baseline</i>	<i>FY15 Target</i>
1. Decrease A1C by one percentage point.	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>
2. Increase number of patients who receive a diabetic eye exam by 10%.			
3. Implement best practice standards of care for community clinic chronic disease management.	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>

**Key Community Partners:** Local ADA Chapter  
 Sister Ministry Clinics (St. Jude Family Health Center, Camino, SOS)

**Initiative (community need being addressed):** FY14 CHNA qualitative and quantitative data show that mental/behavioral health is a significant health concern among communities in central Orange County.

**Goal (anticipated impact):** Increase the proportion of underserved population who receive Mental Health screening and resources in clinic setting.

Outcome Measure	Baseline	FY15 Target	FY17 Target
Number of persons who are screened for depression.	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>

Strategy(ies)	Strategy Measure	Baseline	FY15 Target
1. Integrate behavioral health screening into primary care services.	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>
2. Coordinate referral sources with partners.			
3. Participate in County collaborative efforts.	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>	<i>To be established in collaboration with System Office, Sister Ministries and community partners.</i>

**Key Community Partners:** Healthcare Agency of OC  
Sister Ministry Clinics (St. Jude Family Health Center, Camino, SOS)  
Community based organizations

## **Planning for the Uninsured and Underinsured**

### **Patient Financial Assistance Program**

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

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

### **Medicaid and Other Local Means-Tested Government Programs**

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

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<sup>1</sup> Information about St. Joseph Hospital's Financial Assistance Program is available [INSERT URL](#)

## Other Community Benefit

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

Initiative (community need being addressed):	Program	Description	Target Population (Low Income or Broader community)
1. Access to Dental	La Amistad and Puente a la Salud Dental Services	Provide mobile and fixed comprehensive dental services for adults and children.	Low Income
2. Access to Vision	Puente a la Salud Vision Services	Provide mobile vision services for adults and children.	Low Income
3. Access to Health Screening	Puente a la Salud Mobile Cardiovascular Screening Program	Provide cardiovascular screenings and follow up for adults.	Low Income
4.	Taller San Jose Pre-employment Screening Program	Provide pre-employment drug screening and vaccines to teens and young adults.	Low Income
5.	Laboratory Services	Provide various lab tests to Lestonnac Free Clinic patients.	Low Income
6.	Women’s Heart Center	Provide cardiovascular screenings to women.	Broader Community
7. Postpartum Depression	Postpartum Depression Comprehensive Services	Provide screening and treatment to women referred.	Broader Community
8. Food Insecurity	Meals On Wheels Program	Provide meals to seniors and disabled persons.	Broader Community
9. Access to Rx	Pharmacy Meds Program	Provide needed Rx upon discharge.	Low Income
10. Postpartum follow up	Mother Baby Assessment Center	Provide physical and psycho-social assessment of mother and baby.	Broader Community
11. Cancer awareness	Community Events and Support Groups	Provide free classes and groups to cancer patients in treatment and cancer survivors.	Broader Community

## **Needs Beyond the Hospital's Service Program**

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

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

**Access to affordable, healthy foods:** The Hospital does not directly address access to nutrition for the general public except for in the Meals on Wheels program for seniors and the disabled; however, we support and endorse grant applications to the St. Joseph Health Community Partnership Fund for several local central Orange County community based food banks seeking funding for sustainability. Without this funding, these organizations would not be able to sustain and/or further their work in this area.

**Lack of green space and parks:** The Hospital does not directly address green space and parks; however we support and endorse grant applications to the St. Joseph Health Community Partnership Fund-Community Building Initiative for local community based organizations who directly address these social and infrastructure issues. Without this funding, these organizations would not be able to sustain and/or further their work in this area.

**Affordable and accessible transportation:** The Hospital does not directly address transportation; however, when planning to provide services to underserved communities, we dedicate resources to our mobile clinics that strategically travel to locations, neighborhoods and communities with disproportionate unmet health needs. Our mobile units include dental, vision and health screening services.

**Cultural competency:** The Hospital provides cultural competency training for its employees; however, these trainings are not open to the public.

In addition, SJO will collaborate with community partners that address aforementioned community needs, to coordinate care, referral and address these unmet needs.

*St. Joseph Health, St. Joseph Hospital*  
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**Governance Approval**

This Community Benefit Plan/Implementation Strategy Report was approved at the May 20, 2014 meeting of the SJO Community Benefit Committee of the Board of Trustees.

*A. Nadine Mc Guinness, CST*  
Chair's Signature confirming approval of the FY15-17 Community Benefit Plan

6/3/2014  
Date

