

# 2021 - 2023

## COMMUNITY HEALTH IMPROVEMENT PLAN

### Providence St. Joseph Hospital

Orange, California



Photos by Marides Uytiepo, Phuc To, and Diana Castro



To provide feedback on this CHIP or obtain a printed copy free of charge, please email Cecilia Bustamante-Pixa at [Cecilia.Bustamante-Pixa@stjoe.org](mailto:Cecilia.Bustamante-Pixa@stjoe.org)



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# EXECUTIVE SUMMARY

Providence continues its Mission of service in Orange County through Providence St. Joseph Hospital (SJO). SJO is an acute-care hospital with 465 licensed beds, founded in 1929 and located in Orange, California. The hospital's service area is the entirety of Central Orange County, including 2,590,000 people.

Providence 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 vulnerable. During the most recent calendar year, the hospital provided \$68,180,230 in Community Benefit in response to unmet needs.

The Community Health Needs Assessment (CHNA) is an opportunity for Providence St. Joseph Hospital to engage the community every three years with the goal of better understanding community strengths and needs. The results of the CHNA are used to guide and inform efforts to better address the needs of the community. Through a mixed-methods approach, using quantitative and qualitative data, the CHNA process relied on several sources of information to identify community needs. Across Orange County, information collected includes community data-level from the Orange County Health Improvement Partnership; 2019 Kaiser Permanente CHNA; 2019 University of California, Irvine Medical Center CHNA; CalOptima Member Survey; state and national public health data; and hospital utilization data.

## Collaborating Organizations

Orange County Health Improvement Partnership (HIP), Kaiser Permanente, and CalOptima, and University of California, Irvine (UCI) conducted various community and stakeholder engagement sessions in 2019. While Providence Orange County had planned several for Spring 2020, these sessions had to be cancelled due to the COVID-19 pandemic. In lieu of those sessions, we are leveraging the previously collected information from local partners and will update with additional community feedback and input as appropriate in response to the pandemic.

### ORANGE COUNTY HEALTH IMPROVEMENT PARTNERSHIP (HIP)

Overall, the HIP identified homelessness and housing; environmental health; safety; mental health and substance use; access to care; nutrition; early childhood development; and support for aging populations as the key themes from the sessions. They conducted six diverse focus groups with under-represented communities, including Vietnamese older adults, Spanish-speaking adults and mothers, adolescents, and service providers.

### KAISER PERMANENTE CHNA 2019 (ANAHEIM AND IRVINE)

Kaiser Permanente's 2019 CHNA included focus groups based upon high-level findings from secondary data analysis. Additionally, 18 stakeholder interviews were conducted representing the non-profit sector, education, and county agencies. These stakeholders identified housing insecurity, food insecurity, asthma and stroke disparities, oral health, mental health/suicide, and older adult health as key needs. Kaiser Permanente's identified priorities for the service area were access to health care; economic, housing, and food insecurities; mental health and substance use; stroke; and suicide.

## CALOPTIMA MEMBER SURVEY

CalOptima is a county organized health system that administers health insurance programs for children, adults, seniors with low incomes and people with disabilities. They administered a member survey as part of a comprehensive assessment. The survey reached a wide variety of demographics and included insights into needs beyond members' immediate health care needs, including social determinants of health. The report notes access barriers, lack of awareness of benefits and resources, and negative social and environmental impacts as the key themes identified.

## UNIVERSITY OF CALIFORNIA, IRVINE CHNA 2019

The UCI CHNA included input from stakeholders gathered in Fall 2018, including Orange County Health Care Agency. Stakeholders were asked to rank order identified health needs. The percentage of responses were presented for those needs with severe or significant impact on the community, had worsened over time, and had a shortage or absence of resources available in the community, and level of importance in the community. Substance use and misuse; mental health; and housing and homelessness were the top ranked priorities.

## Providence St. Joseph Hospital Community Health Improvement Plan Priorities

As a result of the findings of our [2021 CHNA](#) and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, St. Joseph Hospital will focus on the following areas for its 2021-2023 Community Benefit efforts:

### MENTAL HEALTH

Creating awareness and services addressing mental health along with substance use.

### HEALTH CARE ACCESS

Increasing health care access as well as other resources for areas that have the biggest challenges.

### HOMELESSNESS AND HOUSING

Social determinants of health, like housing, have an impact on health. Addressing housing, homelessness and homeless prevention will improve health in the communities we serve.

# INTRODUCTION

## Who We Are

**Our Mission** As expressions of God’s healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

**Our Vision** Health for a Better World.

**Our Values** Compassion — Dignity — Justice — Excellence — Integrity

Providence St. Joseph Hospital is an acute care hospital founded in 1929 and located in Orange, California. The hospital has 465 licensed beds, a staff of more than 3,100, and professional relationships with more than 1,000 local physicians. Major programs and services offered to the community include the following: cardiac care, stroke/neuro, orthopedics, rehabilitation, oncology, emergency medicine, and obstetrics.

## Our Commitment to Community

St. Joseph Hospital dedicates resources to improve the health and quality of life for the communities we serve. During Calendar Year 2020, SJO provided \$68,180,230 in Community Benefit<sup>1</sup> in response to unmet needs and to improve the health and well-being of those we serve in Central Orange County.

## Health Equity

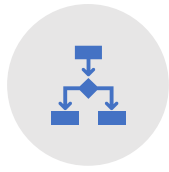
At Providence St. Joseph Health, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is “Health for a Better World,” and to achieve that we believe we must address not only the clinical care factors that determine a person’s length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes.

To ensure that equity is foundational to our CHIP, we have developed an equity framework that outlines the best practices that each of our hospital will implement when completing a CHIP. These practices include, but are not limited to the following:

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<sup>1</sup> Per federal reporting and guidelines from the Catholic Health Association.

**Figure 1. Best Practices for Centering Equity in the CHIP**



Address root causes of inequities by utilizing evidence-based and leading practices



Explicitly state goal of reducing health disparities and social inequities



Reflect our values of justice and dignity



Leverage community strengths

## Community Benefit Governance

Providence St. Joseph Hospital demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration with community partners. The Director of Community Health Investment is responsible for coordinating implementation of State and Federal 501r requirements.

A charter approved in 2007 and revised in 2020 established the formation of the SJO Community Health Committee. The role of the Community Health 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 Health Committee is charged with developing policies and programs that address identified needs in the service area particularly for underserved populations, overseeing development and implementation of the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP), and overseeing and directing the Community Benefit (CB) activities.

The Community Health Committee has a minimum of eight members including three members of the Board of Trustees. Current membership includes 3 members of the Board of Trustees and 10 community members. A majority of members have knowledge and experience with the populations most likely to have disproportionate unmet health needs. The Community Health Committee generally meets quarterly.

### ROLES AND RESPONSIBILITIES

#### *Senior Leadership*

- Chief Executive and senior leaders including the hospital's Chief Mission Integration Officer, are directly accountable for CB performance.

### *Community Health Committee (CHC)*

- CHC 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 CHC serve as ‘board level champions.’
- The Committee provides recommendations to the Board of Trustees regarding budget, program targeting and program continuation or revision.

### *Community Health (CH) Department*

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

### *Local Community*

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

## Planning for the Uninsured and Underinsured

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

One way Providence St. Joseph Hospital informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient 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. For information on our Financial Assistance Program click

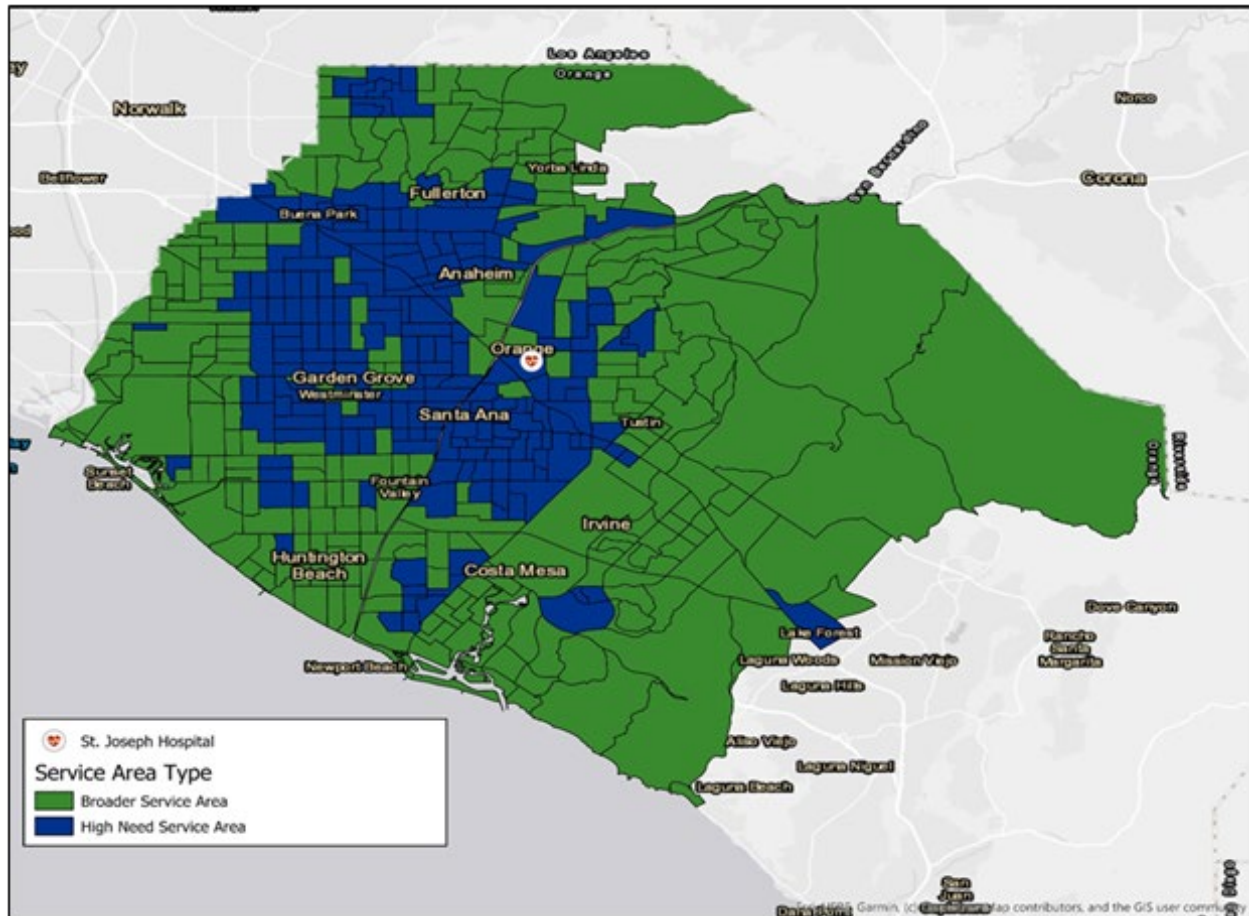
<https://www.providence.org/obp/ca>



# OUR COMMUNITY

## Description of Community Served

Providence St. Joseph Hospital’s service area is central Orange County and includes a population of approximately 2,590,000 people. The population in SJO’s total service area makes up 80% of Orange County.



Of the over 2,590,000 permanent residents of central Orange County, roughly 47% live in the “high need” area, defined by lower life expectancy at birth, lower high school graduation rates, and more households at or below 200% FPL compared to census tracts across the county. For reference, in 2020, 200% FPL represents an annual household income of \$52,400 or less for a family of four. These households are more likely to regularly make spending tradeoffs regarding utilities, rent, groceries, medicine, and other basic expenses.



## Community Demographics

### POPULATION AND AGE DEMOGRAPHICS

Of the over 2,590,000 permanent residents in the total service area, the male-to-female distribution is roughly equal across geographies.

The high need service area has a higher percentage of people under 34 years of age, 61.5%, compared to 47.4% in the broader community.

**Table 1. Demographics Indicators for Orange County Service Area**

Indicator	Broader Service Area	High Need Service Area	Total Service Area	Orange County
2019 Total Population	1,381,295	1,209,139	2,590,434	3,252,459
Female Population	50.9%	49.8%	50.4%	50.5%
Male Population	49.1%	50.2%	49.6%	49.5%

### POPULATION BY RACE AND ETHNICITY

Individuals identifying as Hispanic had a higher percentage living in high need service areas, 59.1% versus the broader service area, 19.9%. The same was noted for individuals identifying as “other” race, 28.5% versus 7.0%.

People identifying as Asian and white were less likely to live in high need census tracts. For Asians, 19.9% lived in high need service areas and 26.5% in the broader service area. For whites, 44% lived in high need service areas, and 58.9% in the broader community.

### SOCIOECONOMIC INDICATORS

**Table 2. Income Indicators for Orange County Service Area**

Indicator	Broader Service Area	High Need Service Area	Orange County
<b>Median Income</b> Data Source: American Community Survey Year: 2019	\$101,892	\$60,065	\$88,453
<b>Percent of Renter Households with Severe Housing Cost Burden</b> Data Source: American Community Survey Year: Estimates based on 2013 – 2017 data	23.7%	32.2%	28.0%

The high need service area's median household income is approximately \$40,000 *less than* that of the broader service area, and \$28,000 *less than* the Orange County overall.

Severe housing cost burden is defined as households that spend 50% or more of their income on housing costs. A greater proportion of renter households are severely housing burdened in the high need service area (one out of every three households, 32.2%) in comparison to the broader service area (one out of every four households, 23.7%).

**Full demographic and socioeconomic information for the service area can be found in the [2021 CHNA](#) for St. Joseph Hospital of Orange.**

# COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

## Summary of Community Needs Assessment Process and Results

Improving the health of our communities is foundational to our Mission and deeply rooted in our heritage and purpose. Our Mission calls us to be steadfast in serving all, with a special focus on our most economically poor and vulnerable neighbors. This core belief drives the programs we build, investments we make, and strategies we implement.

Knowing where to focus our resources starts with our Community Health Needs Assessment (CHNA), an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets, and opportunities. The 2021 CHNA was approved by the SJO Community Health Committee on April 6, 2021.

## Significant Community Health Needs Prioritized

Through a collaborative process engaging Community Health Committee members and the Director of Community Health Investment, the hospital worked from a list of the seventeen (17) health and social needs identified by data from the Orange County Health Improvement Partnership, 2019 Kaiser Permanente CHNA, 2019 University California, Irvine Medical Center CHNA, CalOptima Member Survey, morbidity and mortality data; and hospital-level data. Staff developed a point system to assign each of the seventeen (17) identified needs to gain perspective and develop a hierarchy of which top needs have the potential to offer the highest impact in the High Desert. Each need was listed, and assessed based on the following:

- Trend over time (Getting “Worse” or “Better”)
- Impact on low-income or communities of color (“Very High” to “Very Low”)
- Are “High Need Areas” worse off than state averages? (“Yes” or “No”)
- Opportunity for Impact (“Low” to “Very High”)
- Alignment with System Priorities (“Yes” or “No”)
- Community Vital Signs Priority (“Yes” or “No”)
- Attorney General Requirement (“Yes” or “No”)

Based upon the scoring system and discussion, SJO’s Community Health Committee identified the following priorities:

### PRIORITY 1: MENTAL HEALTH

Improved system to access mental health and substance use services to ensure that patients receive care at the appropriate level of care and not in the Emergency Department, reduced mental health stigma in the community and increase in resources for youth.

### PRIORITY 2: HEALTH CARE ACCESS

Increasing health care access as well as other resources for areas that have the biggest challenges.

### PRIORITY 3: HOMELESSNESS AND HOUSING

Social determinants of health, like housing, have a substantial impact on health behaviors and health outcomes. Addressing housing instability, housing affordability, and preventing homelessness will improve health in the communities we serve.

### Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. We are committed to continuing our Mission partnering with like-minded partners that count with the capacity and expertise to address the needs of Orange County Residents by funding other non-profits through our Care for the Poor program managed by Providence St. Joseph Hospital.

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

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

- **Obesity/Food Insecurity/Nutrition:** While not identified as a priority in the CHNA, SJO will continue to support the Move More, Eat Healthy Initiative as part of the health equity/racial disparities priority. This initiative also addresses food insecurity and nutrition. SJO donates unused food as part of our efforts to address food insecurity.
- **Economic Issues:** While SJO has not selected economic issues as a top priority, the majority of its community benefit programs are targeted to the low-income population. SJO partners with Orange County Community Action Partnership, the county anti-poverty agency on several initiatives as well as the Intersections Initiative of Central Orange County, a collaborative address workforce in low-income areas. SJO has a policy of a just living wage and in that way serves as a role model for other organizations in the community.
- **Safety:** The declining crime rate has not made this a priority, but SJO participates in local collaboratives that focus on the needs of at-risk youth with a goal to reduce gang involvement and crime.
- **Diabetes:** SJO will continue to work with the OC Health Improvement Partnership which is addressing diabetes in Orange County.
- **Early Childhood Development:** While this did not make the top priorities, the Director, Community Health Investment participates in the Santa Ana Early Learning Initiative which is addressing this issue.
- **Environment/Climate:** [Providence St. Joseph Health has committed to being carbon negative by 2030](#). This effort will involve all hospital staff.
- **Ageing Population:** While this is not one of the selected priorities, St. Joseph Hospital partners with the Southern California Council on Aging. Over the past two years, St. Joseph Hospital has

funded a program that provides isolated, low-income older adults in central Orange County with social service resources and referrals, mental health services, and a volunteer visiting program.

In addition, St. Joseph Hospital will collaborate with several local organizations that address the aforementioned community needs to coordinate care and referrals to address these unmet needs.

In addition, the hospital will collaborate with local non-profit, like-minded organizations that address the aforementioned community needs to coordinate care and referrals to address these unmet needs.

# COMMUNITY HEALTH IMPROVEMENT PLAN

## Summary of Community Health Improvement Planning Process

Providence St. Joseph Hospital developed a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners, considering resources, community capacity, and core competencies. The CHIP process integrated the community input received from over 50 stakeholders at a regional housing/homeless forum, input from the Board of St. Jude Neighborhood Health Centers related to their plans and builds on our mental health partnerships. The 2021-2023 CHIP was approved on October 5, 2021 and made publicly available no later than December 28, 2021.

The 2021-2023 Community Health Improvement Plan (CHIP) process was impacted by the SARS-CoV-2 virus and COVID-19, which has impacted all of our communities. While we have focused on crisis response, it has required a significant re-direction of resources and reduced community engagement in the CHIP process.

This CHIP is currently designed to address the needs identified and prioritized through the 2021 CHNA, though COVID-19 will have substantial impacts on our community needs. These impacts are likely to exacerbate some of the needs identified, and cause others to rise in level of priority. While this is a dynamic situation, we recognize the greatest needs of our community will change in the coming months, and it is important that we adapt our efforts to respond accordingly. We are committed to supporting, strengthening, and serving our community in ways that align with our Mission, engage our expertise, and leverage our Community Benefit dollars in the most impactful ways.

Providence St. Joseph Hospital anticipates that implementation strategies may change and therefore, a flexible approach is best suited for the development of its response to the CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by SJO in the enclosed CHIP.

# Addressing the Needs of the Community: 2021- 2023 Key Community Benefit Initiatives and Evaluation Plan

## COMMUNITY NEED ADDRESSED #1: MENTAL HEALTH & SUBSTANCE USE DISORDERS

*Initiative Name*

Mental Health and Substance Use Disorders

*Population Served*

Communities living in central Orange County

*Long-Term Goal(s)/ Vision*

Improved system to access mental health and substance use services to ensure that patients receive at the appropriate level of care and not in the Emergency Department, reduced mental health stigma in the community and increase resources for youth.

**Table 3. Strategies and Strategy Measures for Addressing Mental Health**

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
Participate in the Be Well Clinical Campus Steering Committee and ensure strong referral protocols are in place to reduce inappropriate ED visits for mental health and substance use and to decrease ED length of stay.	Patients with mental health and substance use disorders	% reduction in ED visits for mental health and substance use	3,280 avoidable ED visits related to behavioral health (including mental health and substance use) in 2019	30% reduction from 2019 baseline
Implement MAT Program in Emergency Department.	Patients with Opioid Use Disorders	# of patients receiving MAT services in ED	5	60 per year
Adapt the Each Mind Matters Campaign/ Promise to Talk in	Latinas and their households with low incomes and Vietnamese community	# of residents active on the EMM/PTT social media site	12,898 in FY20	20,000



response to COVID 19				
Implement Work2Be Well Program	Middle and high school students	# of schools engaged in Work2Be Well in Central Orange County	0	1 School District (2-4 schools)
Partner with mental health organizations to advocate for mental health legislation	Persons with mental illness and Substance Use Disorders	# of bills passed	TBD	TBD

*Evidence Based Sources*

Preventing Drug Use among Children and Adolescents (In Brief) Prevention Principles

<https://www.drugabuse.gov/publications/preventing-drug-use-among-children-adolescents/prevention-principles>

<https://theathenaforum.org/CSAPprinciples>

*Resource Commitment*

\$250,000 to \$300,000 per year for Each Mind Matters, Work2Be Well, Chemical Dependency Counselor and other mental health strategies.

*Key Community Partners*

Be Well OC; St. Joseph Emergency Medical Group; St. Jude Medical Center, Mission Hospital; PSJH Work2Be Well; Westbound Communications; Orange County Mental Health; St. Jude Neighborhood Health Centers; Santa Ana Unified School District.

## COMMUNITY NEED ADDRESSED #2: LACK OF ACCESS TO CARE

### Initiative Name

Access to Health Care

### Population Served

Uninsured and underinsured communities in Central Orange County

### Long-Term Goal(s)/ Vision

Increase the number of primary care, dental care, vision, and mental health visits

**Table 4. Strategies and Strategy Measures for Addressing Access to Care**

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
Expand health services at La Amistad Health Center	Central Orange County communities with low incomes	% increase in visits for primary, dental, vision, & mental health	22,204	TBD (subsequent Medi-Cal expansion to individuals over 50 years, undocumented)
Expand Obstetrics Program at La Amistad Health Center	Medi-Cal pregnant women who have low incomes	# of patients receiving prenatal care visits at La Amistad in 2021 and 2022	2021-75 2022- 120	140
Open Main Street Women’s Health Site	Medi-Cal pregnant women who have low incomes	# of patients receiving prenatal care visits at Main Street Women’s Health Site	TBD	TBD
Integrate virtual visits into clinic operations as a way to reduce barriers to care	Low income, uninsured and underinsured persons	% increase in virtual visits at La Amistad	0 before COVID-19	40% of visits
Provide ED Navigator to prevent avoidable visits	ED and hospital Medi-Cal patients at St. Joseph Hospital	# of ED patients referred to appropriate care setting	(~pre-COVID) 705	825

Expand Transitional Care Clinic	Uninsured/underinsured hospital patients who need post-hospital care outpatient visits	# of patients who receive post-hospital care outpatient visits and secure a medical home	495	600
Advocate to expand MediCal to undocumented populations currently not covered	Undocumented immigrants	Passage of expansion of MediCal eligibility for persons who are undocumented	1 expansion policy passed by State legislature effective May 2022	TBD

*Evidence Based Sources*

County Health Rankings and Roadmap: Access to Care- Policies and Programs that Work

*Resource Commitment*

\$1.4 million in capital and operating support to SJNHC and \$1 million per year for all access initiatives in 2022 and 2023

*Key Community Partners*

St. Jude Neighborhood Health Centers

## COMMUNITY NEED ADDRESSED #3: HOMELESSNESS AND AFFORDABLE HOUSING

### *Initiative Name*

Homelessness and Housing

### *Population Served*

Homeless population and low-income residents in Central Orange County

### *Long-Term Goal(s)/ Vision*

Reduce chronic homelessness, increase the number of affordable housing units and strengthen affordable housing policies in the 2021-2028 housing elements.

**Table 5. Strategies and Strategy Measures for Addressing Homelessness and Affordable Housing**

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
Train a minimum of 100 additional housing champions in Central Orange County cities	Residents	# of housing champions trained in Central Orange County	151	251
Engage with housing champions in local city housing element to promote stronger policies in the 2021-2028 housing elements that will result in more affordable housing	Resident engagement with Planning and City Council	# of cities with inclusionary housing ordinances and other strong policies promoting affordable housing in Central OC	0	3
Support the approval of affordable housing projects in the pipeline so that at least 200 new units are built by 2023 in Central Orange County	Advocacy with Planning Commissions and City Councils	# of affordable housing units built by 2023 in Central OC	0	200
Continue homeless navigation program and implement best practices identified in the region	People experiencing chronic homelessness	Decrease in the number of days patients experiencing homelessness are in the hospital beyond what is medically necessary without	70 total days for all patients combined	40 total days

		an appropriate place to discharge		
Influence Cal Optima (Cal Aim Program clients) to add additional in lieu services to support the needs of persons experiencing homelessness that are being discharged from the hospital	Cal Optima members who are experiencing homelessness	# of in lieu services provided by Cal Optima for CalAim clients	0	5

*Evidence Based Sources*

Center for Evidenced Based Solutions on Homelessness: Chronic Homelessness  
[www.evidenceonhomelessness.com](http://www.evidenceonhomelessness.com)

Evidence Based Interventions to Address Homelessness; Utah State Legislature Issue Brief 2018

*Resource Commitment*

\$405,000 is budgeted in 2021 and 2022 to support this effort and our partners, which include one homeless navigator and grants to partner organizations

*Key Community Partners*

The Kennedy Commission; United Way OC; YIMBY, Habitat for Humanity

## Other Community Benefit Programs and Evaluation Plan

**Table 6. Other Community Benefit Programs in Response to Community Needs**

Initiative (Community Need Addressed)	Program Name	Description	Population Served (Low Income, Vulnerable or Broader Community)
Access to health screening	Taller San Jose Hope Builders pre-employment screening program	Provide pre-employment screening and vaccines to teens and young adults	Low-Income
Transportation	Taxi Vouchers	Provide transportation support to ED and inpatient population	Low-Income
Postpartum Services	Post-partum Depression Comprehensive Services	Provide screening and treatment to women referred	Broader Community
	Mother/Baby Assessment Center	Provide physical and psycho-social assessment of mother and baby	Broader Community
Food Insecurity	Meals On Wheels Program	Provide meals to seniors and disabled persons	Broader Community
Access to Prescriptions	Pharmacy Meds Program	Provide needed Rx to patients upon discharge from the hospital	Low-Income
Access to Social Services and Resources	Senior Visitation Program	Provide vulnerable and isolated seniors visits by a CLSW to assess needs, resources and referrals	Low-Income

# 2021- 2023 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Community Health Committee of the hospital on October 5, 2021. The final report was made widely available by December 28, 2021.



10-5-21

Jeremy S. Zoch  
Chief Executive, St. Joseph Hospital

Date



10-20-2021

Ruben A. Smith  
Chair, St. Joseph Hospital Community Health Committee

Date



12-17-2021

Justin Crowe  
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To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Improvement Plans please email [CHI@providence.org](mailto:CHI@providence.org).