2023

COMMUNITY HEALTH NEEDS ASSESSMENT

Mission Hospital,

St. Joseph Hospital,

St. Jude Medical Center

Orange County, California

This CHNA was conducted in partnership with Charitable Ventures, Santa Ana, CA.

To provide feedback on this CHNA or obtain a printed copy free of charge, please email Cecilia Bustamante Pixa at Cecilia.BustanmantePixa@stjoe.org or Christy Cornwall at Christy.Cornwall@stjoe.org

Providence

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EXECUTIVE SUMMARY

Understanding and Responding to Community Needs

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 2023 CHNA was approved by the Mission Hospital Community Health Committee November 14, 2023, the St. Joseph Hospital Community Health Committee on November 16, 2023, and the St. Jude Medical Center Community Health Committee on November 15, 2023. The report will be made publicly available by December 28, 2023.

Gathering Community Health Data and Community Input

Through a mixed-methods approach, using quantitative and qualitative data, we collected information from the following sources: American Community Survey, Behavioral Risk Factor Surveillance System, local public health data, California Department of Public Health, California Office of Statewide Health Planning and Development, California Health Interview Survey, Orange County Health Care Agency's Data Portal, Orange County Equity Map, the National Cancer Institute, and local community health reports, all of which are listed in Appendix 1B: Secondary Data - Community Report References.

To actively engage the community, we conducted eight (8) listening sessions with people who have chronic conditions, are from diverse communities, have low-incomes, and/or are medically underserved, focusing on historically underserved and underrepresented "micro communities." We also received 70 responses to a key informant survey from organizations that serve these populations as well as other underserved populations, to gain deeper understanding of community strengths and opportunities. Some key findings include the following:

- Access to culturally, linguistically, and socially responsive care is a critical need to improve health equity for all micro-communities.
- Behavioral health and substance use support are critical needs for all, and especially populations that speak multiple languages and those who have undocumented status.
- The fulfillment of basic needs, such as equitable access to fresh, nutritious food and affordable housing, are top of mind among social determinants of health.
- Historically underrepresented micro-communities need efforts that increase social connectivity and sense of belonging.
- Residents and non-profit organizations representing these micro-communities are eager to collaborate with hospitals on an ongoing and strategic basis to improve outcomes.

While care was taken to select and gather data that would tell the story of each hospital's service area, it is important to recognize the limitations and gaps in information that naturally occur.

Identifying Top Health Priorities Across Orange County

Through a collaborative process engaging Community Health Committee members, executive leaders from Providence Orange County hospitals, the CHNA Advisory members (Mission Hospital only), and the Community Health Committees at our respective hospitals identified the following priority areas (listed in alphabetical order):

Table 1. CHNA Priority Areas Across Providence Orange County Hospitals

Priority Area/Hospital Name	Mission Hospital	St. Joseph Hospital	St. Jude Medical Center
ACCESS TO CARE Access to health care as well as other resources for addressing barriers creating the greatest challenges	x	x	x
AFFORDABLE HOUSING/HOMELESSNESS Social determinants of health, like housing, affect health. Addressing housing, homelessness and homeless prevention will improve health in the communities we serve.		x	x
BEHAVIORAL HEALTH Creating awareness and providing services addressing mental health along with substance use.	x	x	x
ECONOMIC STABILITY The ability to access resources that are essential to one's life and well-being.	x		

Our hospitals will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners. The 2024-2026 CHIP will be approved and made publicly available by May 15, 2024.

Measuring Our Success: Results from the 2021 CHNA and 2021-2023 CHIP

This report evaluates the impact of the 2021-2023 CHIP. Our hospitals responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices. In addition, we invited written comments on the 2021 CHNA and 2021-2023 CHIP, made widely available to the public through posting on our website and distribution to community partners. No written comments were received on the 2021 CHNA or 2021-2023 CHIP. The 2021 CHNA and 2021-2023 CHIP priorities across our Orange County hospitals were the following: Mental Health and Homelessness and Housing across all three hospitals, Health Care Access at St. Jude Medical Center and St. Joseph Hospital of Orange, and Health Equity & Racial Disparities at Mission Hospital and St. Jude Medical Center.

Key outcomes from the previous CHIP can be found in each hospital's section of this report.

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

Mission Hospital, an acute-care hospital founded in 1971 by a group of physicians, partnered in 1993 with Children's Hospital of Orange County (CHOC) to provide pediatric services. In 1994, the hospital became a member of St. Joseph Health. In 2009, Mission Hospital acquired South Coast Medical Center in Laguna Beach. In 2016 Mission Hospital joined the Providence Health family of 51 hospitals. Mission Hospital has two locations, one in Mission Viejo and the other in Laguna Beach, California. It has 523 licensed beds, of which 504 are currently available. Mission Hospital has a staff of more than 2,500 and professional relationships with more than 700 local physicians. Major programs and services offered to the community include a Level II Trauma Center, cardiac care, critical care, diagnostic imaging, emergency medicine, and obstetrics.

St. Joseph Hospital is an acute-care hospital founded in 1929 and located in Orange, California. The hospital has 465 licensed beds, 379 of which are currently available, and a campus that is approximately 38 acres in size. St. Joseph Hospital has 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 cardiac care, critical care, diagnostic imaging, emergency medicine and obstetrics.

St. Jude Medical Center is an acute-care hospital founded in 1957 and located in Fullerton, California. The hospital has 320 licensed beds, all of which are currently available, and a campus that is approximately 40 acres in size. St. Jude Medical Center has a staff of 2,527 caregivers and professional relationships with 615 local physicians and 83 independent allied health professionals. Major programs and services offered to the community include cardiac care, stroke care and neurology, orthopedics, rehabilitation, oncology, emergency medicine, and obstetrics.

For more information on the resources invested to improve the health and quality of life for the communities we serve, please refer to our Annual Report to our Communities: https://www.providence.org/about/annual-report.

COLLABORATING PARTNERS AND CONTRACTOR

Collaborating Community Partners

The CHNAs for Mission Hospital, St. Joseph Hospital, and St. Jude Medical Center would not have been possible without the engagement and participation of crucial community partners, including leadership from various Community Based Organizations (CBOs), school districts and educational institutions, Federally Qualified Health Centers (FQHC), medical centers, faith-based and community-based organizations, law enforcement, cities, and government agencies. A complete list of those that participated in the key informant survey and AANHPI provider focus group can be found in **Appendix 3.** Additionally, several partners were critical in their outreach and facilitation of resident listening sessions. Those include: The Cambodian Family, the Illumination Institute, Korean Community Services (KCS), the LGBTQ Center Orange County, the Orange County Aging Services Collaborative, HEAL Collective, UNIDOS South Orange County, and Vital Access Care Foundation (VACF).

Contractor

The hospitals partnered with Charitable Ventures, a regional nonprofit incubator and social impact consultancy, in the collection and analysis of data, and development of the report. Charitable Ventures facilitated community input and analyzed the information received, collected and presented data to our local Community Health Committees, facilitated the data presentations to aid in the priority setting process and played a key role in the development of this report.

OVERVIEW OF CHNA FRAMEWORK AND PROCESS

Equity Framework

Our vision, Health for a Better World, is driven by a belief that health is a human right. Every person deserves the chance to live their healthiest life. At Providence, we recognize that long-standing inequities and systemic injustices exist in the world. This has led to health disparities among communities that have been marginalized because of their race, ethnicity, gender, sexual orientation, age, ability, religion, or socioeconomic status. Our health equity statement can be found online: https://www.providence.org/about/health-equity.

The CHNA is an important tool we use to better understand health disparities and inequities within the communities we serve, as well as the community strengths and assets. Through the literature and our community partners, we know that racism and discrimination have detrimental effects on community health and well-being. We recognize that racism and discrimination prevent equitable access to opportunities and the ability of all community members to thrive. We name racism as contributing to the inequitable access to all the determinants of health that help people live their best lives, such as safe housing, nutritious food, responsive health care, and more.

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

Approach

Explicitly name our commitment to equity

Take an asset-based approach, highlighting community strengths

Use people first and non-stigmatizing language

Community Engagement

Actively seek input from the communities we serve using multiple methods

Implement equitable practices for community participation

Report findings back to communities

Quantitative Data

Report data at the census tract level to address masking of needs at county level

Disaggregate data when responsible and appropriate

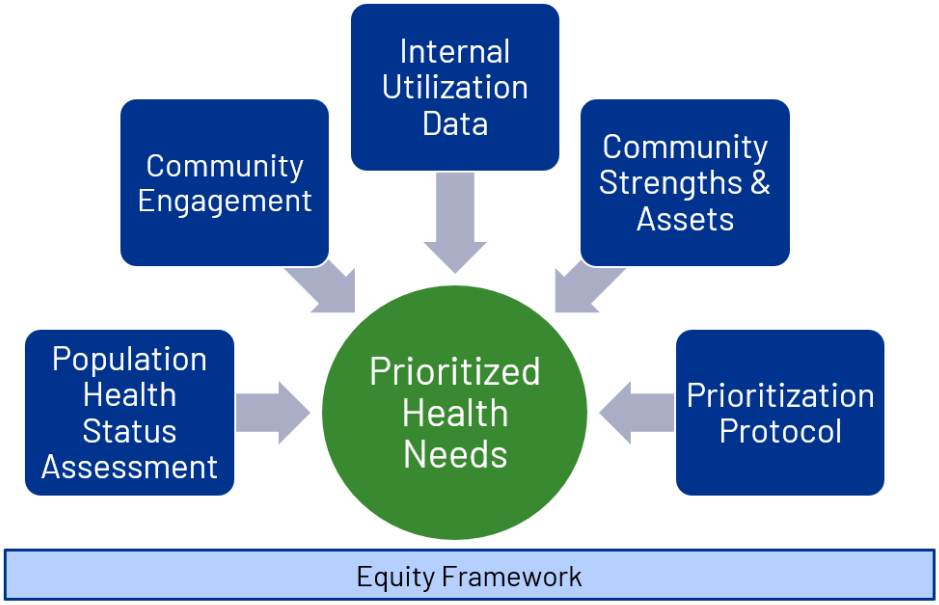
Acknowledge inherent bias in data and screening tools

Specific efforts were made to center equity in these CHNAs, which include elevating the insight of eight aformentioned historically underserved and underrepresented micro-communities: Asian American,

Native Hawaiian and Pacific Islander (AANHPI), Black/African American, Individuals with Disabilities, Older Adults, Korean speaking, Spanish speaking in South Orange County, and Vietnamese speaking. Listening sessions were held in English, as well as Korean, Spanish, and Vietnamese. Additionally, community indicators were analyzed by race/ethnicity where possible in order to identify disparities correlating with race/ethnicity.

CHNA Framework

The equity framework is foundational to our overall CHNA framework, a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) developed by the National Association of County and City Health Officials (NACCHO). The modified MAPP framework takes a mixed-methods approach to prioritize health needs, considering population health data, community input, internal utilization data, community strengths and assets, and a prioritization protocol.



*modified MAPP Framework

Data Sources

In gathering information on the communities served by the Mission Hospital, St. Joseph Hospital, and St. Jude Medical Center, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. In addition, we recognize that there are often geographic areas where the conditions for supporting health are poorer than nearby areas. Whenever possible and reliable, data are reported at census tract level. These smaller geographic

areas allow us to better understand the neighborhood level needs of our communities and better address inequities within and across communities.

We reviewed data from the following sources:

Table 2. Primary and Secondary CHNA Data Sources

Primary Data Sources	Secondary Data Sources
• Community listening sessions • Key informant survey • Internal hospital utilization data • Providence leadership listening sessions • CHNA Advisory Board (Mission Hospital only)	• American Community Survey • Behavioral Risk Factor Surveillance System (BRFSS) • U.S. Census Bureau • 2021 American Community Survey • Orange County Health Care Agency's Health Data Portal • Regional hospital CHNAs and local community health reports by community-based organizations (See: Appendix 1B for all CHNA and community report references)

Data Limitations and Information Gaps

While care was taken to select and gather data that would tell the story of the hospital's service area, it is important to recognize the limitations and gaps in information that naturally occur, including the following:

- Not all desired data were readily available, so sometimes we had to rely on tangential or proxy measures or not have any data at all. For example, there is little community-level data on the incidence of mental health or substance use.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly (such as percentage of people uninsured) and the most recent data available are not a good reflection of the current state.
- Reporting data at the county level can mask inequities within communities. This can also be true when reporting data by race, which can mask what is happening within racial and ethnic subgroups. Therefore, when appropriate and available, we disaggregated the data by geography and race.
- Data that are gathered through listening sessions and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population as a whole.

- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents and how honest people are in providing their answers.

Process for Gathering Comments on Previous CHNA and Summary of Comments Received

Written comments were solicited on the 2021 CHNA and 2021-2023 CHIP reports, which were made widely available to the public via posting on the internet in December 2021 (CHNA) and May 2021 (CHIP), as well as through various channels with our community-based organization partners. No written comments were received on the 2021 CHNA and 2021-2023 CHIP.

OUR COMMUNITY

Hospital Service Area and Community Served

Mission Hospital, St. Joseph Hospital, and St. Jude Medical Center provide Orange County communities with access to advanced care and advanced caring. The hospitals' communities include Orange County and parts of Los Angeles, Riverside and San Bernardino Counties. More details on the hospitals' service area are included in each hospital's section: Mission Hospital, St. Joseph Hospital, and St. Jude Medical Center.

Orange County Indicators

Out of 58 California counties, Orange County currently ranks 6th in health outcomes (length and quality of life) and 7th in health factors (health behaviors, clinical care, social-economic environment and physical environment) according to the County Health Rankings 2023.[1] In aggregate, Orange County ranks well in access to exercise opportunities (99% of population have access to exercise spaces), low uninsurance rates (8%), and greater access to primary care physicians (1,000 individuals:1 PCP), and access to dentists (830 individuals:1 individual) than in California and the US.

Orange County is also California's ninth most diverse county with a 69.2% "diversity index."[2] The three largest race and ethnicity groups in Orange County are white (53.6%), Latino/a (34.0%), and Asian (21.3%). People identifying as "other race" (12.9%), two or more races (9.5%), Black or African American (1.7%), American Indian and Alaska Native (0.6%), and Native Hawaiian and Pacific Islander (0.3%) made up the remainder of the county population.[3]

Residents of Orange County are also diverse in their country of origin and languages spoken at home:

- Almost half (45.1%) of the county's population age 5 and over speak a language other than English at home with nearly 25% speaking Spanish, over 15% speaking Asian or Pacific Islander languages, nearly 5% speaking "other" Indo-European languages, and 1.2% speaking "other" languages.[4]

To better understand the context of health disparities in Orange County, we first seek to understand the social inequities that prevent some Orange County residents from reaching optimal health. The Community Demographics section of each Hospital section provides insight into differences by census tract based on income, education, and language. Below is additional context related to social inequities from the 2020 US Census, the 2021 American Community Survey, and the Orange County Health Care Agency's Health Data Portal, organized by areas of focus.

1 "Orange, California", County Health Rankings and Roadmap, accessed at https://www.countyhealthrankings.org/explore-health-rankings/california/orange.
2 U.S. Census Bureau, 2020
3 American Community Survey, 2021 5-Year Estimate
4 American Community Survey, 2021, 5-Year Estimate

Education

- There is a wide gap in educational attainment based on where people live. For example, in Santa Ana (92701), 57% of people 25 years and older have a high school degree compared to 100% in Newport Beach (92661).[5]
- Similarly, in Newport Beach, 55% of individuals have completed a bachelor's degree or higher (92661), while only 12% in Santa Ana have done the same (92701).[6]
- Disparities exist in the percentages of individuals 25 years and older with a high school degree or higher by race/ethnicity: 92% of Black/African American individuals have received at least a high school diploma, 91% of white individuals, 89% of Asian individuals, 82% of individuals of "two or more races", 73% of American Indian or Alaska Native, 92% of Native Hawaiian and other Pacific Islander, and 68% of Hispanic/Latino individuals.[7]

Income and Poverty

- Like educational attainment, median household incomes also vary widely by geography in Orange County. For example, $57,796 in Santa Ana (92701) and $169,911 in Newport Beach (92661).[8]
- Ten percent of the county's population live 100% below the Federal Poverty Line (FPL). Poverty levels by race/ethnicity are as follows: 15% of individuals identifying as "other" race are most likely to live below 100% of the FPL, which is notably above the county average. 13% of Black/African American individuals and Hispanic/Latino individuals live below the 100% of the FPL. 11% of Asian individuals and American Indian/Alaska Native individuals live below the 100% of the FPL. 10% of Native Hawaiian and Other Pacific Islander individuals are living below the poverty level, and finally 8% of those identifying as two or more races and 7% of white/non-Hispanic individuals.[9]
- Areas with higher concentrations of poverty among individuals 65 years of age and older are in Tustin (17%), Westminster (16%), Garden Grove (16%), Santa Ana (14%), and Stanton (14%). Areas with lower percentages of older adults living in poverty are in Laguna Beach (1%), Rancho Santa Margarita (4%), and Dana Point (4%).[10]

Access to Care

- Residents of Orange County without a high school diploma are more likely to lack insurance than those with a high school degree or higher, with 21% of residents without a high school diploma lacking insurance.[11]

[5] American Community Survey, 2021 5-Year Estimate (use of Zip Code Tabulation Areas)
[6] American Community Survey, 2021 5-Year Estimate (use of Zip Code Tabulation Areas)
[7] American Community Survey 2021, 5-Year Estimate
[8] American Community Survey, 2021 5-Year Estimate (use of Zip Code Tabulation Areas)
[9] American Community Survey, 2021 5-Year Estimate
[10] American Community Survey, 2021 5-Year Estimate (use of "cities")
[11] American Community Survey, 2021 5-Year Estimate

- Those identifying as "some other race" are most likely to lack insurance (17%), followed by American Indian/Alaska Native (14%), Hispanic/Latino (13%), those of two or more races (8%), Black/African American, Native Hawaiian or Other Pacific Islander, and White (6%, respectively), and Asian (5%).[12]

Despite high rankings in health outcomes and health factors, there are significant health disparities by race and ethnicity due to systemic inequities and racism in Orange County. The effects of racism, stress, and intergenerational trauma have very real physical effects. We also acknowledge that there is overlap between the areas in the community that are part of our high need service area and areas where there are greater health disparities.

Life Expectancy

- Life expectancy for individuals in Orange County in 2020, by race, is as follows: Asian (87.2 years), Hispanic (83.2 years), American Indian and Alaska Native (82.5 years), white (81.6 years), and Black/African American (80.4 years).[13]
- Life expectancy at birth is the lowest in North and Central Orange County, ranging from a high of 85.0 years in Irvine to 77.6 years in Stanton.[14]
- Mortality rates are highest for white individuals followed by Native Hawaiian or Other Pacific Islander (NHOPI) and Black/African American individuals. When it comes to COVID-19 related deaths, the mortality rates are highest for NHOPI, followed by Hispanic/Latino, followed by Asian, Black/African American, and white individuals.[15]

Obesity

- In Orange County, 49% of Hispanic/Latino, 45% of Native Hawaiian/Pacific Islander, and 23% of white 5th graders are obese.[16]
- In adulthood, Hispanic/Latino (62%) and white (57%) adults are more obese than the average among the total adult population (52%).[17]

[12] American Community Survey, 2021 5-Year Estimate
[13] Orange County Health Data, Life Expectancy at Birth in Orange County in Year 2020, accessed at https://ochealthdata.com/dashboard/health-mortality.
[14] Orange County Health Care Agency, 2015 accessed at https://www.ochealthinfo.com/sites/hca/files/import/data/files/47656.pdf
[15] Orange County Health Data, OC Mortality Rates, 2020, accessed at https://ochealthdata.com/dashboard/health-mortality.
[16] California Dept. of Education, Physical Fitness Testing Research Files (Jan. 2020). Accessed from Students Who Are Overweight or Obese, by Race/Ethnicity and Grade Level", 2019, Kids Data, accessed at https://tinyurl.com/5n6kccza.
[17] California Health Interview Survey, 2019. Accessed at Orange County Health Data, "Overweight or Obese Adults, by Race/Ethnicity," https://ochealthdata.com/health-priorities/health-promotion-disease-prevention .

Diabetes

- Diabetes is the 8th leading cause of death in Orange County overall, but 5th for Black/African American individuals, 6th for Latino and Asian individuals and 8th for white individuals.[18]

Cancer

- Cancer is the second leading cause of death in the county (crude rate of 147.8 per 100,000).[19]
- Black/African American people have a higher age-adjusted incidence rate of prostate care (173.1 per 100,000) compared to the overall cases (110.5).[20]
- American Indian/Alaskan Native (181.0) and white females (150.5) have the highest rates of breast cancer in the county and are also the only races to have rates over both the California (121.0) and US rates (127.0) including all races.[21]
- The cervical cancer rate for all women in Orange County is 6.6 per 100,000, lower than the statewide average of 7.3.[22]

Heart Disease

- Heart disease was the leading cause of death in Orange County in 2021 (crude rate of 159.4 per 100,000) and males (171.5) had a higher rate of death due to heart disease than women (147.4).[23]
- White individuals (258.8) have the highest rate of death by heart disease in the county followed by Pacific Islander (227.1) and Black/African Americans (201.8). Hispanic people have the lowest rate (124.2). [24]

Health Professional Shortage Area

Mission Hospital, St. Joseph Hospital, and St. Jude Medical Center are not located within Health Professional Shortage Areas (HPSA), although parts of the service area are designated as shortage areas.

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[18] California Department of Public Health Death Statistical Masters files from Orange County (OC), 2021. Leading Causes of Death 2017-2021, Orange County, California, accessed at https://ochealthinfo.com/sites/healthcare/files/2022-09/Leading_Cause_of_Death_OC_2017-2021.pdf

[19] California Department of Public Health Death Statistical Masters files from Orange County (OC), 2021. Leading Causes of Death 2017-2021, Orange County, California, accessed at https://ochealthinfo.com/sites/healthcare/files/2022-09/Leading_Cause_of_Death_OC_2017-2021.pdf

[20] SEER Incidence Data for 2020, November 2022 Submission (1975-2020), SEER 22 registries.

[21] Incidence Rate Report for California by County, Breast (All Stages), 2016-2020, All Races (includes Hispanic), Female, All Ages. Age-adjusted incidence rate cases per 100,000. Created by statecancerprofiles.cancer.gov.

[22] Incidence Rate Report for California by County, Cervix (All Stages), 2016-2020, All Races (includes Hispanic), Female, All Ages. Age-adjusted incidence rate cases per 100,000. Created by statecancerprofiles.cancer.gov.

[23] California Department of Public Health Death Statistical Masters files from Orange County (OC), 2021. Leading Causes of Death 2017-2021, Orange County, California, accessed at https://ochealthinfo.com/sites/healthcare/files/2022-09/Leading_Cause_of_Death_OC_2017-2021.pdf

[24] California Department of Public Health Death Statistical Masters files from Orange County (OC), 2021. Leading Causes of Death 2017-2021, Orange County, California, accessed at https://ochealthinfo.com/sites/healthcare/files/2022-09/Leading_Cause_of_Death_OC_2017-2021.pdf

Census tracts near Stanton, Garden Grove, and Santa Ana are considered Primary Care HPSAs. Parts of Anaheim and Santa Ana are considered Mental Health HPSAs.

Medically Underserved Area/ Medically Underserved Population

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are defined by the Federal Government to include areas or populations that demonstrate a shortage of health care services. This designation process was originally established to assist the government in allocating the Community Health Center Fund to the areas of greatest need. MUAs are identified by calculating a composite index of need indicators compiled and with national averages to determine an area's level of medical "under service." MUPs are identified based on documentation of unusual local conditions that result in access barriers to medical services. MUAs and MUPs are permanently set, and no renewal process is necessary.

Central Santa Ana is the only MUA in Orange County. People with low incomes are a designated MUP in parts of Laguna Beach, Dana Point, Brea, West La Habra, Fullerton, and Garden Grove, among others.

Projected Impact of Climate Change in Orange County

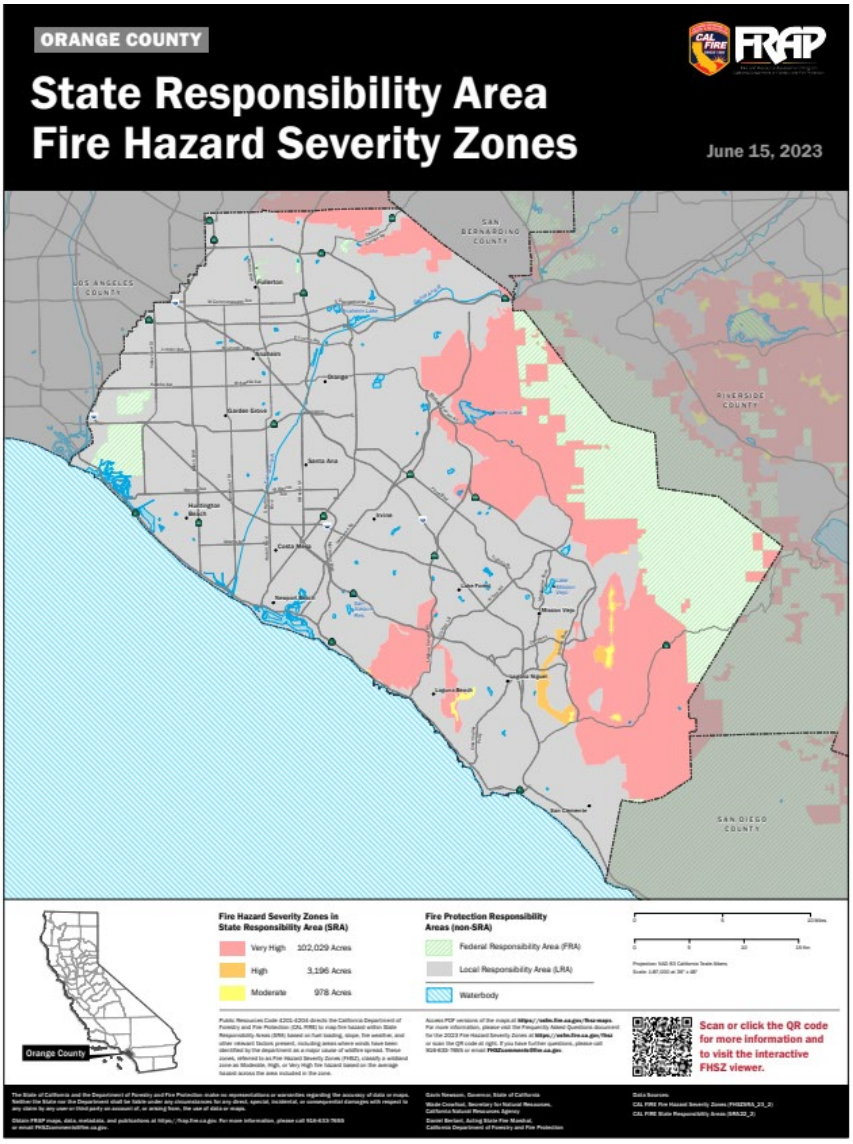
We recognize that climate change creates additional risks and challenges for the communities that we serve.

WILDFIRES

With changes to weather patterns, the threat of wildfires also increases. In Orange County, in 2023, there are 102,029 acres categorized as "Very High" fire hazard severity.[25]

[25] "Fire Hazard Severity Zones in State Responsibility Area – Orange County" accessed at https://osfm.fire.ca.gov/media/yifnpdzi/fhsz_county_sra_e_2022_orange_2.pdf.

Figure 1. Fire Hazard Severity Orange County, 2023



CLIMATE CHANGE AND HEALTH

As outlined by the Centers for Disease Control and Prevention, climate change negatively affects health in a variety of ways including increased heat-related illness and death, asthma, cardiovascular disease and failure, malnutrition, and mental health challenges (see Figure C).[26] For more detail on the health impacts of heat and drought, as well as information related to how climate change affects vector-borne illnesses and food insecurity, see the full Climate Change and Health Profile Report, Orange County.

COVID: IMPACT ON VULNERABLE COMMUNITIES

In Orange County, COVID-19 impacted all populations, but low-income communities and communities of color were affected disproportionately and recovery from this impact persists. When considering 2020 mortality rates disaggregated by race/ethnicity, COVID-19 was most severe in the Native Hawaiian and Other Pacific Islander (NHOPI) community, followed by Hispanic/Latino.[27] In 2021, COVID-19 was still the third leading cause of death in Orange County overall, and the number one cause of death among Hispanic/Latino and NHOPI residents.

In 2023, even as the COVID-19 Public Health Emergency has been declared "over," long-term mental and physical health trends remain a concern.[28] The CDC estimates that nearly 20% of those who lived through a COVID virus infection are still experiencing long-term symptoms,[29] mental health and substance use issues created and exacerbated over the pandemic continue,[30] learning loss, especially for individuals with special needs due to extended school closures,[31] economic challenges, and more.

Summary of Findings – Regional Community Health Reports

The CHNA framework included reviews of other regional hospital CHNAs as well as local community health reports by community-based organizations. Reports most aligned with the CHNA framework are listed below. A summary of each of these reports can be found in Appendix 1B: Summaries of Selected Regional Community Health Reports.

[26] Climate Effects on Health", CDC, accessed at https://www.cdc.gov/climateandhealth/effects/default.htm.
[27] OC Mortality Rates 2020 and Leading Causes of Death Orange County 2021, Orange County Health Care Agency, accessed at https://ochealthdata.com/dashboard/health-mortality.
[28] Custodio, Spencer, "Figuring Out the Impacts of Long Covid on Orange County Residents", *Voice of* OC, accessed at https://voiceofoc.org/2022/08/figuring-out-the-impacts-of-long-covid-on-orange-county-residents/
[29] Custodio, Spencer, "Figuring Out the Impacts of Long Covid on Orange County Residents", *Voice of* OC, accessed at https://voiceofoc.org/2022/08/figuring-out-the-impacts-of-long-covid-on-orange-county-residents/
[30] Chacon NC, Walia N, Allen A, Sciancalepore A, Tiong J, Quick R, Mada S, Diaz MA, Rodriguez I. Substance use during COVID-19 pandemic: impact on the underserved communities. Discoveries (Craiova). 2021 Dec 31;9(4): e141. doi: 10.15190/d.2021.20.
[31] Dvorsky MR, Shroff D, Larkin Bonds WB, Steinberg A, Breaux R, Becker SP. Impacts of COVID-19 on the school experience of children and adolescents with special educational needs and disabilities. Curr Opin Psychol. 2023 Aug; 52:101635. doi: 10.1016/j.copsyc.2023.101635. Epub 2023 Jun 17. PMID: 37451025; PMCID: PMC10275652.

COMMUNITY INPUT

Description of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members and other key stakeholders, representatives from Providence Orange County in partnership with Charitable Ventures carried out three approaches for gaining community input: 1) community listening sessions, 2) a key informant survey and 3) dialogue sessions with leaders from each of the three Providence Orange County Hospitals.

Eight listening sessions were held with specific communities who have unique needs: Asian American/Native Hawaiian/Pacific Islander (AANHPI), Black/African American, Individuals with Disabilities, Older Adults, Korean speaking, Spanish speaking in South Orange County, and Vietnamese speaking. These sessions were held online as well as in person, in settings that were most accessible for participants. They were conducted in partnership with trusted messenger organizations with unique connections as well as language skills to reach community members. During these sessions, the needs, issues, barriers, visions for health, community strengths, and ideas for innovation, collaboration, and the pursuit of equity were discussed. Seven sessions were directed toward residents, with one particular to a community specific to the Mission Hospital service area (South Orange County – Spanish Speaking), and one was toward providers to AANHPI community.

The key informant survey was distributed widely to faith- and community-based organizations, school districts and educational institutions, Federally Qualified Health Centers (FQHC), medical centers, law enforcement, city representatives, government agencies, and other providers and leaders knowledgeable about community health. Finally, feedback from Providence Leadership was also obtained.

Our public health agency, the Orange County Health Care Agency, was engaged through key informant surveys and was represented in Mission Hospital's Community Health Committee where priority areas were identified. Our Community Health Investment leaders maintained close communications with key Orange County Health Care Agency staff who were conducting a coinciding needs assessment for Orange County. The OC Health Care Agency Office of Population Health and Equity Priorities for 2023-2028 and the 2020-2022 Orange County Health Improvement Plan were reviewed and used as a reference to ensure alignment with county public health findings and priorities.

Below is a high-level summary of the findings of these sessions and survey. **See Appendix 2 for methodology and participant detail.**

Community Listening Session Findings

The eight (8) listening sessions were completed between July 24 and August 9, 2023. Discussion centered around community needs, community strengths, and visions for a healthy community. Across the eight listening sessions, some common themes emerged.

Participants discussed their most relevant health needs, the barriers to meeting those needs, their visions for healthy communities, and community strengths. Overwhelmingly, aspects of **access to health care** were identified across all groups. This included affordability; lack of coverage for the immigrant population; training and support to navigate the health care system (including the transition between pediatric and adult care for those living with disabilities, particularly); timely access to care – including long waits in the emergency room or to see specialists; a need for chronic disease management; and advanced dental care needs. Cultural and linguistic competency and responsiveness, as well as transportation, were also discussed as barriers. Some participants expressed that hospitals do not always have relationships with the community, but rather it is the community-based organizations that have relationships. Thus, there is an opportunity to enhance partnerships with community-based organizations to engage the community where they are at.

Mental health care was mentioned across six of the listening sessions. Specifically, participants discussed general mental health care/access with attention to older adults living in nursing homes; guidance for parents with kids who are coming out as LGBTQIA+; and support for community members who experienced trauma, violence, and displacement. In addition, there continues to be resistance to mental health services by those in need due to stigma, which is often culturally specific. Regarding youth activities, there is an interest in engaging youth in activities, access to mental health services and providing activities in community spaces to reduce drug and alcohol access and use.

Cultural competency was noted in five listening sessions, including the need to understand the diverse communities in Orange County by race/ethnicity, language, gender, ability, and religious/spiritual beliefs and the intersectionality of these various aspects.

Participants also spoke about the need to address **isolation** – particularly among older adults and older adults whose primary language is not English. There was a sense that these individuals are isolated in terms of mobility and in their ability to engage and socially interact with others.

Housing was brought up in three listening sessions. Specifically, the identification of a need for affordable and adequately sized housing to accommodate larger families, not just small nuclear families.

Transportation was noted in general, with some mentioning the long distance to health care facilities; transportation needs for older adults and especially those with limited English (noting not just a need for transportation for these individuals but also in-language supports with the driver and scheduling); and for those individuals who use a wheelchair.

Lastly, **employment** was identified in two listening sessions. The need to access employment agencies and to provide work and/or training opportunities to adults who worked manual labor for their careers and are no longer able to keep this up physically was shared by respondents.

A table of the needs by micro community is below.

Table 3. Unmet Health Needs by Micro-Community

	AANHPI	Black/ African American	Individuals with Disabilities	LGBTQIA	Older Adults	Korean	Spanish-speaking OC	Vietnamese	Totals
Healthcare access	X	X	X	X	X	X	X	X	**8**
Mental Health	X		X	X		X	X	X	**6**
Cultural Competency	X	X	X	X			X		**5**
Isolation				X	X	X	X		**4**
Housing	X	X			X				**3**
Transportation					X	X		X	**3**
Employment		X					X		**2**

In discussing community strengths, participants overwhelmingly shared the resources available through **community-based programs and organizations.** These resources included churches, schools, non-profit organizations, and other organizational partners. Participants also noted that community presence and voice were strengths. An example was the growing size of the Asian American and Native Hawaiian/Pacific Islander (AANHPI) population and how this was a strength due to increased political voice and more leadership roles. Another example was how residents and community organizations came together to improve the community and to create change – in particular, aligning with other groups to show support and to help each other. Civic engagement, specifically voting, was noted as ways to change systems and to promote access.

Cultural competency and **patient/health care navigation** were also noted as community strengths. Some communities mentioned that mental health access is improving through in-language therapists and peer groups, and health care providers who speak their clients' language (specifically Vietnamese), and phone interpretation were helpful to accessing care. Lastly, two listening sessions noted that **navigator programs** have helped to increase access to services and to address language barriers. A summary of these strengths is in table below.

Table 4. Strengths by Micro-Community

	AANHPI	Black/African American	Individuals with Disabilities	LGBTQIA	Older Adults	Korean	Spanish-speaking	Vietnamese	Totals
Community-based organization/ program	X	X	X	X	X	X	X	X	**8**
Community presence/ voice	X			X			X		**3**
Cultural Competency				X				X	**2**
Patient Navigation	X							X	**2**

Lastly, regarding the **vision** for a healthy community, participants unanimously shared the need for access to health care that is affordable, quality, and timely. Participants identified the following themes for a healthier community: access to medical care with health coverage; diversity, equity and inclusion practices in hospitals that cascade out to the community; better access – to mental health, registered nurses in local clinics; shorter wait times to see providers; access to specialists; and more services that are local – not only in Central Orange County.

Participants from the micro-communities shared that communities that care for each other, take care of each other, and come together, contribute to a healthy community. For them, a caring community includes one that has safe and affordable housing; access to affordable and nutritious food; and community safety. Participants spoke of safe and affordable housing for all, including seniors. They mentioned accessible fresh, nutritious, and culturally-appropriate foods that were available locally at farmers markets and grocery stores – spaces within walking distance.

Table 5. Visions for a Healthy Community by Micro-community

	AANHPI	Black/African American	Individuals with Disabilities	LGBTQIA	Older Adults	Korean	Spanish-speaking	Vietnamese	Totals
Access to health care	X	X	X	X	X	X	X	X	**8**
Cultural Competency			X	X	X	X	X		**5**
Community that cares for each other	X	X		X	X				**4**
Safety		X			X	X	X		**4**
Access to Affordable Food		X		X	X				**3**
Access to Safe and Affordable Housing		X		X	X	X			**4**
Transpor-tation		X		X		X			**3**
Patient Navigation	X		X						**2**

Priorities

Based on input from participants across the eight listening sessions, the following priorities were identified for consideration. They are generally categorized in descending order of relevance, with those recognized as needs by more micro-communities as first priorities and those recognized as needs by fewer micro-communities as later priorities.

1. Promote timely access to specialist care.
2. Provide healthcare options for immigrant, uninsured populations (access to primary care, specialists, mental health, and oral health).
3. Bolster mental health services including therapists who speak the language and understand the culture, cultural health practices, and immigration history/experiences of the community.

4. Improve cultural competency so that there are providers who understand the needs of the specific community and speak the language(s) of the local community (e.g., understand the historical relationship of the community with the health system, have immigration history/experiences, deliver culturally appropriate treatment, etc.).
5. Addressing isolation for populations including people identifying as LGBTQIA+, older adults, South OC Spanish speakers, and Korean older adults.
6. Promote access to safe and affordable housing, including addressing the needs of older adults and large families, such as those with eight to ten family members in a household.
7. Promote affordable and accessible transportation, including language support for scheduling and communicating with the drivers.
8. Chronic disease management, particularly in the local community.
9. Establish relationships with community as well as CBOs.
10. Promote safe and clean neighborhoods.
11. Promote access to affordable, fresh, nutritious food.
12. Specific to South OC Spanish Speaking: Address long distance from language-specific healthcare facilities (e.g., resources are primarily in Central Orange County), by providing more South County resources.

Key Informant Survey Findings

Key informants were invited to participate in a survey about health assets and needs in their communities. Key informants included faith and community-based organizations, school districts and educational institutions, Federally Qualified Health Centers (FQHC), medical centers, law enforcement, city representatives, government agencies, including the Orange County Health Care Agency (our public health agency), and other providers and leaders knowledgeable about community health. The survey aimed to gather feedback to navigate and further understand the key issues explored through resident listening sessions.

Based on principles of community health and previous CHNAs, Providence identified potential unmet health needs, which were organized into five broad categories: Basic needs, Access to care, Environment and Community, Public Safety, and Education. Each category of need included sub-categories. Key informants were asked to comment on the top needs, strengths, and ways that Providence could leverage community strengths. They responded to a series of Likert-scale and open-ended questions. The Likert-scale used was 1-4 (1: Not at all a need, 2: Somewhat of a need, 3: An important need, 4: A top need). Individuals also shared the key populations they serve, and the locations of their service corresponding to all three Providence Orange County service areas.

A table indicating all service area unmet health needs is below.

Table 6. Detailed Unmet Health Needs from Key Informant Survey

Unmet Health Needs	Score (out of 4)
Basic Needs Overall Score	3.4
Affordable housing	3.7
Economic insecurity (lack of living wage jobs and unemployment)	3.5
Food insecurity	3.4
Homelessness	3.3
Access to safe, reliable, affordable transportation	3.0
Access to Care Overall Score	3.1
Behavioral health challenges and access to care (includes both mental health and substance use disorders)	3.7
Culturally and linguistically concordant services	3.3
Access to health services	3.2
Access to dental care	3.1
Aging concerns and issues (e.g., cognitive decline / dementia, mobility, etc.)	3.0
Disability inclusion	2.9
Chronic disease	2.9
Obesity	2.8
Environment and Community Overall Score	2.7
Lack of community involvement and engagement	3.0
Environment concerns (e.g., extreme heat, smoke / air quality, clean water access)	2.8
Few community-building events (e.g., arts and cultural events)	2.5
Public Safety Overall Score	2.7
Racism and discrimination	3.2
Domestic violence, child abuse / neglect	3.0
Gun violence	2.7
Community violence; lack of feeling of safety	2.7
Safe streets for all users (e.g., crosswalks, bike lanes, lighting, speed limits)	2.6
Safe and accessible parks / recreation	2.6
HIV/AIDS	2.0
Education Overall Score	1.8
Job skills training	2.1
Bullying in schools	2.0
Opportunity gap in education (e.g., funding, staffing, support systems, etc. in schools)	1.8
Affordable childcare and preschools	1.4

ADDITIONAL DETAIL RELATED TO UNMET HEALTH NEEDS

Key informants were given multiple opportunities to share about the needs that they have identified as critical in their communities. The following are summaries of those specific additional needs.

Mental Health Services for and related to:

- People with a substance use disorder, particularly fentanyl
- Detox and treatment beds
- LGBTQIA+ affirming and linguistically competent health and mental care for all ages
- Immigrants with undocumented status
- Young people experiencing Adverse Childhood Experiences (ACEs)
- Individuals experiencing loneliness, isolation, and disconnectedness
- Support for families with children who are diagnosed with Autism and ADHD
- Trauma care for older adults

Housing:

- Safe and encouraging homes for people with disabilities
- Lack of affordable workforce housing for families with low incomes
- Providing a living wage to frontline workers
- Living conditions in rental housing and overcrowding in these homes
- Lack of city code enforcement on the quality of homes
- Available housing for families with low incomes

Healthcare:

- Access to an entire system of health and behavioral health at all levels of care
- Lack of affordable health clinics
- Sexual and reproductive health care for young people
- Need for more pediatric disability service providers
- Specialty care for individuals without insurance (neurology, dental, high-risk OB patients, etc.)
- Culturally responsive health education
- Recruiting ethnically diverse healthcare workers
- Access to specialty care (i.e., neurology, ear-nose-throat, oncology) and access to dental specialists

Community:

- Lack of social connection
- Lack of community involvement and engagement
- Need for broad community education on cultural norms and increase cultural sensitivity to diverse populations
- South County has extremes in the populations of those served, from those with very low incomes to very high incomes, which can create conflict and an unhealthy environment

- Lack of bicultural or bilingual Vietnamese speaking law enforcement officers and teachers/administrators
- Continuing drift between communities – lack of belonging for individuals.

EXISTING COMMUNITY STRENGTHS

Survey respondents identified community strengths in each service area:

Table 7. Community Strengths by Service Area from Key Informant Survey

Service Area	Strengths Identified
Mission Hospital	• Resident resilience and resourcefulness • People in disinvested neighborhoods are hard working • Community resilience • Faith leaders who work to support people who have been marginalized • Social and family networks • Strong collaboration among health providers and community organizations, as well as generous philanthropic and volunteer support • Access to health care clinics and family resource centers • Access to outdoor space and recreational facilities
St. Joseph Hospital	• Resident resilience and resourcefulness • People in disinvested neighborhoods are hard working • Utilizing the Protective Factors Framework • Strong collaborations across CBOs and a willingness to work together toward common goals • Resiliency, resourcefulness, and community will • Social and family networks that already exist in the community • Food security • Utilization of Family Resource Centers
St. Jude Medical Center	• Resident resilience, resourcefulness, and will • Community collaboration and networks to create collective impact • Dedicated nonprofits that help to strengthen the community • Focus on community mental health by social networks (i.e., evidence-based practice to build social networks that improve health, providing social networks to people with traumatic brain injuries, existing family networks, building social and community events)

Service Area	Strengths Identified
	• Substance use treatment and mental health crisis stabilization • The strength to come together during challenging times (governmental and non-governmental organizations rallying together to build up the community)

Survey respondents had ample desire for hospitals to collaborate with non-profit partners and residents to address unmet health needs. Ideas included efforts to meet the residents where they are by bringing education and resources to locations that they frequent, strengthen resident groups, and create hospital advisory committees.

They also had ideas for addressing health equity. These included linguistically and culturally responsive outreach and health services, addressing basic needs and social determinants of health *first* as a foundation to health (e.g. healthy food options, housing), provide incentives for non-profits to work together, increase collaboration across clinics, and offer transportation to people with disabilities and older adults.

MISSION HOSPITAL

Providence Need Index

To facilitate identifying health disparities and social inequities by place, we designated a "high need" service area and a "broader" service area, which makes up each of the Mission Hospital, St. Joseph Hospital of Orange, and St. Jude Medical Center Service Areas. Based on work done by the Public Health Alliance of Southern California and their Healthy Places Index (HPI) tool, we identified the high need service area based on income, education, English proficiency, and life expectancy.[32]

For this analysis, census tracks with more people below 200% Federal Poverty Level (FPL), more people without a high school diploma, more limited English households, and a lower life expectancy at birth were identified as "high need". The mean value of nearest neighbors was used to insert missing data for variables by way of the Neighborhood Summary Statistics geoprocessing tool in ArcGIS Pro 3.1. All variables were weighted equally. The census tracts were assigned a score between 0 and 100 where 0 represents the census tract with the lowest need and 100 represents the highest need, according to the criteria. Census tracts that scored higher than the average were classified as a high need service area and are depicted in green.

In the Mission Hospital service area, 49 of 114 census tracts (43%) scored above the average of 33.5, indicating a high need.

Community Demographics

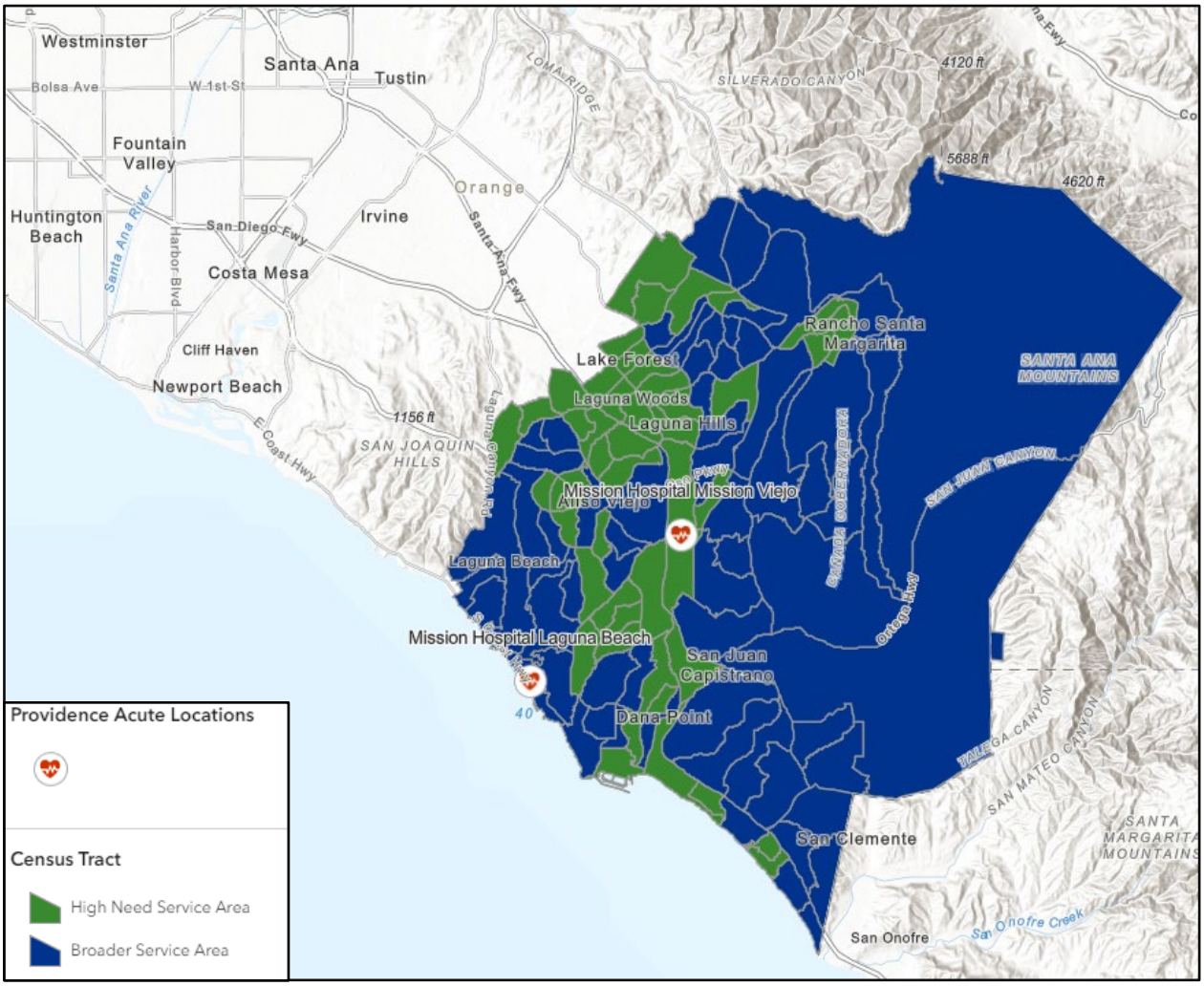
The CHNA service area was determined by first reviewing ZIP Codes corresponding to inpatient discharges and then filling in any gaps in service area that occurred to ensure coverage of the entirety of Orange County. Mission Hospital's service area is defined as South Orange County, inclusive of 114 census tracts, based upon geographic access, other nearby hospitals, and ZIP Codes corresponding to inpatient discharges. Together, Mission Hospital, St. Joseph Hospital, and St. Jude Medical Center serve all of Orange County, as well as certain census tracts in Los Angeles, San Bernardino, and Riverside Counties. For more granular data, census tracts that overlap the ZIP Codes in Table 8 were referenced. We have developed a dashboard that maps each CHNA indicator at the census tract level. The dashboard can be found here: Mission CHNA Data Hub 2023.

[32] The following variables were used for the PNI analysis: Population below 200% the Federal Poverty Level (American Community Survey, 2021); Percent of population with at least a high school education (American Community Survey, 2021); Percent of population, ages 5 Years and older in Limited English Households (American Community Survey, 2021); Life expectancy at birth (estimates based on CDC, 2010 – 2015 data)

Table 8. Cities and ZIP Codes Included in Hospital Service Area - Mission Hospital

Cities/ Communities	ZIP Code(s)
Capistrano Beach	92624
Dana Point	92629
Ladera Ranch	92694
Laguna Beach	92651
Laguna Niguel	92677
Lake Forest	92630
Mission Viejo	92691, 92692
Rancho Santa Margarita	92688
San Clemente	92672, 92673
San Juan Capistrano	92675
Aliso Viejo	92656
Foothill Ranch	92610
Laguna Hills	92653
Laguna Woods	92637
Trabuco Canyon	92679

Figure 2. Mission Hospital's Total Service Area



Of the over 581,000 permanent residents in the total service area, roughly 43% 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 in the total service area. For reference, in 2021, 200% FPL is equivalent to an annual household income of $53,000 or less for a family of 4. These households are more likely to regularly make spending tradeoffs regarding utilities, rent, groceries, medicine, and other basic expenses. The population in Mission Hospital's total service area makes up 18% of Orange County.

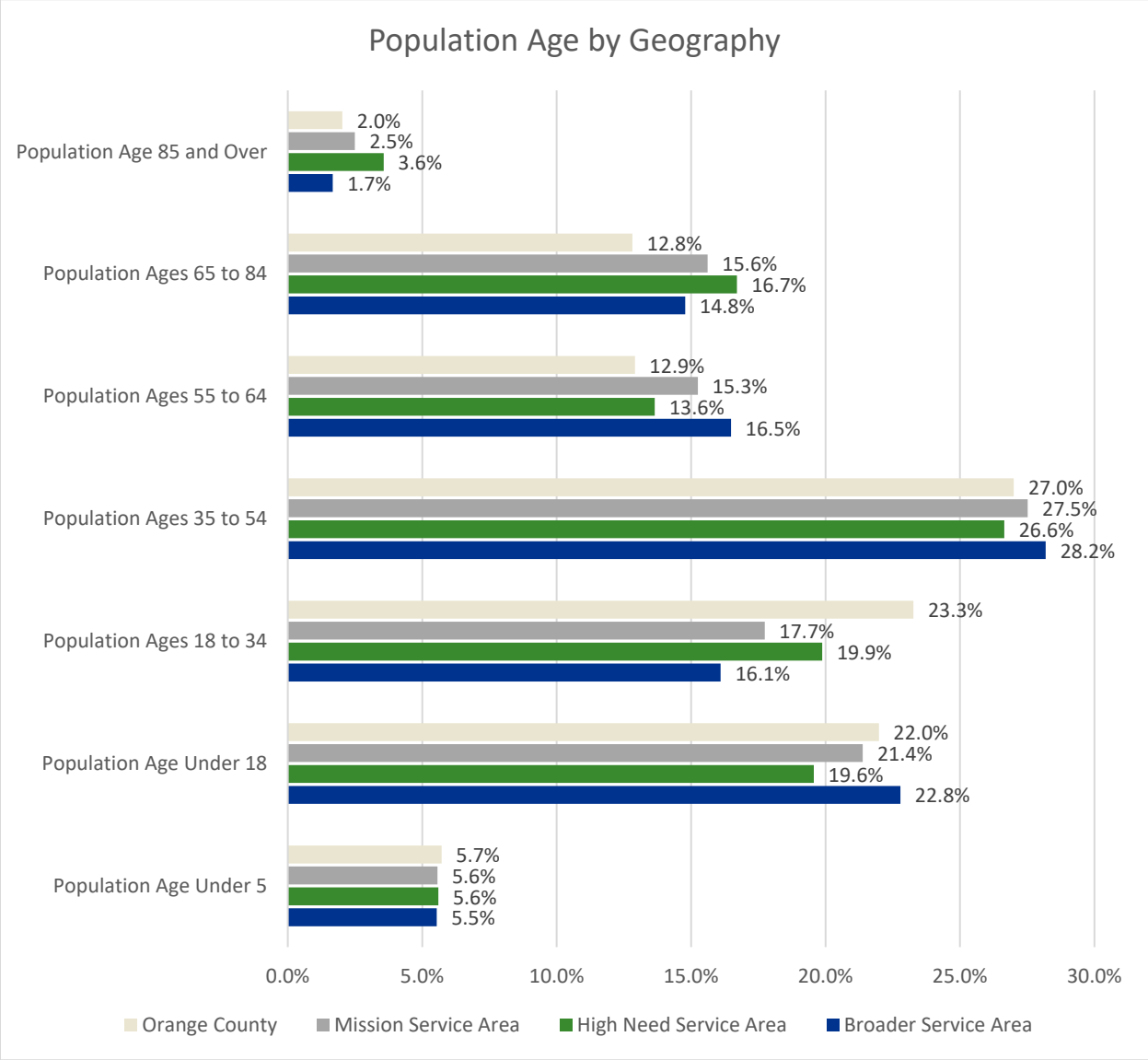
The male-to-female distribution is roughly equal across geographies. Individuals ages 18-34 and 65 and older are more likely to live in high need census tracts.

Table 9. Population Demographics for Mission Hospital Service Area and Orange County

Indicator	Mission Hospital Service Area	Broader Service Area	High Need Service Area	Orange County
Total Population	581,065	328,552	252,513	3,182,923
Female Population	51.1%	50.5%	52.0%	50.4%
Male Population	48.9%	49.5%	48.0%	49.6%

Source: American Community Survey, 2021 5-Year Estimate

Figure 3. Age Groups by Geography for Mission Hospital Service Area

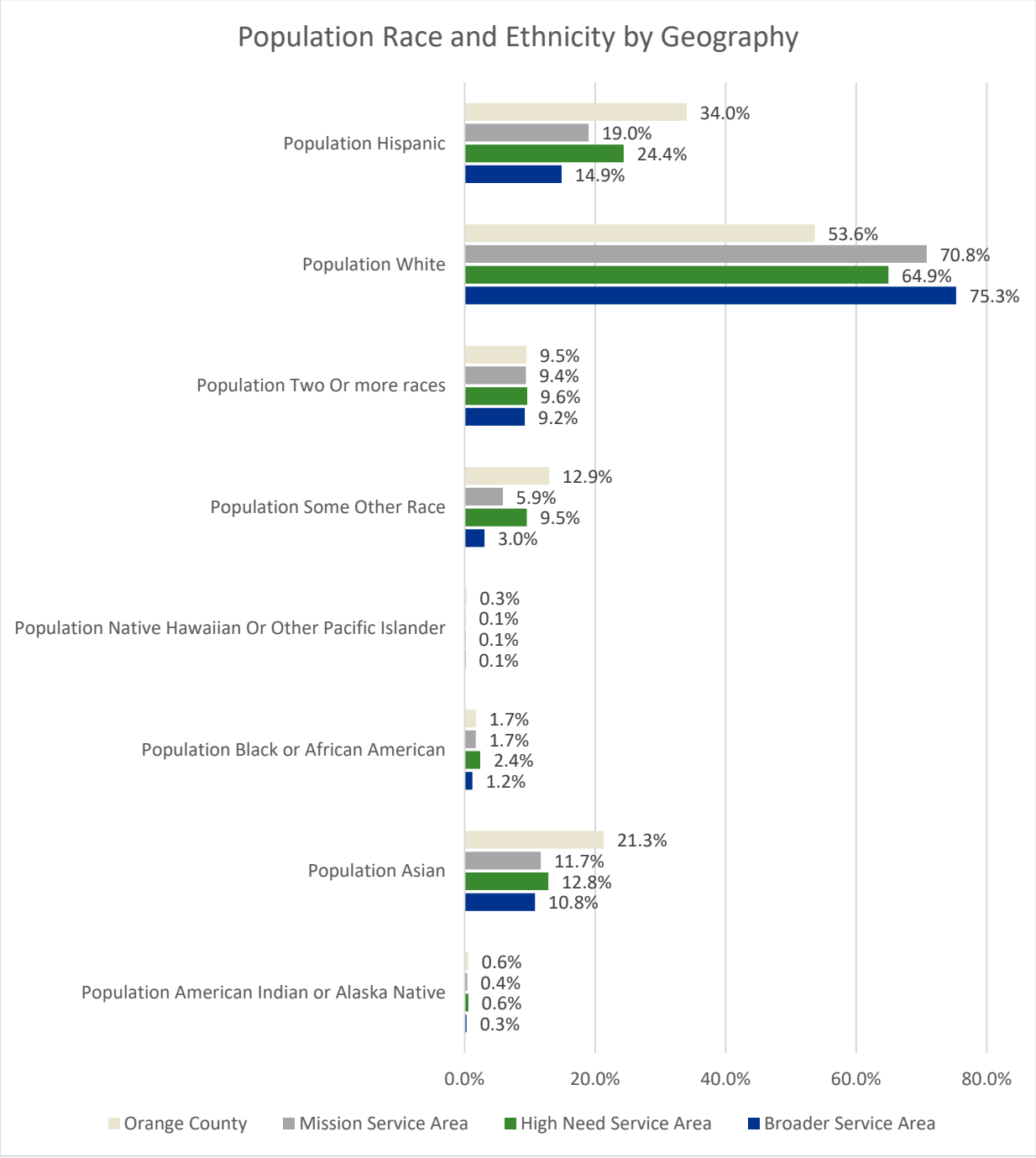


Source: American Community Survey, 2021 5-Year Estimate

POPULATION BY RACE AND ETHNICITY – MISSION HOSPITAL

Individuals who identify as Hispanic, Asian, Black/African American, and "other" race are over-represented in high need census tracts compared to the Mission service area overall. People identifying as white are less likely to live in high need census tracts.

Figure 4. Race and Ethnicity by Geography for Mission Hospital Service Area

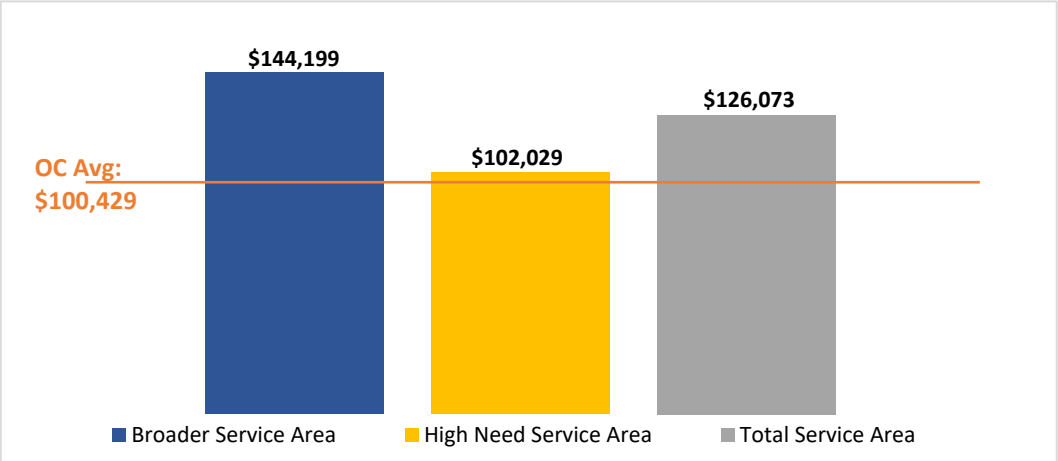


Source: American Community Survey, 2021 5-Year Estimate

MEDIAN INCOME—MISSION HOSPITAL

The median income for the total service area for Mission Hospital is about $25,000 higher than Orange County overall. There is over a $42,000 difference in median income between Mission Hospital's Broader Service Area and the High Need Service Area.

Figure 5. Median Income for Mission Hospital Service Area

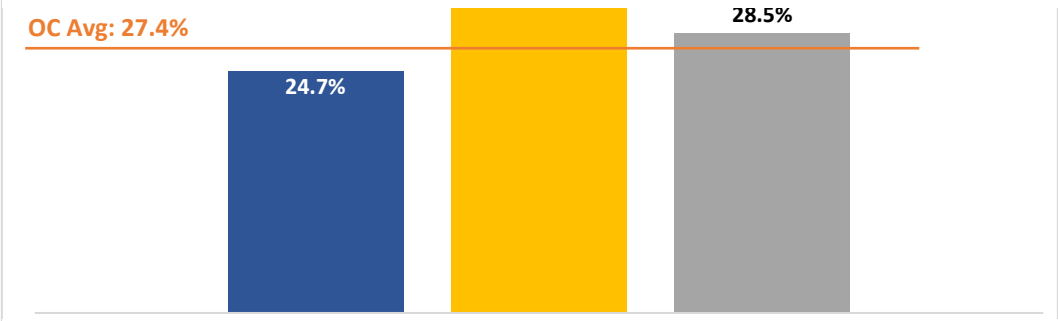


Source: American Community Survey, 2021 5-Year Estimate

HOUSING COST BURDEN

Severe housing cost burden is defined as households that spend 50% or more of their income on housing costs. In the high need service area, 31.2% of renter households are severely housing cost burdened. Within the total service area there are census tracts in which over 50% of households are experiencing severe housing cost burden.

Figure 6. Housing Cost Burden for Mission Hospital Service Area



Source: American Community Survey, 2021 5-Year Estimate

HEALTH INDICATORS – MISSION HOSPITAL

Please refer to the Mission Hospital CHNA Data Hub 2023 to review each of the following health indicators mapped at the census tract level: Mission CHNA Data Hub (arcgis.com)

There are more older adults and non-Latino white people in the Mission Hospital service area than Orange County. Compared to the county, the service area is relatively prosperous, but the summary data hide pockets of poverty within the census tract level, including areas around Lake Forest, San Juan Capistrano, and Laguna Woods. In addition, there are areas in the Mission Hospital service area with higher-than-average rates of uninsured.

Hospital Utilization Data

In addition to public health surveillance data, our hospitals can provide timely information regarding access to care and disease burden across the service area. Avoidable Emergency Department (AED) use is reported as a percentage of all Emergency Department visits over a given period, which are identified based on an algorithm developed by Providence's Population Health Care Management team based on NYU and Medi-Cal definitions. AED use serves as a proxy for inadequate access to or engagement in primary care. We review and stratify utilization data by a several factors including self-reported race and ethnicity, patient origin ZIP Code, age, and sex. This detail helps us identify disparities to better improve our outreach and partnerships. 10

Across Providence's Orange County and High Desert service areas, Mission Hospital had the lowest percentage of avoidable emergency visits at 26.5% in the year 2022, compared to an average of 28.0% for the region. In addition, our Avoidable Emergency Department (AED) data showed the following key insights:

- Patients self-identifying as Black/African American and Native Hawaiian/other Pacific Islander had the highest percentage of AED visits at 32.9% and 32.1% respectively, although they each made up small percentages of the total AED visits at 2.6% and 0.3% respectively.
- Patients self-identifying as Hispanic or Latino had a higher percent of AED visits at 27.8% compared to patients self-identifying as Not Hispanic of Latino at 26.1%.
- Adults ages 40-64 years were most likely to have a potentially AED visit, making up 31% of total AED cases at Mission Hospital.
- Females were most likely to have a potentially AED visit, making up 53% of total AED cases at Mission Hospital.
- More than one-quarter of all AED cases at Mission Hospital came from ZIP Codes 92677, 92675, and 92672.
- The most common diagnoses for all avoidable visits during this time were Substance Use Disorders, Urinary Tract Infections, and Skin Infections.

- Medicaid is the majority payor for avoidable emergency department visits and behavioral health visits at Mission Hospital.

For additional information regarding these findings, please contact Christy Cornwall at Christy.cornwall@stjoe.org.

SIGNIFICANT HEALTH NEEDS

Review of Primary and Secondary Data

After a careful review of the qualitative and quantitative data, we developed a preliminary list of identified community health needs. These needs were identified by key informant surveys and listening sessions.

Charitable Ventures reviewed the quantitative and qualitative data collected for each of the following community health-related needs:

1. Access to care (generally)
2. Behavioral health challenges and access to care (includes both mental health and substance use disorders)
3. Culturally and linguistically appropriate services
4. Isolation (as related to social identities)
5. Housing
6. Access to safe, reliable, affordable transportation
7. Economic insecurity (lack of living wage jobs and unemployment)
8. Access to dental care
9. Aging concerns and issues (e.g., cognitive decline /dementia, mobility, etc.)
10. Food insecurity
11. Domestic violence, child abuse/neglect

Access to care is made difficult because 1) wait times are long and Medi-Cal patients are under the impression they need to have approval to go to Urgent Care and/or Specialists, 2) culturally and linguistically available mental and physical health care providers are either unavailable or largely in Central and North Orange County, and 3) for individuals, especially Transitional Age Youth with disabilities, health care tends not to be compassionate or adaptive to their socio-emotional and even physical needs. Dental care that goes beyond simple preventative cleanings and cavity fillings is also a need.

Substance abuse and mental health are something that are intricately linked, and which community members note to be high needs post COVID-19 pandemic.

Isolation is something experienced by those who are “different” from the dominant groups in the community – in terms of all social identities, in particular, LGBTQIA+, older adult, or being low-income, individuals with disabilities, or Spanish speaking immigrant. Affirming policies, practices, and care, is especially needed for LGBTQIA+ individuals.

Related to economic security, community members who have spent their careers doing manual labor and are no longer able to keep this up physically, express a need for training to transition to dignified work with benefits as they age.

As for food insecurity, community members expressed a strong desire for healthy, fresh options – farmer's markets and local produce. They also see these access points for food as great opportunities for outreach and education.

Identification and Prioritization of Significant Health Needs

On September 26, 2023, the primary and secondary data findings were reviewed with a cross-sector group of community leaders. Of the 27 people who participated, the following sectors were represented: health care, education, government, public health, residents from high-need neighborhoods, housing agencies and other non-profit organizations. They asked questions and engaged with the data. At the end of the review, participants were invited to choose their top three priority needs based on the five criteria below. From this process, the top 5 needs were taken to the Mission Hospital Community Health Committee on October 10, 2023, for further review and to identify the top three priority needs.

The following criteria were used in the prioritization process:

- Worsening trend over time
- Disproportionate impact on low income and/or Black/African American, Brown, Indigenous, and People of Color (BIPOC) communities
- Providence service area/high need service area rates worse than state average and/or national benchmarks
- Opportunity to impact organizational commitment, partnership, severity, and/or scale of need
- Alignment with existing System priorities

2023 Priority Needs – Mission Hospital

The list below summarizes the significant health needs identified through the 2023 Community Health Needs Assessment process (listed in alphabetical order):

ACCESS TO CARE

Access to care goes beyond medical care, and includes dental, vision, primary care, transportation, culturally appropriate care, and care coordination. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

BEHAVIORAL HEALTH (INCLUDING SUBSTANCE USE)

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. Mental health programs include the prevention, screening, assessment, and treatment of mental disorders and behavioral conditions. Mental health is an important part of overall health and well-being.

Substance use/misuse occurs when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and inability to meet major responsibilities at work, school, or home. Substance use/misuse includes the use of illegal drugs and the inappropriate use of legal substances, such as alcohol, prescription drugs and tobacco.

ECONOMIC SECURITY

If a family's total income is less than certain federal poverty measures, then that family and every individual in it is considered in poverty. People with steady employment are less likely to live in poverty and more likely to be healthy. People with disabilities, injuries, or conditions like arthritis may be especially limited in their ability to work. In addition, many people with steady work still don't earn enough to afford the things they need to stay healthy. Employment programs, career counseling, and high-quality childcare opportunities can help more people find and keep jobs. In addition, policies to help people pay for food, housing, health care, and education can reduce poverty and improve health and well-being.

Alignment with Other Community Health Needs Assessments

To ensure alignment with local public health improvement processes and identified needs, we reviewed the needs of other publicly available sources that engaged the community in setting priorities, including the 2023-2028 priorities identified by the Orange County Health Care Agency Office of Population Health and Equity, the 2022 UCI Medical Center CHNA, and the 2022 Hoag Memorial Hospital CHNA. These CHNA reports were reviewed to confirm alignment with other Orange County organizations responsible for conducting CHNAs. The following table provides an overview of the priorities identified by the organizations. **Areas of overlap with Mission Hospital Priority areas are in bold in the table below.**

Table 11. Alignment with Other Community Health Needs Assessments

OC Health Care Agency Office of Population Health and Equity Priorities 2023—2028	UCI Medical Center CHNA 2022	Hoag Memorial Hospital CHNA - 2022
Health Conditions: **1. Mental Health** **2. Substance Use** 3. Maternal / Fetal Health 4. Food Access / Nutrition 5. Oral Health Determinants of Health: **1. Care Navigation** **2. Language Access** 3. Data Access & Supports 4. Housing / Homeless 5. Food Access / Nutrition	1. **Access to health care** 2. Chronic diseases (Alzheimer's disease, asthma, cancer, diabetes, heart disease, liver, stroke) 3. COVID-19 4. Housing and homelessness 5. **Mental health** 6. Overweight and obesity 7. Preventive practices (vaccines and screenings) 8. **Substance use**	**1. Access to Health Care** **2. Behavioral and Mental Health** 3. Cancer/Chronic Disease 4. Community and Family Safety 5. COVID-19 / Contagious and Infectious Diseases **6. Economic and Financial Insecurity** 7. Environment/ Climate Change 8. Housing and Homelessness

Potential Resources Available to Address Significant Health Needs

Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. The organized health care delivery systems include the Department of Public Health and the Orange County Health Care Agency, Hoag Hospitals, AHMC Anaheim, Children's Hospital of Orange County, Kaiser Permanente Orange County, Orange Coast Medical Center, Prime Healthcare Services, Tenet Healthcare, and University of California, Irvine Medical Center in addition to Providence. There are numerous social service non-profit agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs. **See Appendix 3: Community Resources Available to Address Significant Health Needs for a full list of resources potentially available to address the significant health needs.**

EVALUATION OF 2021-2023 CHIP

The 2021 CHNA and 2021-2023 CHIP priorities were the following: Behavioral Health (including Substance Use), Housing/Homelessness, and Equity/Racial Disparities. This report evaluates the impact of the 2021-2023 Community Health Improvement Plan (CHIP). Mission Hospital responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices.

Table 12: Outcomes from Mission Hospital 2021-2023 CHIP

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes based on Fiscal Year Reporting (July 1 – June 30)
Mental Health	Promise To Talk, Stigma Reduction Campaign	Stigma reduction campaign using social media and in person events to increase awareness about mental health in the community, reduce stigma and provide low-cost resources	Encounters OC wide: FY21: 94,447 FY22: 73,220 FY23: 156,674 Promises made OC-wide: 2020 (baseline): 2,064 FY21: 2,715 FY22: 3,442 FY23: 2,997 Percent of surveyed residents who report finding the community 'caring / sympathetic' to people with mental illness: 2021: 79% 2022: 79% 2023: will be available in January 2024
Mental Health	Client Treatment Services	Provide therapeutic, psychoeducational, psychiatric, case management or support group services for clients at the Family Resource Centers	# of clients treated: 2020 (baseline): 430 FY21: 580 FY22: 515 FY23: 641

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes based on Fiscal Year Reporting (July 1 – June 30)
Mental Health	Substance Use Prevention	Increase adult and youth knowledge of the harms related to youth alcohol or other drug use and increase knowledge of substance use prevention strategies	We have 12,000 visits to Raising Healthy Teens website in 2023.
		Reduce the percent of 9th and 11th graders in select South OC high schools who report using alcohol or other drugs within the last 30 days	*2016 Baseline:* *9th Grade: 21%* *11th Grade: 38%* 9th Grade: 11% 11th grade: 27%
Housing/ Homelessness	Housing Champions	Train a minimum of 100 housing champions annually in South Orange County cities to support affordable housing projects	*2020 baseline: n/a* FY21: 200 residents FY22: 185 residents FY23: 43,044 people engaged in public awareness & education across all of Orange County
Housing/ Homelessness	Bridge & Permanent Housing	Provide bridge and permanent supportive housing solutions for identified residents in South Orange County (a collaborative partnership including Mission Hospital, Family Assistance Ministries and Friendship Shelter)	FY21: 20 clients FY22: 64 clients FY23: 77 clients
Housing/ Homelessness	Care Navigation Program	Provide care navigation services for unstably housed individuals who have been patients of Mission Hospital	FY21: 43 clients FY22: 64 clients FY23: 215 clients (higher rates in FY23 due to stronger focus on unstably housed patients)

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes based on Fiscal Year Reporting (July 1 – June 30)
Housing/ **Homelessness**	Care Navigation	Decrease ED visits by clients engaged in program closing out care after > 3 months with no ED visits	In FY23, 198 clients (of 298 or 68% of total) were successfully discharged from the program
Equity/Racial Disparities	Expand Services	Expand services to Limited English Proficient (LEP) individuals with low incomes through efforts coordinated by the Community Health Investment Department	*FY19 (baseline):* *18,535 encounters* FY21: 34,617 FY22: 26,259 FY23: 17,000
Equity/Racial Disparities	Promote inclusion & build resilience	Increase participants attending events that promote inclusion, diversity, multiculturalism, or builds resilience in South Orange County	*FY19 (Baseline):* *165 participants* FY21: 186 FY22: 626 FY23: 1,109
Equity/Racial Disparities	Continue the efforts of the SOC Equity Coalition	Bringing together South OC non-profit leaders and residents to collectively address disparities	The coalition has been renamed to **South OC for All.** In the last three years, the coalition received a CDC grant and funding through Supervisor Lisa Bartlett's office to continue its efforts.
Equity/Racial Disparities	COPE Health Scholars	Expand diversity of the COPE Health Scholars Program at Mission Hospital	% of COPE Scholars that are racially & ethnically diverse: *2020 (baseline): 35%* FY21: 33% FY22: 44% FY23: 41%

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes based on Fiscal Year Reporting (July 1 – June 30)
			% of scholars that speak a language in addition to English: FY21: 61% FY22: 65% FY23: 68%

Addressing Identified Needs

The Community Health Improvement Plan (CHIP) developed for the Mission Hospital service area will consider the prioritized health needs identified in this CHNA and develop strategies to address needs considering resources, community capacity, and core competencies. Those strategies will be documented in the CHIP, describing how Mission Hospital plans to address health needs. If the hospital does not intend to address a need or plans to have limited response to the identified need, the CHIP will explain why. The CHIP will not only describe the actions Mission Hospital intends to take, but also the anticipated impact of these actions and the resources the hospital plans to commit to address the health need.

Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration between Mission Hospital and community-based organizations in addressing the health need. The CHIP will be approved and made publicly available no later than May 15, 2024.

MISSION HOSPITAL—2023 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted by the Community Health Committee of Mission Hospital[33] on November 14, 2023. The final report was made widely available by December 28, 2023.

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Seth Teigen — Date
Chief Executive, Mission Hospital
Providence

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12/11/2023

Virginia Ripslinger — Date
Chair, Mission Hospital Community Health Committee

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12/9/2023

Kenya Beckmann — Date
Chief Philanthropy and Health Equity Officer, South Division
Providence

CHNA/CHIP Contact:

Christy Cornwall, MPH, CHES
Director, Community Health Investment
27800 Medical Center Road, Mission Viejo, CA 92691
Christy.cornwall@stjoe.org

To request a printed copy free of charge, provide comments, or view electronic copies of current and previous Community Health Needs Assessments, please email CHI@providence.org.

[33] **See Appendix 4: Mission Hospital Community Health Committee**

ST. JOSEPH HOSPITAL

Providence Need Index

To facilitate identifying health disparities and social inequities by place, we designated a "high need" service area and a "broader" service area, which together make up the Mission Hospital, St. Joseph Hospital, and St. Jude Medical Center Service Area. Based on work done by the Public Health Alliance of Southern California and their Healthy Places Index (HPI) tool, we identified the high need service area based on income, education, English proficiency, and life expectancy.[34]

For this analysis, census tracks with more people below 200% Federal Poverty Level (FPL), more people without a high school diploma, more limited English households, and a lower life expectancy at birth were identified as "high need." The mean value of nearest neighbors was used to insert missing data for variables by way of the Neighborhood Summary Statistics geoprocessing tool in ArcGIS Pro 3.1. All variables were weighted equally. The census tracts were assigned a score between 0 and 100 where 0 represents the census tract with the lowest need and 100 represents the highest need, according to the criteria. Census tracts that scored higher than the average was classified as high need service areas and are depicted in green.

In the St. Joseph Hospital service area, 208 of 484 census tracts (43%) scored above the average of 38.5, indicating a high need.

Community Demographics

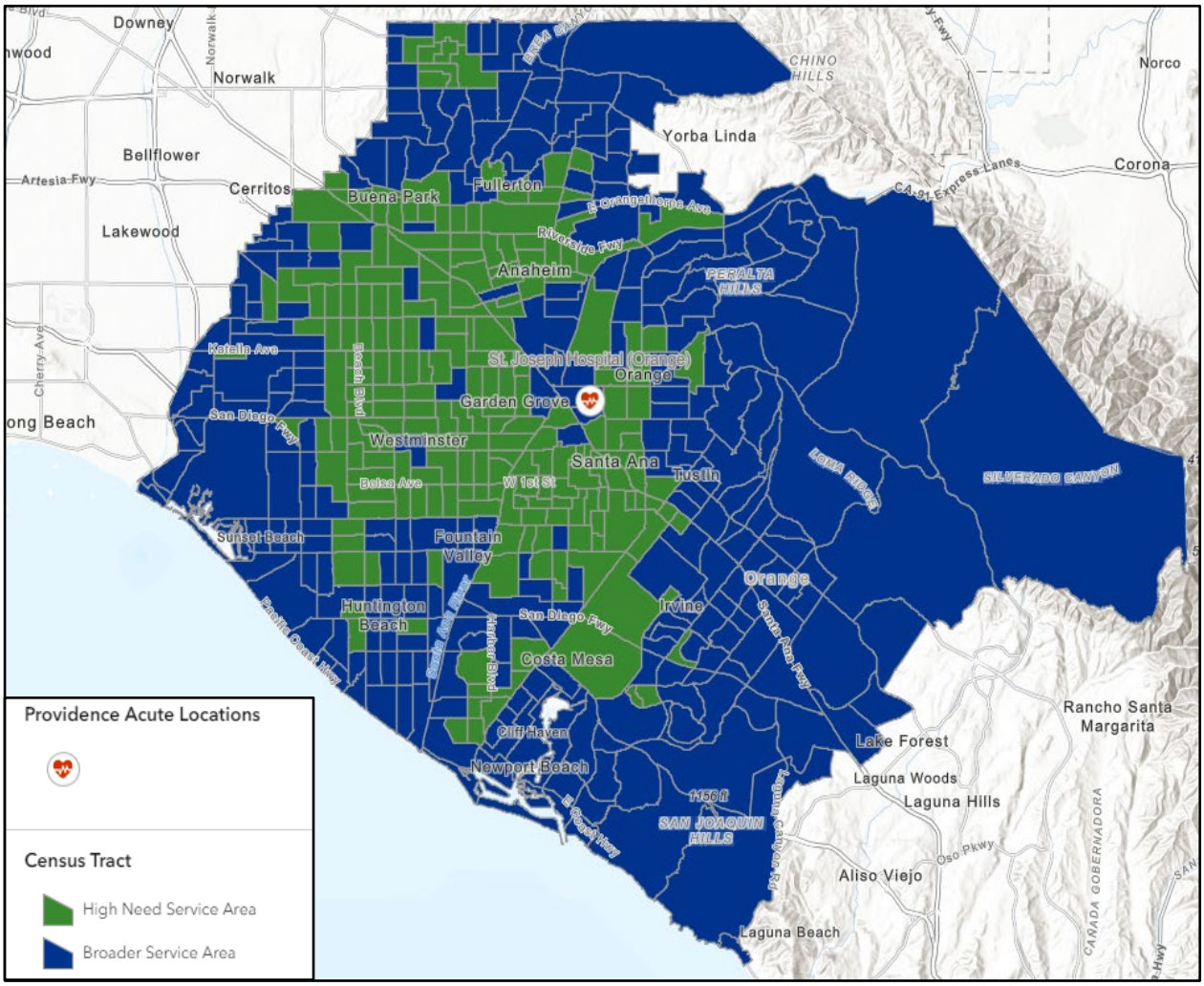
The CHNA service area was determined by first reviewing ZIP Codes corresponding to inpatient discharges and then filling in any gaps in service area that occurred to ensure coverage of the entirety of Orange County. The service area for St. Joseph Hospital was defined using census tracts inside North and Central Orange County with the exclusion of the city of Yorba Linda, based upon geographic access, other nearby hospitals, and ZIP Codes corresponding to inpatient discharges. This includes, but is not limited to, the cities of Anaheim, Brea, Buena Park, Cypress, Fullerton, Costa Mesa, Garden Grove, Irvine, Santa Ana, Westminster, and Orange. In total, there are 484 census tracts within the service area of St. Joseph Hospital. Together, Mission Hospital, St. Joseph Hospital, and St. Jude Medical Center serve all of Orange County, as well as certain census tracts in Los Angeles, San Bernardino, and Riverside Counties. For more granular data, census tracts that overlap the ZIP Codes in Table 13 were referenced.

[34] The following variables were used for the PNI analysis: Population below 200% the Federal Poverty Level (American Community Survey, 2021); Percent of population with at least a high school education (American Community Survey, 2021); Percent of population, ages 5 Years and older in Limited English Households (American Community Survey, 2021); Life expectancy at birth (estimates based on CDC, 2010 – 2015 data)

Table 13. Cities and ZIP Codes Included in Total Service Area - St. Joseph Hospital

Cities/ Communities	ZIP Codes
Anaheim	92801, 92802, 92803, 92804, 92805, 92806, 92807, 92808, 92809, 92814, 92815, 92816, 92817, 92825
Garden Grove	92840, 92841, 92842, 92843, 92844, 92845, 92846
Orange	92856, 92857, 92859, 92862, 92863, 92865, 92866, 92867, 92868
Santa Ana	92701, 92702, 92703, 92704, 92705, 92706, 92707, 92711, 92735, 92799
Tustin	92780, 92781, 92782
Villa Park	92861
Westminster	92683, 92864, 92685
Buena Park	90620, 90621, 90622
Corona	92877, 92878, 92879, 92880, 92881, 92882, 92883
Costa Mesa	92626, 92627, 92628
Cypress	90630
Foothill Ranch	92610
Fountain Valley	92708, 92728
Fullerton	92831, 92833, 92834, 92838
Irvine	92602, 92603, 92604, 92606, 92612, 92614, 92616, 92617, 92618, 92619, 92620, 92623, 92697
Lake Forest	92630
Placentia	92870, 92871
Silverado	92676
Stanton	90680
Yorba Linda	92885, 92886, 92887

Figure 7. St. Joseph Hospital Service Area



The graphs below provide demographic and socioeconomic information about the service area and how the high need area compares to the broader service area. We have developed a dashboard that maps each CHNA indicator at the census tract level. The dashboard can be found here: [SJO CHNA Data Hub 2023]

POPULATION AND AGE DEMOGRAPHICS – ST. JOSEPH HOSPITAL

Of the over 1,778,000 permanent residents in the total service area, roughly 44% 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 in the total service area. For reference, in 2021, 200% FPL is equivalent to an annual household income of $53,000 or less for a family of 4. These households are more likely to regularly make spending tradeoffs regarding utilities, rent, groceries, medicine, and other basic expenses. The population in St. Joseph Hospital's total service area makes up 56% of Orange County.

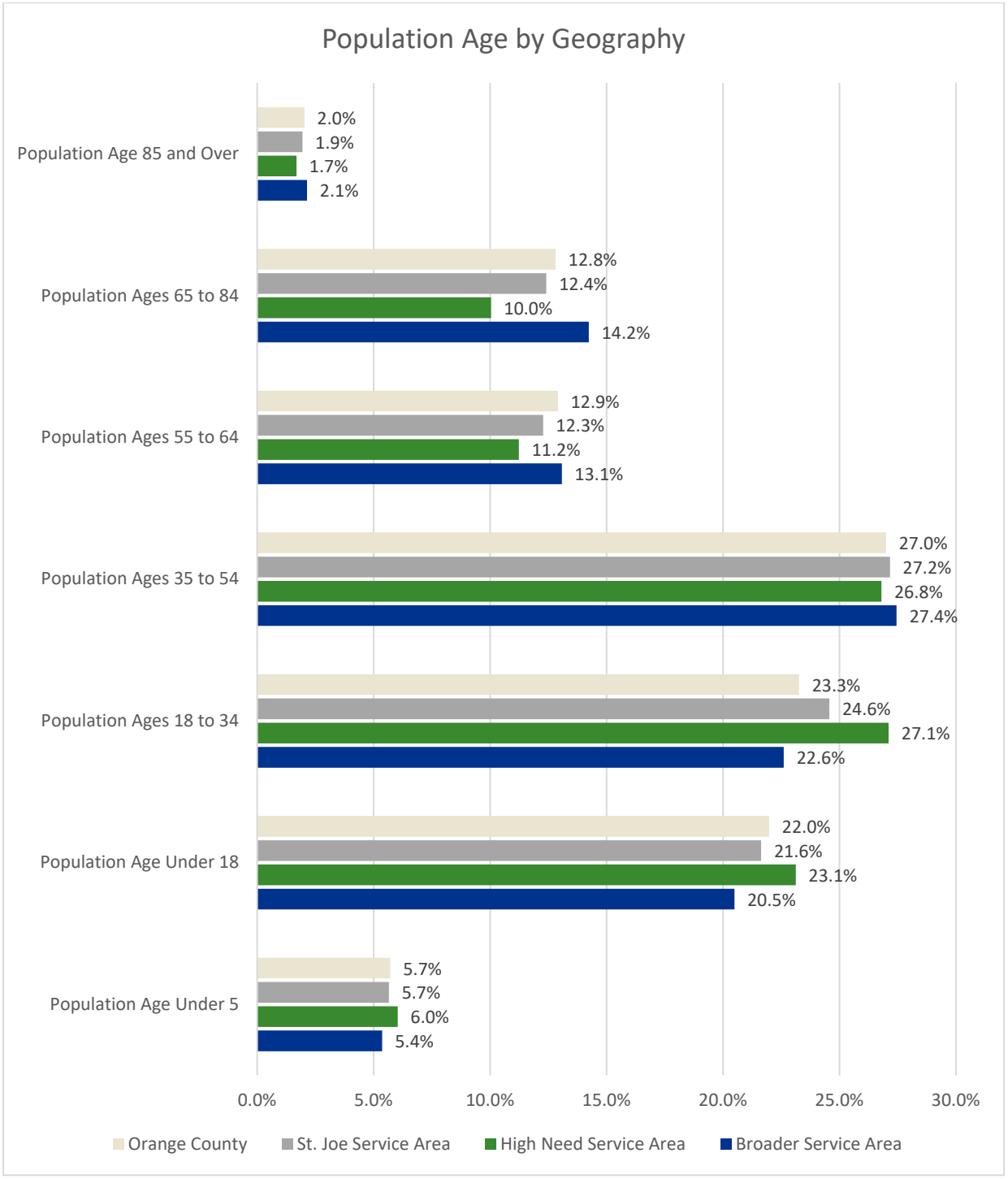
The male-to-female distribution is roughly equal across geographies. Individuals under the age of 35 are more likely to live in high need census tracts.

Table 14. Population Demographics for St. Joseph Hospital Service Area and Orange Count

Indicator	St. Joseph Service Area	Broader Service Area	High Need Service Area	Orange County
Total Population	1,778,822	1,004,727	774,095	3,182,923
Female Population	50.1%	50.5%	49.5%	50.4%
Male Population	49.9%	49.5%	50.5%	49.6%

Source: American Community Survey, 2021 5-Year Estimate

Figure 8. Age Groups by Geography for St. Joseph Hospital Service Area

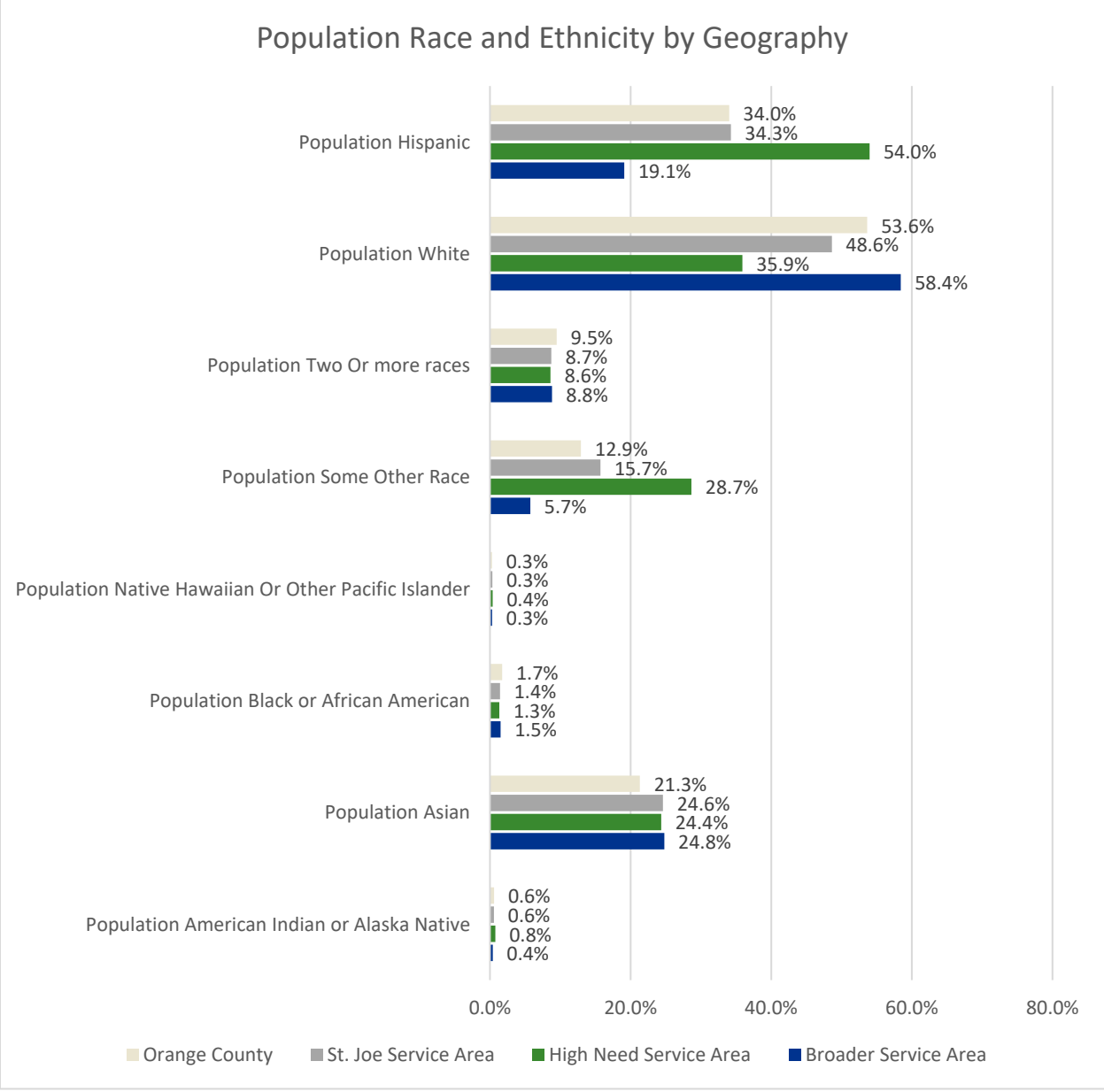


Source: American Community Survey, 2021 5-Year Estimate

POPULATION BY RACE AND ETHNICITY – ST. JOSEPH HOSPITAL

Individuals who identify as Hispanic and "other" race are substantially overrepresented in the high need census tracts compared to the St. Joseph service area and Orange County overall. People identifying as White are less likely to live in high need census tracts.

Figure 9. Race and Ethnicity by Geography for St. Joseph Hospital Service Area

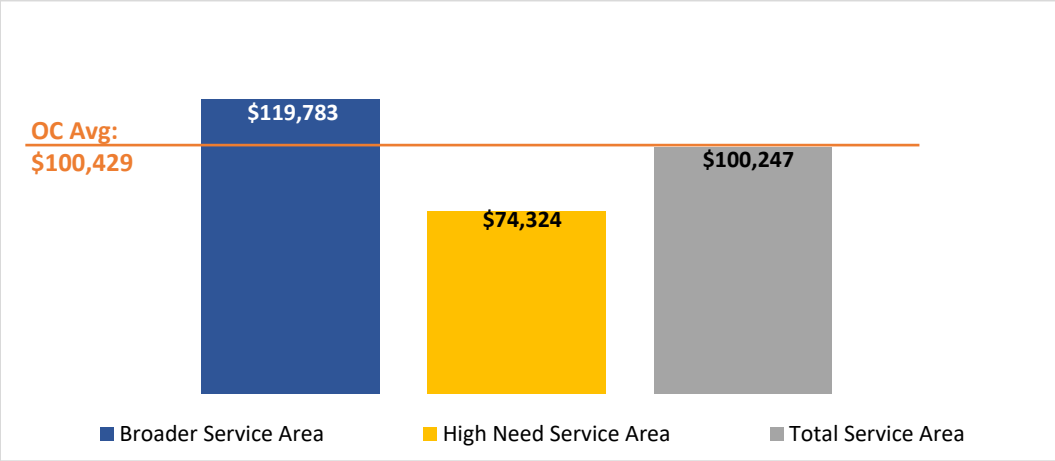


Source: American Community Survey, 2021 5-Year Estimate

MEDIAN INCOME—ST. JOSEPH HOSPITAL

The median income for the total service area for St. Joseph is about the same as Orange County overall. There is over a $45,000 difference in median income between St. Joseph's Broader Service Area and the High Need Service Area.

Figure 10. 2021 Median Income for St. Joseph Hospital Service Area. Adapted from 2021 American Community Survey, 5-Year Estimate

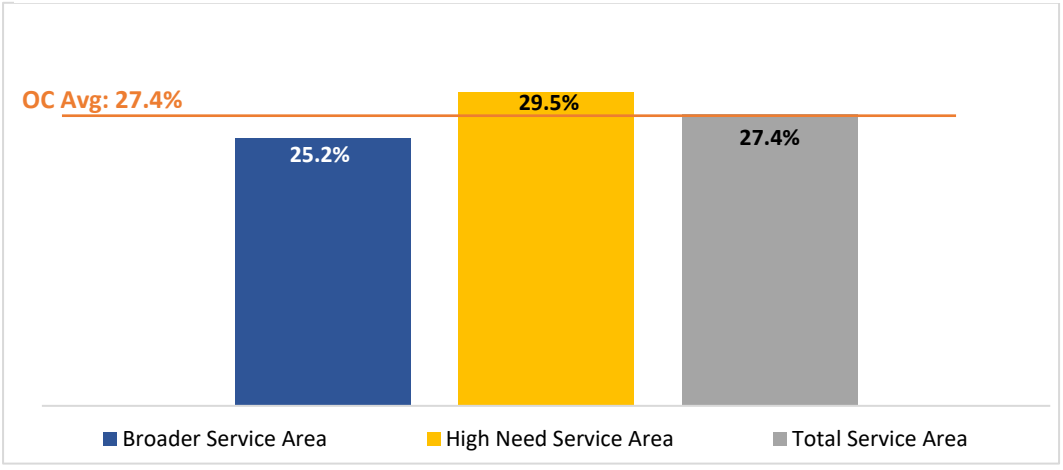


Source: American Community Survey, 2021 5-Year Estimate

HOUSING COST BURDEN—ST. JOSEPH HOSPITAL

Severe housing cost burden is defined as households that spend 50% or more of their income on housing costs. In the high need service area, 29.5% of renter households are severely housing cost burdened. Within the total service area there are census tracts in which over 50% of households are experiencing severe housing cost burden.

Figure 11. Percent of Renter Households with Severe Housing Cost Burden for St. Joseph Service Area.



Source: American Community Survey, 2021 5-Year Estimate

HEALTH INDICATORS

Please refer to the SJO CHNA Data Hub 2023 to review each of the following health indicators mapped at the census tract level: SJO CHNA Data Hub 2023.

There are more adults ages 18-34 in the St. Joseph Hospital service area than Orange County, though other ages ranges and race/ethnicity is about the same as the county. The St. Joseph Hospital service area also has similar income to Orange County. In addition, there are areas in the St. Joseph Hospital service with higher-than-average rates of uninsured and a higher limited English household population.

Hospital Utilization Data

In addition to public health surveillance data, our hospitals can provide timely information regarding access to care and disease burden across our service area. Avoidable Emergency Department (AED) use is reported as a percentage of all Emergency Department visits over a given period, which are identified based on an algorithm developed by Providence's Population Health Care Management team based on NYU and Medi-Cal's definitions. AED use serves as proxies for inadequate access to or engagement in primary care. We review and stratify utilization data by several factors including self-reported race and ethnicity, patient origin ZIP code, age, and sex. This detail helps us identify disparities to better improve our outreach and partnerships.

Across Providence's Orange County and High Desert service areas, St. Joseph Hospital had the highest percentage of avoidable emergency department visits at 28.8% in the year 2022, compared to an average of 28.0% for the region. In addition, our Avoidable Emergency Department (AED) data showed the following key insights:

- Patients self-identifying as Black/African American and Hispanic or Latino had the highest rates of AEDs at 31.7% and 29.0%, respectively. Additionally, patients self-identifying as Hispanic or Latino made up 60.1% of the total avoidable ED cases in 2022.
- Adults ages 18-39 years were the majority age group for AED at 43.2% of total AED cases at St. Joseph Hospital.
- Patients self-identifying as female made up 58% of the total AED cases at St. Joseph Hospital.
- Nearly 20% of all AED cases at St. Joseph Hospital came from ZIP Codes 92701, 92868, and 92703.
- The most common diagnoses for all avoidable visits during this time were Urinary Tract Infections, Skin Infections, and Anxiety and Personality Disorders.
- 53.1% of avoidable visits were from patients with a primary payor of Medicaid (Medi-Cal)

SIGNIFICANT HEALTH NEEDS

Review of Primary and Secondary Data

After a careful review of the qualitative and quantitative data, we developed a preliminary list of identified community health needs. These needs were identified by key informant surveys and listening sessions.

Charitable Ventures reviewed the quantitative and qualitative data collected for each of the following community health-related needs:

1. Behavioral health challenges and access to care (includes both mental health and substance use disorders)
2. Affordable housing
3. Culturally and linguistically concordant services
4. Access to health services/Access to care
5. Lack of community involvement and engagement
6. Access to safe, reliable, affordable transportation
7. Economic insecurity (lack of living wage jobs and unemployment)
8. Food insecurity
9. Basic Needs
10. Homelessness
11. Access to dental care
12. Racism and discrimination
13. Aging concerns and issues (e.g., cognitive decline /dementia, mobility, etc.)

Mental health, especially as related to substance use/misuse, and since the pandemic, is a critical health need in the St. Joseph Hospital service area. The difficulty in accessing mental health and peer support, for those who speak a language other than English, compounds the severity of the need. Additionally, comorbidities compound the severity of the need. St. Joseph Hospital Executive leadership note, increased patients with "multiple organ failure" due to substance use/misuse since the pandemic.[35] Leaders of the Providence Clinical Network have noted the interconnection between substance use, mental health, and domestic violence, presenting another indication of the severity of the need related to substance use/misuse and mental health. While the hospital system has mental health programs and substance use/misuse navigators, they lack sufficient providers to meet patient needs, community partners for successful discharge of substance abuse patients, and social workers to help identify patient needs.

[35] St. Joseph Hospital Executive Leadership Listening Session, August 15, 2023. Fourteen executive leaders from the St. Joseph Hospital shared what they perceived as top community health needs, how they are uniquely equipped to meet those needs, and what they lack currently to meet those needs.

All micro-communities in the St. Joseph Hospital service area, as in other service areas, note access to health care as a top need. They note affordability; coverage for the immigrant population; training and support to navigate the health care system (including the transition between pediatric and adult care for those living with disabilities, particularly); timely access to care – long waits in the emergency room; waits for specialists; and a need for chronic disease management. Hospital leadership perspective supports the lack of access to pediatric care, meeting the needs of patients in their homes (e.g., postpartum, older adults), access to culturally and linguistically matched and responsive resources, depression related to chronic illness.

Community and provider perspective around the need to address isolation tracks with hospital leadership insights as well. Mobility (related to ambulatory capacity for individuals with disabilities and older adults) as well as accessible, affordable transportation for those without personal vehicles impact this need. The isolation that communities experience is often intimately connected to discrimination (e.g., LGBTQIA+, older adults, individuals with disabilities, individuals who are linguistically or culturally isolated). This isolation can also be connected to mental health, substance use, and other illnesses.

The issue of affordable housing and houselessness is ever present. Every primary and secondary dataset touches on this issue. For this service area, housing that accommodates larger, inter-generational families, older adults, and individuals with disabilities is a need.

Identification and Prioritization of Significant Health Needs

On September 21, 2023, the primary and secondary data findings were reviewed with members of a cross-sector group Community Health Committee along with members of Providence staff. They asked questions and engaged with the data. At the end of the review, Committee members were invited to choose their top three priority needs based on the five criteria below. As in-person attendance was lower than expected, later selections were received after the Director of Community Health Investment carried out 1 on 1s with individual Committee members to review the findings, ask questions, and provide their input.

The following criteria were used in the prioritization process:

- Worsening trend over time
- Disproportionate impact on low income and/or Black/African American, Brown, Indigenous, and People of Color (BBIPOC) communities
- Providence service area/high need service area rates worse than state average and/or national benchmarks
- Opportunity to impact organizational commitment, partnership, severity, and/or scale of need
- Alignment with existing System priorities

2023 Priority Needs

The list below summarizes the significant health needs identified through the 2023 Community Health Needs Assessment process (listed in alphabetical order):

ACCESS TO CARE

Access to care goes beyond medical care, and includes dental, vision, primary care, transportation, culturally appropriate care, and care coordination. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

BEHAVIORAL HEALTH (INCLUDING SUBSTANCE USE)

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. Mental health programs include the prevention, screening, assessment, and treatment of mental disorders and behavioral conditions. Mental health is an important part of overall health and well-being.

Substance use/misuse occurs when the recurrent use of alcohol/or drugs causes clinically significant impairment, including health problems, disability, and inability to meet major responsibilities at work, school, or home. Substance use/misuse includes the use of illegal drugs and the inappropriate use of legal substances, such as alcohol, prescription drugs and tobacco.

AFFORDABLE HOUSING

Lack of affordable housing can have a number of negative impacts on individuals, families, and communities. When basic needs, such as housing, are not met, they impact a family's emotional, psychological, developmental, and physical well-being. Over the last few years, Orange County has been facing a critical housing shortage. It has become ever more difficult for communities with low incomes who work in Orange County to also live in Orange County. As a result, families must seek substandard housing with multiple families living in one dwelling. Affordable housing is defined by an individual or family spending 30% or less of their gross income toward housing. Low-income communities in Orange County can expect to spend over 50% of their gross income on housing.

Alignment with Other Community Health Needs Assessments

To ensure alignment with local public health improvement processes and identified needs, we reviewed the needs of other publicly available sources that engaged the community in setting priorities, including the 2023-2028 priorities identified by the Orange County Health Care Agency Office of Population Health and Equity, the 2022 UCI Medical CHNA and the 2022 Hoag Memorial Hospital CHNA. These CHNA reports were reviewed to confirm alignment with government and non-profit organizations serving Orange County. The following table provides an overview of the priorities identified by the

organizations. St. Joseph Hospital is prioritizing three needs that are also among the top needs identified by the OC Health Care Agency Office of Population Health and Equity and by Hoag Memorial Hospital. **All areas of overlap are in bold in the table below.**

Table 15. Alignment with Other Community Health Needs Assessments

OC Health Care Agency Office of Population Health and Equity Priorities 2023—2028	UCI Medical Center CHNA 2022	Hoag Memorial Hospital CHNA - 2022
Health Conditions: 1. **Mental Health** 2. **Substance Use** 3. Maternal / Fetal Health 4. Food Access / Nutrition 5. Oral Health Determinants of Health: **6. Care Navigation** **7. Language Access** 8. Data Access & Supports 9. Housing / Homeless 10. Food Access / Nutrition	1. **Access to health care** 2. Chronic diseases (Alzheimer's disease, asthma, cancer, diabetes, heart disease, liver, stroke) 3. COVID-19 4. **Housing and homelessness** 5. **Mental health** 6. Overweight and obesity 7. Preventive practices (vaccines and screenings) 8. **Substance use**	**1. Access to Health Care** **2. Behavioral and Mental Health** 3. Cancer/Chronic Disease 4. Community and Family Safety 5. COVID-19 / Contagious and Infectious Diseases 6. Economic and Financial Insecurity 7. Environment/ Climate Change **8. Housing and Homelessness**

Potential Resources Available to Address Significant Health Needs

Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. The organized health care delivery systems include the Department of Public Health and the Orange County Health Care Agency, Hoag Hospitals, AHMC Anaheim, Children's Hospital of Orange County, Kaiser Permanente Orange County, Orange Coast Medical Center, Prime Healthcare Services, Tenet Healthcare, and University of California, Irvine Medical Center in addition to Providence. There are numerous social service non-profit agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs. **See Appendix 3 for a full list of resources potentially available to address the significant health needs.**

EVALUATION OF 2021-2023 CHIP

The 2021 CHNA and 2021-2023 CHIP priorities were the following: Mental Health and Substance Use, Access to Care, and Homelessness and Affordable Housing. This report evaluates the impact of the 2021-2023 Community Health Improvement Plan (CHIP). St. Joseph Hospital responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices.

Table 16. Outcomes from the St. Joseph Hospital 2021-2023 CHIP

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Mental Health	Promise to Talk, Stigma Reduction Campaign	Stigma reduction campaign using social media and in person events to increase awareness about mental health in the community, reduce stigma and provide low-cost resources	Encounters OC wide: FY21: 94,447 FY22: 73,220 FY23: 156,674 Promises made OC-wide: 2020 (baseline): 2,064 FY21: 2,715 FY22: 3,442 FY23: 2,997 Percent of surveyed residents who report finding the community 'caring / sympathetic' to people with mental illness: 2021: 79% 2022: 79% 2023: will be available in January 2024
Mental Health	MAT Program in Emergency Department	Provide Medication-Assisted Treatment Program to patients with opioid use disorder	Patients served: 27 FY21: (baseline)649 FY22: 649 FY23: 405
Mental Health	Work2BeWell Program	Partner with local High Schools to implement Work2BeWell curriculum	FY21: (baseline) postponed to 2021-2022 School Year due to COVID-19 FY22: MOU signed with Santa Ana Unified School District FY23: 4 High Schools Engaged

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Mental Health	BeWell OC	% reduction in ED visits for mental health and substance use	BeWell Campus opened in 2021 FY23: Protocol and referral process established. BeWell mobile van open 7 days/wk. 8AM-8PM
Access to Care	La Amistad Health Center (FQHC)	Expand health services to low-income uninsured/underinsured	# of encounters FY21: 21,498 FY22: 21,011 FY23: 20,419
	La Amistad Obstetrics Program	Expand obstetric services to pregnant clinic patient population	# of encounters FY21: 77 FY22: 57 FY23: 243
Access to Care	Virtual Clinic Visits	Integrate virtual visits into clinic operations to reduce barriers to care	# of virtual visits FY21: 10,749 FY22: 10,364 FY23: 4,152
Access to Care	Avoidable ED Navigator	Provide AED Navigator to prevent avoidable visits	# of patients served by AED Navigator FY21: 705 FY22: 1,871 FY23: 2,677
Access to Care	Transitional Care Clinic	Provide uninsured/underinsured hospital patients post-hospital care and follow up	# of encounters FY21: 530 FY22: 786 FY23: 912
Access to Care	Medi-Cal Expansion Efforts	Advocate to expand Medi-Cal to undocumented population currently not covered	FY21: 1 expansion policy passed by State Legislature By 2024, expansion will open access to all age groups.
Homelessness/ Housing	Housing Champions	Train a minimum of 100 housing champions annually in Central Orange County cities	FY21: 81 housing champions FY22: 630 FY23: 807
Homelessness/ Housing	Resident engagement with Planning and City Council	Engage housing champions to promote stronger policies in the 2021-2028 Housing Element	FY21: 3 cities committed to conducting studies around inclusionary housing ordinances in their Housing Elements

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Homelessness/ Housing	Affordable Housing Approval	Support approval of affordable housing projects	FY21: Three projects totaling 183 units opened in central OC
Homelessness/ Housing	Homeless Navigation Program	Decrease the # of administrative/custodial days for homeless patient population	FY21: 70 days FY22: 356 days FY23: 582 days
Homelessness/ Housing	CalAIM for homeless population	# of "in lieu of services" (ILOS) provided by CalOptima for CalAIM clients	FY21: 0 ILOS FY22: 14 FY23: 14

Addressing Identified Needs

The Community Health Improvement Plan developed for the St. Joseph Hospital service area will consider the prioritized health needs identified in this CHNA and develop strategies to address needs considering resources, community capacity, and core competencies. Those strategies will be documented in the CHIP, describing how St. Joseph Hospital plans to address the health needs. If the hospital does not intend to address a need or plans to have limited response to the identified need, the CHIP will explain why. The CHIP will not only describe the actions St. Joseph Hospital intends to take, but also the anticipated impact of these actions and the resources the hospital plans to commit to address the health need.

Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration between St. Joseph Hospital and community-based organizations in addressing the health need. The CHIP will be approved and made publicly available no later than May 15, 2024.

ST. JOSEPH HOSPITAL—2023 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted by the Community Health Committee[36] of the hospital on November 16, 2023. The final report will be made widely available by December 28, 2023.

DocuSigned by:
Brian Helleland
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12/10/2023

Brian Helleland — Date
Hospital Chief Executive, St. Joseph Hospital
Providence

DocuSigned by:
Ruben Smith
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12/10/2023

Ruben Smith — Date
Chair, St. Joseph Hospital Community Health Committee

DocuSigned by:
A0817163947C474...

12/9/2023

Kenya Beckmann — Date
Chief Philanthropy, Health Equity & Officer, South Division Providence

CHNA/CHIP Contact:

Cecilia Bustamante Pixa, MPH, MHCML
Director, Community Health Investment
1100 W. Stewart Drive, Orange, CA 92868
Cecilia.Bustamante-Pixa@stjoe.org

To request a printed copy free of charge, provide comments, or view electronic copies of current and previous Community Health Needs Assessments, please email CHI@providence.org.

[36] **See Appendix 4: St. Joseph Hospital Community Health Needs Assessment Committee**

ST. JUDE MEDICAL CENTER

Providence Need Index

To facilitate identifying health disparities and social inequities by place, we designated a "high need" service area and a "broader" service area, which together make up the Mission Hospital, St. Joseph Hospital, and St. Jude Medical Center Service Area. Based on work done by the Public Health Alliance of Southern California and their Healthy Places Index (HPI) tool, we identified the high need service area based on income, education, English proficiency, and life expectancy.[37]

For this analysis, census tracks with more people below 200% Federal Poverty Level (FPL), more people without a high school diploma, more limited English households, and a lower life expectancy at birth were identified as "high need." The mean value of nearest neighbors was used to insert missing data for variables by way of the Neighborhood Summary Statistics geoprocessing tool in ArcGIS Pro 3.1. All variables were weighted equally. The census tracts were assigned a score between 0 and 100 where 0 represents the census tract with the lowest need and 100 represents the highest need, according to the criteria. Census tracts that scored higher than the average were classified as a high need service areas and are depicted in green.

In the St. Jude Medical Center service area, 145 of 327 census tracts (44%) scored above the average of 38.0, indicating a high need.

Community Demographics

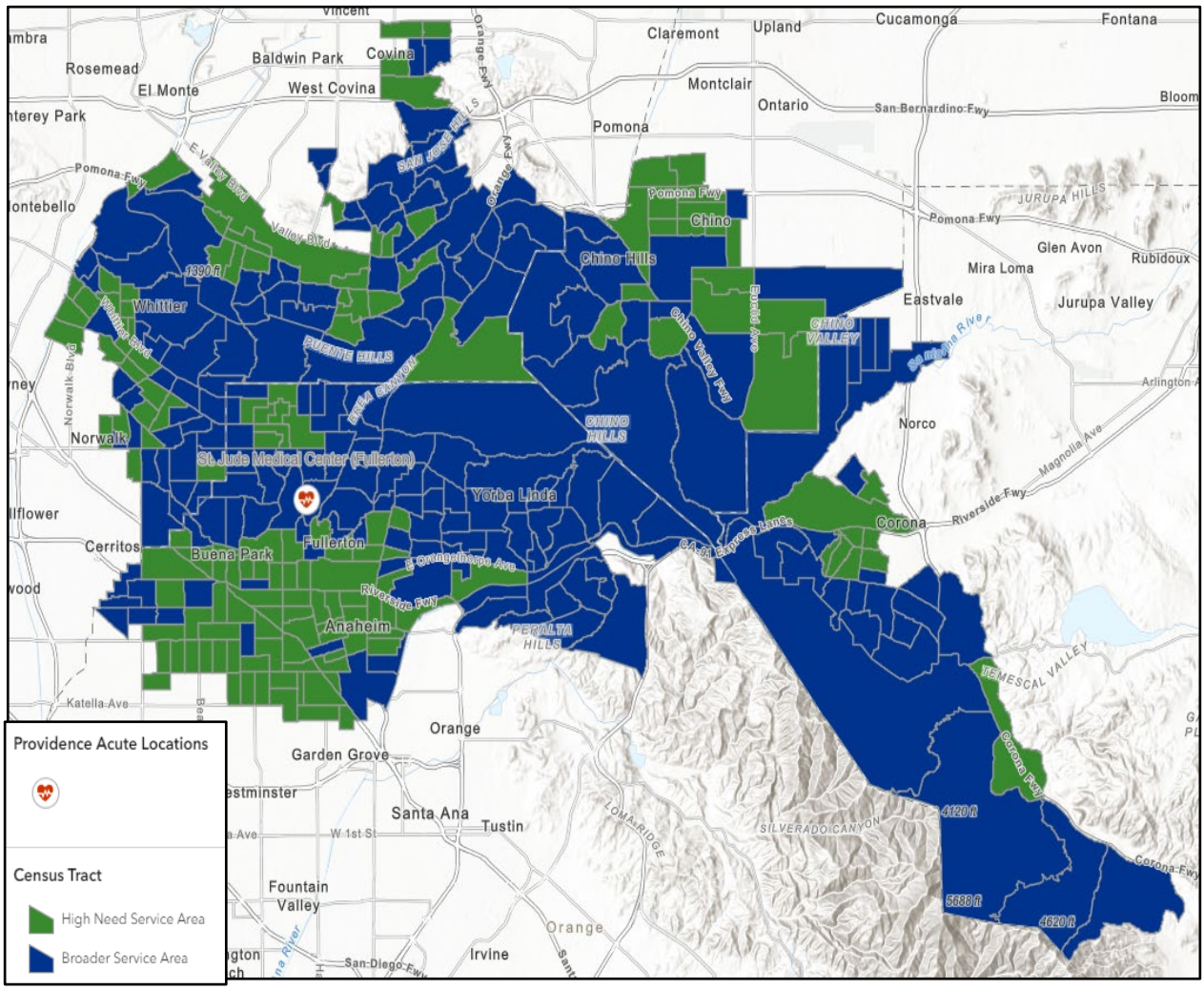
The CHNA service area was determined by first reviewing ZIP Codes corresponding to inpatient discharges and then filling in any gaps in service area that occurred to ensure coverage of the entirety of Orange County. St. Jude Medical Center's service area includes 327 census tracts based upon geographic access, other nearby hospitals, and ZIP Codes corresponding to inpatient discharges. Census tracts that overlapped with the ZIP Codes in Table 17 were used to define the service area. St. Jude Medical Center's Community Benefit Committee determined it will focus its investments in the high need areas of Orange County because there are other non-profit hospitals serving the secondary areas outside of the county. Orange County cities include Anaheim, Buena Park, Brea, La Habra, Fullerton, Placentia, and Yorba Linda. Together, Mission Hospital, St. Joseph Hospital, and St. Jude Medical Center serve all of Orange County, as well as certain census tracts in Los Angeles, San Bernardino, and Riverside Counties.

[37] The following variables were used for the PNI analysis: Population below 200% the Federal Poverty Level (American Community Survey, 2021); Percent of population with at least a high school education (American Community Survey, 2021); Percent of population, ages 5 Years and older in Limited English Households (American Community Survey, 2021); Life expectancy at birth (estimates based on CDC, 2010 – 2015 data)

Table 17. Cities and ZIP Codes Included in Total Service Area - St. Jude Medical Center

Cities	ZIP Codes
Brea	92821, 92822, 92823, 92835, 92886
Diamond Bar	91765, 91789
Fullerton	90621, 90631, 92801, 92831, 92832, 92833, 92834, 92835, 92836, 92837, 92838
La Habra	90004, 90631, 90632 & 90633
La Mirada	90637, 90638, 90639
Placentia	92811, 92870, 92871
Rowland Heights	91748
Yorba Linda	92885, 92886, 92887
Anaheim	92801, 92802, 92803, 92804, 92805, 92806, 92807, 92808, 92809, 92812, 92814, 92815, 92816, 92817, 92825, 92831, 92850, 92868, 92870, 92880, 92887, 92899
Buena Park	90620, 90621, 90622, 90623, 90624, 92833
Chino	91708, 91710, 92880
Chino Hills	91708, 91709, 91765, 92880, 92887
Corona	92877, 92878, 92879, 92880, 92881, 92882, 92883
Hacienda Heights	91745
Walnut	91724, 91788, 91789, 91792
Whittier	90601, 90602, 90603, 90604, 90605, 90606, 90607, 90608, 90609

Figure 12. St. Jude Medical Center Service Area



POPULATION AND AGE DEMOGRAPHICS – ST. JUDE MEDICAL CENTER

Of the over 1,690,000 permanent residents in the total service area, 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 in the total service area. For reference, in 2021, 200% FPL is equivalent to an annual household income of $53,000 or less for a family of 4. These households are more likely to regularly make spending tradeoffs regarding utilities, rent, groceries, medicine, and other basic expenses. The population in St. Jude Medical Center's total service area makes up 53% of Orange County.

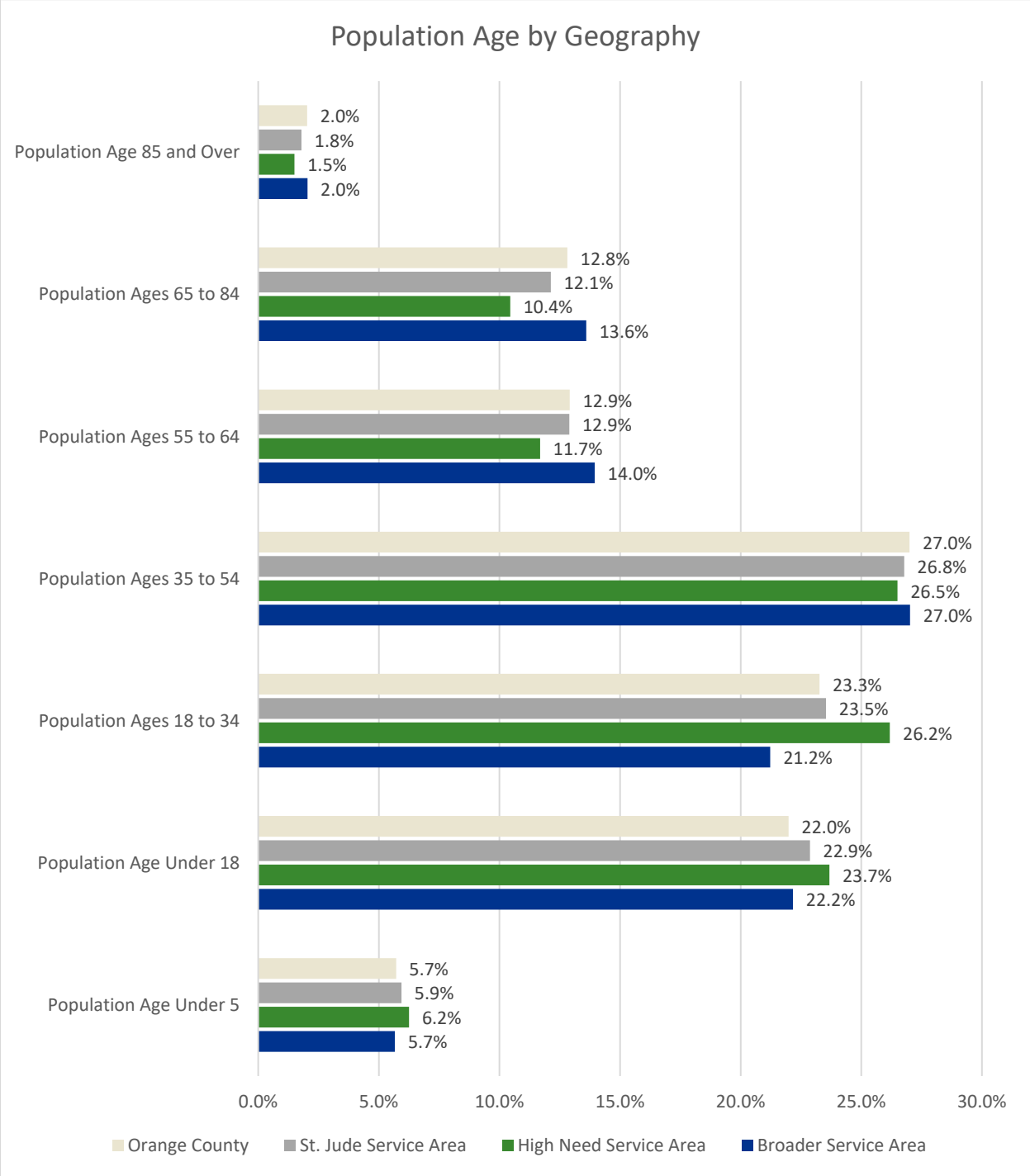
The male-to-female distribution is roughly equal across geographies. Individuals under the age of 35 are more likely to live in high need census tracts.

Table 18. Population Demographics for St. Jude Medical Center Service Area and Orange County

Indicator	St. Jude Medical Center Service Area	Broader Service Area	High Need Service Area	Orange County
Total Population	1,690,479	901,553	788,926	3,182,923
Female Population	50.4%	50.8%	50.0%	50.4%
Male Population	49.6%	49.2%	50.0%	49.6%

Source: American Community Survey, 2021 5-Year Estimate

Figure 13. Age Groups by Geography for St. Jude Medical Center

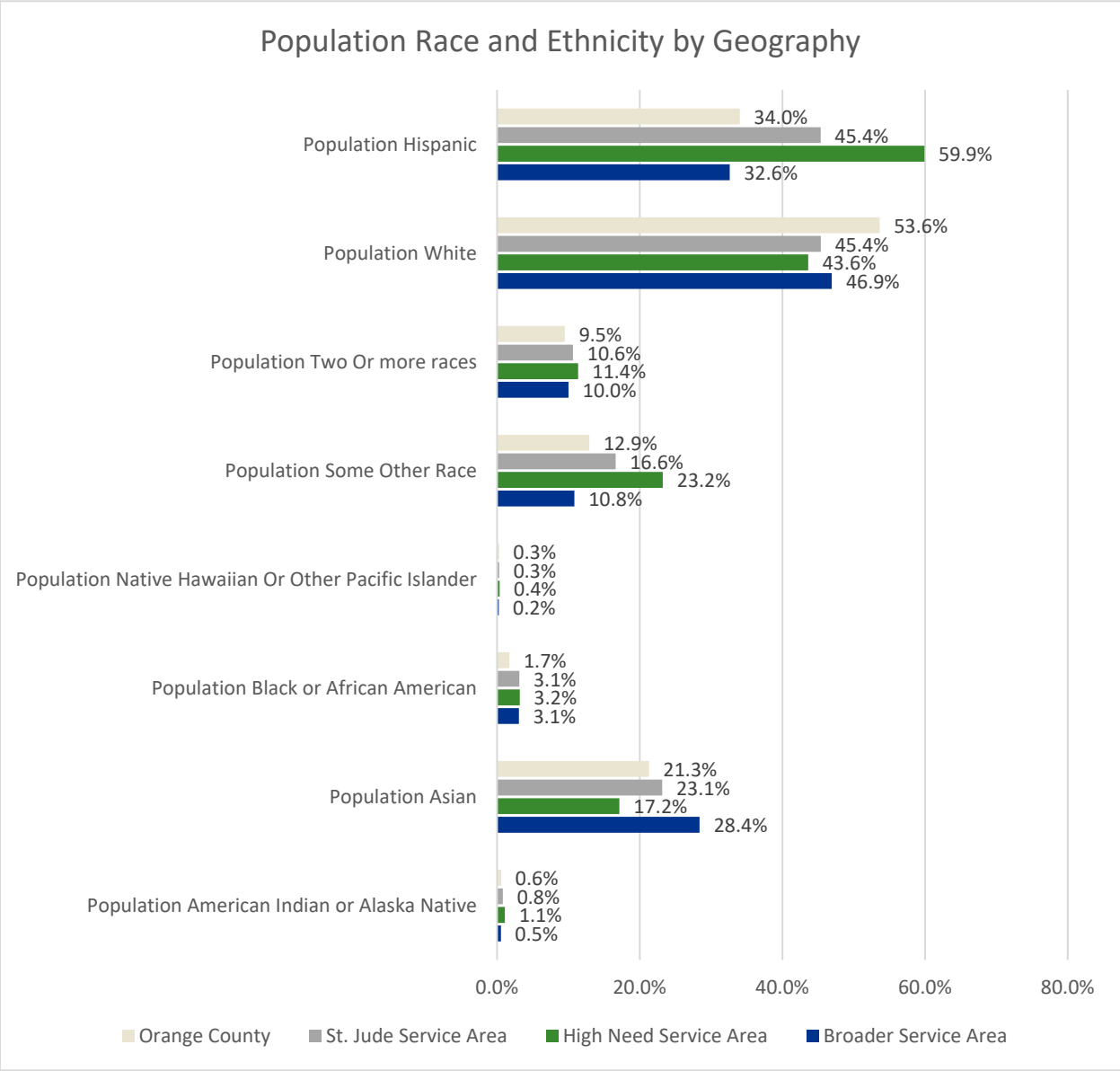


Source: 2021 American Community Survey, 5-Year Estimate

POPULATION BY RACE AND ETHNICITY – ST. JUDE MEDICAL CENTER

In comparison to the St. Jude service area overall, the people identifying as Hispanic, two or more races, some other race, and American Indian or Alaska Native are overrepresented in the high need service area. People identifying as white and Asian are overrepresented in the broader service area.

Figure 14. Race and Ethnicity by Geography for St. Jude Medical Center Service Area

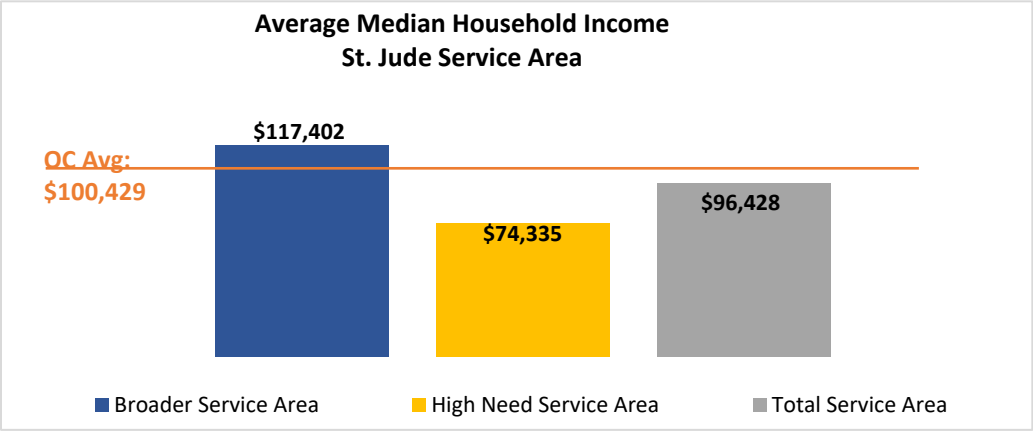


Source: 2021 American Community Survey, 5-Year Estimate

MEDIAN INCOME—ST. JUDE MEDICAL CENTER

The median income for the total service area for St. Jude Medical Center is slightly lower than Orange County overall. There is over a $43,000 difference in median income between St. Jude Medical Center Broader Service Area and the High Need Service Area.

Figure 15. 2021 Median Income for St. Jude Medical Center Service Area.

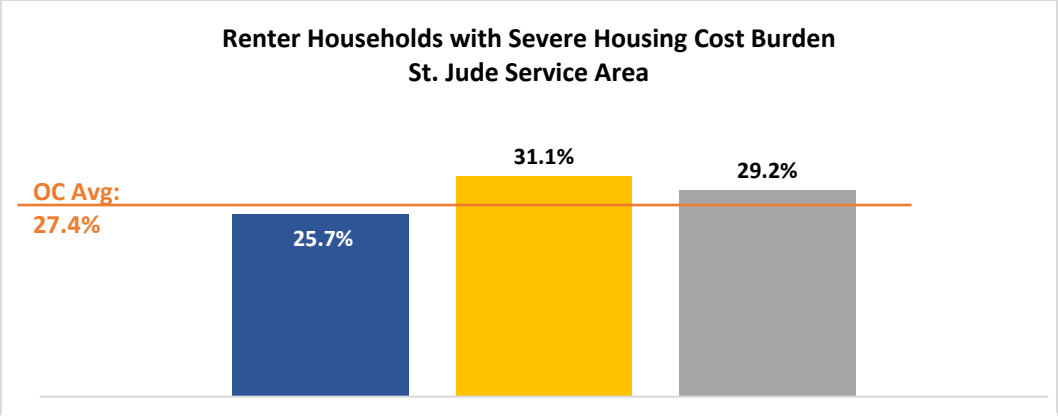


Source: 2021 American Community Survey, 5-Year Estimate

HOUSING COST BURDEN—ST. JUDE MEDICAL CENTER

Severe housing cost burden is defined as households that spend 50% or more of their income on housing costs. In the high need service area, 31.1% of renter households are severely housing cost burdened. Within the total service area there are census tracts in which over 50% of households are experiencing severe housing cost burden.

Figure 16. Percent of Renter Households with Severe Housing Cost Burden for St. Jude Medical Center Service Area.



Source: 2021 American Community Survey, 5-Year Estimate

HEALTH INDICATORS

Please refer to the St. Jude Medical Center CHNA Data Hub 2023 to review each of the following health indicators mapped at the census tract level: St. Jude CHNA Data Hub 2023.

The age ranges of individuals living in the St. Jude Medical Center service area is about the same as Orange County. St. Jude Medical Center service area has a higher percentage of Hispanic residents than in Orange County.

In addition, St. Jude Medical Center service area has a higher than Orange County average of uninsured and limited English-speaking households.

Hospital Utilization Data

In addition to public health surveillance data, our hospitals can provide timely information regarding access to care and disease burden across our service area. Avoidable Emergency Department (AED) use is reported as a percentage of all Emergency Department visits over a given period, which are identified based on an algorithm developed by Providence's Population Health Care Management team based on NYU and Medi-Cal's definitions. AED use serves as proxies for inadequate access to or engagement in primary care. We review and stratify utilization data by several factors including self-reported race and ethnicity, origin ZIP code, age, and sex. This detail helps us identify disparities to better improve our outreach and partnerships.

Across Providence's Orange County and High Desert service areas, St. Jude Medical Center had about the same avoidable emergency department visits as St. Joseph Hospital, 28.7% and 28.8%, respectively. In addition, our Avoidable Emergency Department (AED) data showed the following key insights:

- Patients self-identifying as Black/African American and American Indian or Alaska Native had the highest rate of AEDs, 32.5% and 30.4%, respectively.
- Patients self-identifying as Hispanic or Latino had AED rates higher than the St. Jude Medical Center average at 29.6% and made up 44.7% of all avoidable ED visits.
- Adults ages 40-64 years had the highest percentage of avoidable ED visits amongst other patient age groups at 29.9% and were the majority age group by volume at 31.5% of all avoidable visit.
- Patients self-identifying as female has an avoidable visit rate of 29.6% and make up 59% of total AED cases at St. Jude Medical Center.
- Nearly one-third of all AED cases at St. Jude Medical Center came from zip codes 90631, 92833, or 92832.
- 41.7% of avoidable visits and 55.3% of behavioral health ED visits were from patients with a primary payor of Medicaid (Medi-Cal)
- The most common diagnoses for all avoidable visits during this time were Urinary Tract Infections, Bronchitis and Other Upper Respiratory Disease, and Skin infections

SIGNIFICANT HEALTH NEEDS

Review of Primary and Secondary Data

After a careful review of the qualitative and quantitative data, we developed a preliminary list of identified community health needs. These needs were identified by key informant surveys and listening sessions.

Charitable Ventures reviewed the quantitative and qualitative data collected for each of the following community health-related needs:

1. Affordable housing
2. Behavioral health challenges and access to care (includes both mental health and substance use disorders)
3. Culturally and linguistically concordant services
4. Access to health services/access to care
5. Access to safe, reliable transportation
6. Lack of community involvement and engagement
7. Economic insecurity (lack of living wage jobs and unemployment)
8. Basic needs
9. Food insecurity
10. Homelessness
11. Access to dental care
12. Racism and discrimination
13. Domestic violence, child abuse/neglect

Affordable housing is a need identified by all hospitals and all datasets. For the St. Jude Medical Center service area, it is noted that affordable housing for caregivers is important.

For community members and key informants, mental health is a critical need. This includes the need for med-psych facilities and other care options.

Underlying all the needs in this service area is the need for services to be culturally and linguistically matched.

Related to access to care, as with other hospitals, the needs are primarily related to affordability; insurance coverage for the immigrant population; training and support to navigate the health care system (including the transition between pediatric and adult care for those living with disabilities, particularly); timely access to care – long waits in the emergency room; wait times for specialists; and a need for chronic disease management. For St. Jude Medical Center, transportation as a barrier to access, lack of access to specialty care, med-psych facilities, and lack of access to care at home (e.g., for older adults with comorbidities and high-risk OB patients) were highlighted.

Identification and Prioritization of Significant Health Needs

On September 20, 2023, the primary and secondary data findings were reviewed with members of a cross-sector group Community Health Committee along with members of Providence staff. They asked questions and engaged with the data. One member requested that Health Education be added as a top significant need, which it was. At the end of the review, Committee members were invited to choose their top three priority needs based on the five criteria below.

The following criteria were used in the prioritization process:

- Worsening trend over time
- Disproportionate impact on low income and/or Black/African American, Brown, Indigenous, and People of Color (BBIPOC) communities
- Providence service area/high need service area rates worse than state average and/or national benchmarks
- Opportunity to impact: organizational commitment, partnership, severity, and/or scale of need
- Alignment with existing System priorities

2023 Priority Needs

The list below summarizes the significant health needs identified through the 2023 Community Health Needs Assessment process.

ACCESS TO CARE

Primary and secondary data shows that access to health care is challenging and inequitable, which can lead to inequitable health outcomes. There is race/ethnic/linguistic inequity. Black/African American and Hispanic or Latino individuals have the highest rate of AEDs and Behavioral Health ED visits in the St. Jude Medical Center service area. To reduce racial/ethnic disparities, outreach and services should be culturally and linguistically responsive. This includes a representative workforce and high-quality, widely available medical interpretation, and materials. People identifying as LGBTQIA+ and people with disabilities may experience inequities in health care access as well. For many individuals, culturally and linguistically responsive health education is important to their ability to access care (e.g., when to access preventive services, urgent care, ED, how to manage chronic conditions, etc.). Bringing health education and health services to community where they are and partnering with trusted messenger community-based organizations is critical to community health as well. Transportation is an ongoing barrier to access.

BEHAVIORAL HEALTH (INCLUDING SUBSTANCE USE)

There is a need for more capacity (e.g., more facilities, providers, space, etc.) as well as mental health services that directly address the stigma of accessing mental health and substance use care, which varies by culture and community. Specific populations that were identified in listening sessions as needing

additional mental health support include older adults in isolation and assisted living facilities, parents/caregivers of children identifying as LGBTQIA+, and people who have experienced trauma, violence, and displacement.

HOMELESSNESS

A lack of affordable housing can contribute to homelessness. Community members shared that affordable housing, especially for larger and multi-generational families is a need. Hospital leaders note the importance of meeting the needs of those who are housing insecure and/or unhoused.

Alignment with Other Community Health Needs Assessments

To ensure alignment with local public health improvement processes and identified needs, we reviewed the needs of other publicly available sources that engaged the community in setting priorities, including the 2023-2028 priorities identified by the OC Health Care Agency Office of Population Health and Equity and the 2022 Hoag Memorial Hospital CHNA. These CHNA reports were reviewed to confirm alignment with government and non-profit organizations serving Orange County. The following table provides an overview of the priorities identified by the organizations. The St. Jude Medical Center CHNA is prioritizing three needs that are also among the top needs identified by the OC Health Care Agency Office of Population Health and Equity and by Hoag Memorial Hospital. These other entities have also identified other priorities, which while highly significant to St. Jude Medical Center, are not among the top three priority needs. St. Jude Medical Center, based on equity criteria and service area population has also identified populations of focus that align with some of the OC Health Care Agency Office of Population Health and Equity's priority populations. All areas of overlap are in bold in the table below.

Table 19. Alignment with Other Community Health Needs Assessments

OC Health Care Agency Office of Population Health and Equity Priorities 2023—2028	UCI Medical Center CHNA 2022	Hoag Memorial Hospital CHNA - 2022
Health Conditions: 1. **Mental Health** 2. **Substance Use** 3. Maternal / Fetal Health 4. Food Access / Nutrition 5. Oral Health Determinants of Health: 6. **Care Navigation** 7. **Language Access** 8. Data Access & Supports 9. Housing / Homeless 10. Food Access / Nutrition	1. **Access to health care** 2. Chronic diseases (Alzheimer's disease, asthma, cancer, diabetes, heart disease, liver, stroke) 3. COVID-19 4. **Housing and homelessness** 5. **Mental health** 6. Overweight and obesity 7. Preventive practices (vaccines and screenings) 8. **Substance use**	**1. Access to Health Care** **2. Behavioral and Mental Health** 3. Cancer/Chronic Disease 4. Community and Family Safety 5. COVID-19 / Contagious and Infectious Diseases 6. Economic and Financial Insecurity 7. Environment/ Climate Change **8. Housing and Homelessness**

Potential Resources Available to Address Significant Health Needs

Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. The organized health care delivery systems include the Department of Public Health and the Orange County Health Care Agency, Hoag Hospitals, AHMC Anaheim, Children's Hospital of Orange County, Kaiser Permanente Orange County, Orange Coast Medical Center, Prime Healthcare Services, Tenet Healthcare, and University of California, Irvine Medical Center in addition to Providence. There are numerous social service non-profit agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs. **See Appendix 3 for a full list of resources potentially available to address the significant health needs.**

EVALUATION OF 2021-2023 CHIP

The 2021 CHNA and 2021-2023 CHIP priorities were the following: Mental Health, Access to Care, Homelessness & Housing, and Health Equity and Racial Disparities. This report evaluates the impact of the 2021-2023 Community Health Improvement Plan (CHIP). St. Jude Medical Center responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices.

Table 20. Outcomes from 2021-2023 CHIP for St. Jude Medical Center

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Mental Health	BeWell OC	% reduction in ED visits for mental health and substance use	FY22: 7% reduction (2,382 ED Visits). FY23: Protocol and referral process established. BeWell mobile van open 7 days/wk. 8AM-8PM
Mental Health	MAT Program in Emergency Dept.	Provide Medical Assistance Treatment Program to patients with opioid disorder	Patients served: FY21: (baseline) 0 FY22: 839 FY23: 726
Mental Health	Promise to Talk, Stigma Reduction Campaign	Stigma reduction campaign using social media and in person events to increase awareness about mental health in the community, reduce stigma and provide low-cost resources	Encounters OC wide: FY21: 94,447 FY22: 73,220 FY23: 156,674 "Promise to Talk" promises made OC-wide: 2020 (baseline): 2,064 FY21: 2,715 FY22: 3,442 FY23: 2,997 Percent of surveyed residents who report finding the community 'caring / sympathetic' to people with mental illness: 2021: 79% 2022: 79% 2023: will be available in January 2024

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Mental Health	Work2BeWell Program	Partner with local High Schools to implement Work2BeWell curriculum	FY21: (baseline) postponed to 2021-2022 School Year due to COVID-19 FY22: N/A FY23: Postponed due to COVID-19. Follow up will occur with Fullerton Joint Union High School District
Access to Care	Ponderosa Park Site	Open a new site in high need area in Anaheim	# of encounters FY21: (baseline) Opened in Jan. 2022 FY22: 2,939 FY23: 8,536
Access to Care	Open Manchester Site	Open new site in high need area in Anaheim in partnership with Jamboree Housing Inc.	FY23: Site will open in early 2024
Access to Care	Virtual Clinic Visits	Integrate virtual visits into clinic operations to reduce barriers to care	% of virtual visits FY21: N/A FY22: 48% of visits FY23: 18% of visits
Homelessness/ Housing	Housing Champions	Train a minimum of 100 housing champions annually in Central Orange County cities	FY21: 151 housing champions FY22: 260 FY23: 807
Homelessness/ Housing	Resident engagement with Planning and City Council	Engage housing champions to promote stronger policies in the 2021-2028 Housing Element	FY21: 6 cities committed to conducting studies around inclusionary housing ordinances in their Housing Elements
Homelessness/ Housing	Affordable Housing Approval	Support approval of affordable housing projects	FY21: Two affordable housing projects totaling 80 units opened in north OC
Homelessness/ Housing	Homeless Navigation Program	Decrease the # of administrative/custodial days for homeless patient population	FY21: 49 days FY22: 13 days FY23: 566 days

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Health Equity/ Racial Disparities	Asian and Pacific Islander (API) Underserved Communities	Develop a plan to address one issue that is a priority for the API population	FY21: Meeting with API organizations to develop priority FY22: N/A FY23: Partnered with Korean Community Services to address substance use disorders

Addressing Identified Needs

The Community Health Improvement Plan developed for the St. Jude Medical Center service area will consider the prioritized health needs identified in this CHNA and develop strategies to address needs considering resources, community capacity, and core competencies. Those strategies will be documented in the CHIP, describing how St. Jude Medical Center plans to address the health needs. If the hospital does not intend to address a need or plans to have limited response to the identified need, the CHIP will explain why. The CHIP will not only describe the actions St. Jude Medical Center intends to take, but also the anticipated impact of these actions and the resources the hospital plans to commit to address the health need.

Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration between St. Jude Medical Center and community-based organizations in addressing the health need. The CHIP will be approved and made publicly available no later than May 15, 2024.

ST. JUDE MEDICAL CENTER—2023 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted by the Community Health Committee[38] of the hospital on November 15, 2023. The final report will be made widely available by December 28, 2023.

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LAURA RAMOS
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12/9/2023

Laura Ramos — Date
Hospital Chief Executive, St. Jude Medical Center
Providence

DocuSigned by:
Sister Mary Rogers
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12/11/2023

Sister Mary Rogers — Date
Chair, St. St. Jude Medical Center

DocuSigned by:
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12/9/2023

Kenya Beckmann — Date
Chief Philanthropy, Health Equity & Officer, South Division
Providence

CHNA/CHIP Contact:

Cecilia Bustamante Pixa, MPH, MHCML
Director, Community Health Investment
101 E. Valencia Mesa Drive, Fullerton, CA 92835
Cecilia.Bustamante-Pixa@stjoe.org

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[38] **See Appendix 4: St. Jude Medical Center Community Committee**

APPENDICES

Appendix 1A: Secondary Data - Community Report References

The following community reports provide more insight into the specific community needs of micro-communities and health needs that were elevated in this CHNA through community input and the key informant survey.

Table_Apx 1. Community Report References

Report Name	Article Link	Community Need Area
2019 Hoag Memorial Hospital Community Health Needs Assessment	https://issuu.com/advanceoc/docs/hoag_chna_2019	Overall Community Health Need
2019 Orange County Needs and Gaps Analysis	https://issuu.com/advanceoc/docs/107926	Overall Community Health Need
2020-2022 OC Health Improvement Plan	https://ochealthinfo.com/sites/healthcare/files/2022-11/OC%20Health%20Improvement%20Plan%202020-2022%20FINAL.pdf	Older Adults, Individuals with Disabilities
2021-2022 Beyond Equity: Seeking Liberation, Autonomy and Justice in Orange County	https://issuu.com/advanceoc/docs/oc-equity-report-2021.2022-final-final	AANHPI, Overall Equity
2022 County Health Profiles	https://issuu.com/advanceoc/docs/chsp2022_20220421	AANHPI, Black, Hispanic/Latino, Overall Health
2022 UCI Medical Center Community Health Needs Assessment	https://www.ucihealth.org/-/media/files/pdf/about/2022-community-health-needs-assessment.pdf?la=en	Overall Health Need
2023 OC Equity Map	https://issuu.com/advanceoc/docs/ochca-equitytoolmanual-english_210914_v5-3	Overall equity (health, language, gender, wellbeing, basic needs, housing)
An Equity Profile of Orange County	https://dornsife.usc.edu/assets/sites/242/docs/EP_Summary-Orange_County_15_final.pdf	AANHPI, Black, Hispanic/Latino
CalOptima: 2023 Report to the Community	2023 Report to the Community (ca.gov)	Overall Health Need

CAP OC2024 - 2025 Community Needs Assessment and Community Action Plan	2024-2025 CNA and CAP.pdf (capriverside.org)	Overall Health Need
CHOC: 2022 Community Health Needs Assessment	https://www.choc.org/files/CHOC-CHNA-Report.pdf	Overall Health Need
Conditions of Children in Orange County	https://www.ssa.ocgov.com/sites/ssa/files/2022-12/2022_12_6_COCR_.pdf	Child Needs, AANHPI, Black, Hispanic/Latino
First 5 OC: 2022-2023 OC Community Indicators	https://first5oc.org/wp-content/uploads/2022/10/FINAL_DIGITAL_CommunityIndicators22-Reduced.pdf	Hispanic/Latinos, AANHPI, Overall Health Need
Kaiser Permanente: 2022 Community Health Needs Assessment	2022 Community Health Needs Assessment (www.kaiserpermanente.org)	Overall Health Need
Orange County Community Indicators Report	https://ocbc.org/research/community-indicators-project/	Overall Health Need
The State of Orange County: An Analysis of Orange County's Policies on Immigration and a Blueprint for an Immigrant Inclusive Future	https://resilienceoc.org/wp-content/uploads/2019/01/State-of-OC-Report.pdf	Immigration, ANHPI, Hispanic/Latinos, Black

Appendix 1B: Summaries of Selected Regional Community Health Reports

HEALTHCARE PROVIDERS AND AGENCY REPORTS

CalOptima Health: 2023 Report to the Community

The Cal Optima Health: 2023 Report to the Community highlights the organizational and community achievements in 2022 and identifies four primary health focus areas: 1) Homeless Health, 2) Health Networks, 3) Quality Measures and 4) Cal Fresh. In 2022, CalOptima Health identified "Housing is health, and improving care for members experiencing homelessness" as a strategic priority, allocating $100 million dollars to the homeless health reserve. The focused area of growth within Homeless Health is implementing new technologies to ensure continuity of coverage with added benefits. CalOptima expanded its Health Networks in 2022 to promote member choice and engagement which in turn improves outcomes. There will be a continued focus on expanding and improving partners' experience including quicker claim payments, increased education, and expanded opportunities.

In 2021, Cal Optima Health had 5 quality measures that were above the national 90th percentile – Controlling Blood Pressure, Diabetes Adequate Control, Diabetes Eye Exam, Statin Therapy for Patients with Diabetes, and Immunizations for adolescents. CalOptima Health looks to make future quality measure gains through new specialty care programs, financial incentives, research, and advocacy with a focus on transplant care, addressing health disparities, conducting a needs assessment, and initiating Pay for Value Programs. Cal Optima Health launched a CalFresh campaign in 2022 to promote program awareness and enrollment. CalOptima Health intends to strengthen mental health services and deepen community connections by working with new and different partners and focusing on School-Based Mental Health. For more information, the full CalOptima Health: 2023 Report to the Community can be found here.

2022 UCI Medical Center Community Health Needs Assessment

In 2022, UCI Medical Center (UCIMC) conducted a Community Health Needs Assessment (CHNA), which is completed every three years to develop an Implementation Strategy in response to community needs. The 2022 UCIMC CHNA employed a review of secondary data as well as 14 key informant interviews, which included a broad range of stakeholders concerned with health and wellbeing in Orange County who spoke to issues and needs in the communities served by the hospital. Significant needs were initially identified through the review of secondary health data and validated through stakeholder interviews. The identified significant needs included: 1) Mental health, 2) Access to health care, 3) Chronic diseases (Alzheimer's disease, asthma, cancer, diabetes, heart disease, liver, stroke), 4) Housing and homelessness, 5) Preventive practices (vaccines and screenings), 6) Overweight and obesity, 7) COVID-19, and 8) Substance use. Click here to view the full UCIMC CHNA report.

Children's Hospital Orange County (CHOC): 2022 Community Health Needs Assessment

The purpose of the CHOC: 2022 Community Health Needs Assessment (CHNA) is to identify community health assets and issues, determine and monitor the population's overall health, and assist CHOC's Board of Directors and leadership team in setting priorities and allocating resources for 2022-2024. CHOC's CHNA identified two priority health issues – 1) Mental Health and 2) Access to Care.

CHOC's CHNA approach compared the qualitative data obtained from the community engagement against the quantitative data which included health status, quality of life and risk factors to identify priority areas for population health improvement. The methodology for community engagement included a countywide survey with 1,248 respondents, a community meeting, 3 Focus groups, and 12 key informant interviews. For more information on the 2022 CHOC CHNA, click here.

2022 Hoag Community Health Needs Assessment

The 2022 Hoag Community Health Needs Assessment (CHNA) builds upon earlier assessments, distills new qualitative and quantitative research, prioritizes local health needs, and identifies areas for improvement. Community health needs were identified by synthesizing primary qualitative research data and secondary data and filtering those needs against a set of criteria. Hoag identified 8 health needs, listed in alphabetical order. 1) Access to Health Care 2) Behavioral and Mental Health 3) Cancer/Chronic Disease 4) Community and Family Safety 5) COVID-19 / Contagious and Infectious Diseases 6) Economic and Financial Insecurity 7) Environment/ Climate Change 8) Housing and Homelessness. To access the complete 2022 Hoag Community Health Needs Assessment, click here.

2022 Orange County Health Profile, California Department of Public Health

The Orange County Health Status Profile reports data on selected public health indicators chosen in collaboration with local health officers and epidemiologists. This annual report provides California and county age-adjusted rates, crude rates, or percentages for mortality, infant mortality, morbidity conditions, and other public health related categories. The report also provides a comparison of current period to previous period rates and percentages for California and the counties.

The 2022 Orange County Health Profile reported the following improvements compared to the previous 3-year period: there has been an overall decrease in lung cancer mortality rate, chronic lower respiratory disease mortality rate and births to adolescent mother ages of 15 to 19. An increase in age-related adjusted death rates were reported for deaths due to accidents or unintentional injuries and drug induced deaths. Data also indicates an increase in rates of measured sexually transmitted infections including rate of individuals living with HIV/AIDS, new cases of chlamydia, new cases of gonorrhea among females and males 15 to 44 years old, new cases of congenital syphilis, and new cases of primary and secondary syphilis. Finally, the California birth cohort infant mortality death rate for all races/ethnicities averaged 3.9 per 1,000 live births; infant mortality death rates for Blacks were disparately higher at 7.6 infant deaths per 1,000 live births. Click here for the full report.

2020-2022 Orange County Health Improvement Plan, Orange County Health Care Agency

The 2020-22 Orange County Health Improvement Plan (HIP) was informed by a year-long community health assessment that found that while Orange County's health, as a whole, continues to fare well compared to other areas, there are some troubling trends and disparities that impact our communities. The HIP identified that improving health in Orange County requires a close look at the conditions that create health inequities. To that end, two of the six focus areas in this plan address overall system issues: Social Determinants of Health and Access and System Navigation. The remaining four areas highlight health topics identified as the most pressing to work on in the next three years: Health Promotion and Disease Prevention; Mental Health and Substance Use; Older Adult Health; and Sexual Health. Click here for the full report.

COMMUNITY BASED ORGANIZATIONS AND COMMUNITY PARTNER REPORTS

An Equity Profile of Orange County – USC Dornsife, 2019

Like much of California, Orange County experienced demographic change ahead of national shifts and will continue to do so through at least 2050. Today Orange County is the 18th most diverse region among the 150 largest regions in the country with about 58 percent residents of color. In addition, 70 percent of Orange County's youth (under age 18) are people of color, compared with only 36 percent of the region's seniors (age 65 and older); however racial and economic inequalities persist. This profile draws from a unique Equitable Growth Indicators Database developed by PolicyLink and PERE. This database incorporates hundreds of data points from public and private data sources, such as the U.S. Census Bureau, the U.S. Bureau of Labor Statistics, and Woods & Poole Economics, Inc.

Eleven Steps to Equity for Orange County were identified were: 1) Commit to reducing disparities and improving outcomes for all in Orange County; 2) use data for cross-sector dialogue; 3) link inclusion with innovation; 3) invest in early childhood education and other early interventions; 4) ensure affordable housing for all; 5) embed and operationalize a prevention- oriented approach to advance health equity; 6) promote immigrant integration; 7) build civic health among underrepresented voices; 9) build a culture in which racial equity is discussed and is a shared goal; 10) Partner with peer regions pursuing similar goals; 11) develop a regional equity strategy, indicators of progress, and a data system for measuring progress. An Equity Profile of Orange County is available here.

Conditions of Children in Orange County, 2022

The 2022 Conditions of Children in Orange County studies four interdependent focus areas: Good Health, Economic Well-Being, Educational Achievement and Safe Homes and Communities. Each focus area includes the most recent data for indicators to assess improving or worsening trends over 10 years.

COVID continues to impact children, families, and the data sources utilized in the report. The rate of uninsured children continued to decline, while early prenatal care hit a 10-year high and breastfeeding rates remained steady. The child poverty rate fell, as did the percentage of children receiving CalWORKs and CalFresh. The high school dropout rate hit a 10-year low, while college readiness hit a 10-year high.

The juvenile arrest rate continued a decade-long decline, as did juvenile sustained petitions. The report's population-level data and subgroup data continue to bring the disparities more clearly into view – revealing both the progress being made and struggles experienced among children and youth particularly as it relates to socioeconomic status. The 28th Conditions of Children in Orange County report can be found here.

Orange County 2022-2023 Community Indicators

The OC Community Indicators Report is developed in collaboration with CalOptima Health, Orange County Community Foundation, First 5 Orange County, and Orange County United Way, and examines Orange Conty in terms of education, infrastructure, health, income and the economy. Orange County demographics continue to shift – the numbers of Asian, Latino, and African American residents have all increased, while the number of White residents has declined since 2010; and older residents over the age of 65 are the only segment expected to see population growth from 2022 to 2060.

Notably in 2022, there has been an overnight transformation of Orange County education at every level from kindergarten to graduate school; graduation rates have also increased, and high school dropout rates have decreased. Since 2012, home prices have more than doubled, only 29% of first-time home buyers can afford an entry level home in 2022 versus 41% in 2020. Low-income residents struggle the most with Orange County's high cost of living and home ownership rates are disparate amongst race/ethnicities; significant additional efforts need to be made to increase housing equity in the region. The proportion of Orange County residents lacking health insurance continued to decline in 2020 while Orange County deaths related to diabetes and strokes increased. However, there were some positive developments, as deaths related to heart disease declined and deaths related to chronic lower respiratory disease. For more information on the 2022-2023 Community Indicators, click here for the report in its entirety.

2019 The State of Orange County: Analysis of OC's Policies on Immigration and a Blueprint for an Immigrant Inclusive Future

Orange County is home to almost 3.2 million residents. Today, nearly one third of Orange County's residents are immigrants and the county's foreign- to- born population is the fourth largest in the country. In this report, the Immigrant Legal Resource Center, Resilience Orange County, and the UC Irvine School of Law Immigrant Rights Clinic provide a window into the state of Orange County's immigration policies, their impact on residents and the considerations and values that ought to guide a vision for a new Orange County. The Report offers a first look at data obtained through Public Records Act requests from the Orange County Sheriff's Department (OCSD) and ICE. It concludes with 20 questions that ought to inform any discussion going forward about immigration policy in the sixth most populous county in the nation. The report concludes with A Blueprint for the Future which includes Transparency and Honest Engagement, Public Safety and Community Trust, Fiscal Responsibility and Future Prosperity. The report in its entirety can be found here.

Appendix 2: Community Input

METHODOLOGY

Listening Session Participants

The hospital completed 8 listening sessions that included a total of 66 participants. The sessions took place between July and August 2023.

Table_Apx 2. Listening Session Participants and Details

Community Input Type	Micro-community/ Population	Outreach Partner	Facilitation Partners	Venue	Date	Language
Listening Session	Disabled	Illumination Institute	Charitable Ventures	Online	July 24, 2023	English
Listening Session	LGBTQIA+	LGBTQ Center OC	LGBTQ Center OC/Charitable Ventures	LGBTQ Center OC	July 26, 2023	English
Listening Session	Korean	Korean Community Services (KCS)	Korean Community Services (KCS)/Charitable Ventures	KCS	July 26, 2023	Korean
Listening Session	Vietnamese	Vital Access Care Foundation (VACF)	Vital Access Care Foundation (VACF)/Charitable Ventures	VACF	August 1, 2023	Vietnamese
Listening Session	Older Adults	Orange County Aging Services Collaborative	Charitable Ventures	Online	August 2, 2023	English
Listening Session	South OC (Spanish)	UNIDOS South OC	UNIDOS South OC/Charitable Ventures	CHEC FRC	August 3, 2023	Spanish
Listening Session	AANHPI	CV via AANHPI Population Health Collective	Charitable Ventures	Online	August 4, 2023	English
Listening Session	Black/African American	HEAL Collective	HEAL Collective/Charitable Ventures	Online	August 9, 2023	English

Key Informant Survey

Providence, in partnership with Charitable Ventures, distributed a survey by email to over 3,000 potential key informants, and 70 responses were received. The survey was in the field for three weeks in August 2023.

The goal was to engage representatives from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. The hospital included members of the Office of Population Health and Equity of the Orange County Health Care Agency to ensure the input from regional governmental public health department.

Table_Apx 3. Key Informant Survey Respondents

Organization	Name	Title	Sector or Target Population
3B Wellness	Maurina Lee	Director	Health Care
America On Track	Claire Braeburn	Executive Director	Youth
Anaheim Elementary School District	Mary Grace	Assistant Superintendent Education Services	School District
Anaheim Lighthouse	Tamara Jimenez	Community Relations Manager	Behavioral Health – Substance Use
Big Brothers Big Sisters	Keith Mataya	VP of Impact and Research	Youth
Boys & Girls Club of Laguna Beach - also serving Saddleback area	Pamela Estes	CEO	Youth
Boys & Girls Clubs of Capistrano Valley	Nicole Watson	Associate Executive Director	Youth
Boys & Girls Clubs of Garden Grove	Christina Sepulveda	VP Community Impact	Youth
Brain Rehabilitation and Injury Network	Joan Jensen	Board Treasurer	Non-profit
Brea Police Department	Adam Hawley	Chief of Police	Law Enforcement
CalOptima Health	Jordan Abushawish	Sr. Director Government Affairs	Health Care
CIELO (Community for Innovation, Entrepreneurship, Leadership, & Opportunities)	Iosefa Alofaituli	Executive Director & Co-Founder	Income Stability

Organization	Name	Title	Sector or Target Population
City of Buena Park	Jim Box	Director of Community Services	City
*Community Action Partnership of Orange County	Hiram Rodriguez	Diaper Bank Manager	Low-Income
CommunityHealthComm	John Ralls, DrPH	Director	Consultant
*Council on Aging - Southern California	Lisa Jenkins	President & CEO	Older Adults
County of Orange Social Services Agency	Jaime Muñoz	Senior Human Services Manager	Government
Capistrano Unified School District	Aurea Mandujano	Special Program Liaison	School District
Dayle McIntosh Center	Beck Levin	Systems Change Advocate	Individuals with Disabilities
Encore Presentation	Tahera Christy	Founder and Creative Director	Homeless
FAM (Family Assistance Ministries)	Paula Neal Reza	Director of Client Services	Homeless
*Families Forward	Madelynn Hirneise	CEO	Homeless
Friendship Shelter	Dawn Price	CEO/Executive Director	Homeless
Fullerton Collaborative	Dr. Debra Stout	Executive Director	Housing, Health, Education, Older Adults
Fullerton School District	Rossana Fonseca	Director, SEL and Family Supports	School District
*Good Hands Foundation	James Cho	CEO	AANHPI + Older Adults
Higher Ground Youth & Family Services	Christine Sanchez	Director of Mission Advancement	Youth
Holistic Acupuncture for a Better Life	Brian	Owner	Health Care
HOPE Center of Orange County	Kellee Fritzal	Executive Director	Faith Based

Organization	Name	Title	Sector or Target Population
*Hope Community Services	Annie Phan	Program Manager	AANHPI
Jamboree Housing	George Searcy	CIO	Housing
Korean Community Services	Ellen Ahn	Executive Director	AANHPI + FQHC
*Laguna Beach Seniors at the Susi Q	Martha Hernandez	Director of Care Management	Older Adults
Laguna Food Pantry	Anne Belyea	Executive Director	Food Insecurity
Lestonnac Free Clinic	Ed Gerber	Executive Director	Health Care
LGBTQ Center OC	Peg Corley	Executive Director	LGBTQIA+
Mission Hospital: CHEC Family Resource Center	Hilda Santana Heredia	Supervisor Community Services	Health Care
Moving Forward Psychological Institute, Inc	Paul Hoang, LCSW	President & CEO	Mental Health
*OC Health Care Agency	Amy Castro	Research Analyst IV	Health Care
*OC United	Amy Gaw	Director of Programs	Youth
Orange County Communities Organized for Responsible Development (OCCORD)	Ely Flores	Executive Director	Equity
Orange County Grantmakers	Taryn Palumbo	Executive Director	Funder
Orange County United Way	Susan Parks	CEO	Housing/Homelessness, Youth
Our Lady of Guadalupe Church	Scott Miller	Business Manager	Faith Based
People for Housing OC	Elizabeth Hansburg	Cofounder & Director	Housing
Planned Parenthood of Orange and San Bernardino Counties	Janet Jacobson, MD	Senior Vice President of Clinical Services & Medical Director	Health Care
*Providence Mission Hospital Trauma Center	Georgi Mercado	Trauma Injury Prevention Coordinator	Health Care

Organization	Name	Title	Sector or Target Population
*Saddleback College	Israel Dominguez	Director, Economic & Workforce Development	School District
Santa Ana Active Streets	Kristopher Fortin	Project Director	Transportation
Santa Ana Early Learning Initiative (SAELI)	Stephanie Soto Lara	Project Director	Youth + Education
Second Baptist Church	Kelita Gardner	Executive Director of Operations	Faith Based
Sisters of St. Joseph of Orange	Barry Ross	Executive Director, Justice Partnerships	St. Joseph Hospital
SoulRapha	Francis Marzec	Chief Operating Officer	Older Adults
*St. Jude Neighborhood Health Centers	Timothy J. Brown	Chief Executive Officer	St. Jude Medical Center
Start Well	Sandy Avzaradel	Director	Youth
The Kennedy Commission	Cesar Covarrubias	Executive Director	Housing
*Unidos South OC	Heather Chapman	Co-Executive Director	Latinx
Unlimited Possibilities (UP)	Christina D. Garkovich, CFRE	VP, Philanthropy & Marketing	Individuals with Disabilities
Urban Social Services and Advocacy	Tatiana Turner	CEO	Re-Entry
Wellness & Prevention Center	Susan Parmelee, LCSW	Executive Director	Health Care
Western Youth Services	Lorry Leigh Belhumeur	CEO	Youth
*YMCA of Orange County	Lee Lombardo	Associate Executive Director, Y Community Services	Youth

*Those with asterisks represent organizations/agencies for which more than one participant responded. To maintain equal representation, only one response was included in the final analysis. Additionally, six

respondents requested not to be named and thus, their information is not cited here, but their responses are included in the analyzed data anonymously.

Facilitation Guides

For the listening sessions, participants were asked an icebreaker and three questions:

- Community members' definitions of health and well-being
- The community needs
- The community strengths

For the key informant survey, Providence and Charitable Ventures developed a survey that gleaned ample quantitative and qualitative insights from key informants from multiple sectors. The survey included questions about:

- The community served by the key informant's organization
- Prioritization and discussion of unmet health related needs in the community, including social determinants of health
- Suggestions for how to leverage community strengths to address community needs
- Successful community health initiatives and programs
- Opportunities for collaboration between organizations to address health equity

Training

The facilitation guides provided instructions on how to conduct a key informant interview and listening session, including basic language on framing the purpose of the sessions. Charitable Ventures worked with Community Based Organization partners who participated in facilitating in-language focus groups.

Data Collection

Listening sessions were held in person and virtually. Notes were taken by co-facilitators. The key informant survey was distributed via email and responses were collected via Survey Monkey.

Analysis

Qualitative data analysis was conducted by Charitable Ventures. For listening sessions, the analyst coded dominant categories within three domains related to the topics of the questions: 1) vision, 2) needs, and 3) strengths by geography as well as by micro-community. The analyst determined the frequency each category was applied to the dataset, highlighting which codes were mentioned most frequently. Codes for unmet health-related needs were cross-referenced with the domains to better understand the populations most affected by a certain unmet health-related need. The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together.

As for the key informant survey, the analyst categorized unmet health needs in order of greatest to least average Likert-scale ranking by geography. The analyst also organized qualitative responses in categories of additional detail, ideas for collaboration between community and Providence, and ideas for advancing equity.

Significant needs were defined by cross referencing top needs from both datasets and presenting the needs in order of significance – highest needs for key informants and residents being presented first and needs reported only by key informants coming at the end of the list.

Limitations

While key informants and listening sessions participants were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a key informant. Multiple interviewers may affect the consistency in how the questions were asked. Multiple note-takers may affect the consistency and quality of notes across the different sessions.

Some listening sessions were conducted virtually, which may have created barriers for some people to participate. Virtual sessions can also make facilitating conversation between participants more challenging.

Each dataset was analyzed with collaboration of at least three analysts. However, one analyst was lead, and therefore some level of their own subjectivity or bias is possible.

Appendix 3: Community Resources Available to Address Significant Health Needs

Mission Hospital cannot address all the significant community health needs by working alone. Improving community health requires collaboration across community stakeholders and with community engagement. Below outlines a list of community resources potentially available to address identified community needs.

Table_Apx 4. Community Resources Available to Address Significant Health Needs - Mission Hospital

Significant Health Need Addressed	**Organization or Program Addressing Significant Health Need**
Access to care (generally)	Camino Health Center, Laguna Beach Community Clinic, Coalition of Community Health Centers; Community Health Initiative of Orange County, OC HCA
Behavioral Health and Substance Use	Camino Health Center; CHEC Family Resource Center; Child Guidance Center; Mariposa Women's Center; Omid Multicultural Institute for Development; Seneca Family of Agencies; South Orange County Family Resource Center; Wellness and Prevention Center; Wellness Center; Western Youth Services; AA Meetings; Friendship Shelter, Be Well Orange County, OC HCA, Start Well

Culturally and linguistically concordant services	LGTBQ Center OC, Vital Access Care Foundation (Vietnamese), Korean Community Services (KCS), OMID Multicultural Institute for Development (Farsi, Arabic), Latino Health Access, UNIDOs South OC, CHIRLA, OC Herald Center, Good Hands Foundation
Isolation	LGTBQ Center OC, Vital Access Care Foundation (Vietnamese), Korean Community Services (KCS), OMID Multicultural Institute for Development (Farsi, Arabic), CHEC Family Resource Center; Catholic Charities; Diocese of Orange County; Saddleback College Adult Education; South Orange County Family Resource Center, Dayle McIntosh Center, Illumination Institute, OC Access, Unlimited Possibilities.
Housing	Families Forward; Family Assistance Ministries; South County Outreach, Alternatives Sleeping Location (ASL Homeless Shelter); Camino Health Center; Friendship Shelter; Helping Hands Worldwide; Henderson House; Laguna Beach Community Clinic; Laguna Resource Center; Our Fathers Table; South Orange County Taskforce on Homelessness, Family Solutions Collaborative, Orange County United Way, People for Housing OC, SVUSD McKinney Vento Community Liaison
Access to safe, reliable, affordable transportation	OC Access, 211 Orange County, OCTA, Age Well Senior Services
Economic insecurity	Families Forward; Family Assistance Ministry; Helping Hands Worldwide; Laguna Resource Center; South County Outreach; South Orange County Family Resource Center, OC SSA, CIELO, Community Action Partnership OC
Access to dental care	Healthy Smiles, Camino Health Clinic
Aging concerns and issues	Community and Senior Centers, Alzheimer's Orange County, Alzheimer's Association of Orange County, Healthy Aging Center: Laguna Woods (formerly known as South County Adult Day Services), Irvine Adult Day Health Center, Council on Aging, Laguna Beach Seniors at the Susi Q.
Food insecurity	CHEC Family Resource Center; Families Forward; Family Assistance Ministry; Helping Hands Worldwide; Laguna Beach Community Clinic; Laguna Food Pantry; Laguna Resource Center; Mission Basilica; Our Fathers Table; South County Outreach; South Orange County Family Resource Center, Women, Infant & Children's Clinic (WIC)

Domestic violence, child abuse/neglect	CHEC Family Resource Center; South Orange County Family Resource Center; Boys & Girls Club Chapters; CREER, San Juan Capistrano; Capistrano Unified School District; CHEC Family Resource Center; Families Forward; Saddleback College Adult Education; Saddleback Valley Unified School District; South County Outreach; South Orange County Family Resource Center

St. Joseph Hospital cannot address all the significant community health needs by working alone. Improving community health requires collaboration across community stakeholders and with community engagement. Below outlines a list of community resources potentially available to address identified community needs.

Table_Apx 5. Community Resources Available to Address Significant Health Needs – St. Joseph Hospital

Significant Health Need Addressed	**Organization or Program Addressing Significant Health Need**
Behavioral health and substance use	Mariposa Women's Center; Seneca Family of Agencies; Western Youth Services, The Gary Center Substance Abuse Counseling System, Recovery Road, Families and Communities Together (FaCT) Family Resource Centers, Be Well Orange County, Moving Forward Psychological Institute, Start Well
Affordable Housing	Kennedy Commission; NeighborWorks; Habitat for Humanity; Mercy House; Jamboree Housing; YIMBY, Illumination Foundation, Families Forward, Family Solutions Collaborative, Orange County United Way, People for Housing OC
Culturally and linguistically concordant services	LGTBQ Center OC, Vital Access Care Foundation (Vietnamese), Korean Community Services (KCS), OMID Multicultural Institute for Development (Farsi, Arabic), Latino Health Access, CHIRLA, The Cambodian Family, Hope Community Services, Good Hands Foundation
Access to health services/access to care	AltaMed Medical & Dental Group, Central City Community Health Center, UCI Family Health Center, Benevolence Health Centers, Anaheim – Benevolence Health Center, KCS Health Center, Lestonnac Free Clinic, Hope Clinic, SOS Community Health Center, Sierra Health Center, AltaMed Medical Group, Central City Community Health Center, CHOC Clinic, Nhan Hoa Comprehensive Health Center, SOS & Peace Center Health Clinic, The Center for Comprehensive Care & Diagnosis of Inherited Blood Disorders, CHOC at the Boys and Girls Club of Santa Ana, Clínica CHOC Para Niños, Hurtt Family Health Clinic, Serve The People Community Health Center, SOS-EL SOL

	Wellness Center, UCI Family Health Center, Central City Community Health Center, Livingston Free Clinic, Families Together of Orange County, Friends of Family Health Center, VNCOC Asian Health Care, Planned Parenthood O&SB – Orange, Planned Parenthood O&SB – Costa Mesa, Planned Parenthood O&SB – Santa Ana, Planned Parenthood O&SB – Anaheim, Planned Parenthood O&SB – Westminster AHMC Anaheim Regional Medical Center, Fairview Developmental Center, Hoag Orthopedic Institute, Norooz Clinic Foundation, OC HCA, Pacific Clinics
Lack of community involvement and engagement	Santa Ana Early Learning Initiative, Community Action Partnership of Orange County, Latino Health Access
Access to safe, reliable, affordable transportation	OC Access, 211 Orange County, OCTA, Santa Ana Active Streets
Economic security (lack of living wage jobs and unemployment)	Community Access Partnership Orange County, Taller San Jose: Hope Builders, CAPOC, One Stop, CIELO, OC SSA
Food insecurity	Second Harvest, Abound, Bracken's Kitchen.
Basic needs	Families and Communities Together (FaCT) Family Resource Centers
Homelessness	Family Solutions Collaborative, Mercy House Shelter, Orange County United Way
Access to dental care	Healthy Smiles, West Coast Dental Hygiene Clinic, AltaMed Medical & Dental Group
Racism and discrimination	Groundswell
Aging concerns and issues (e.g., cognitive decline /dementia, mobility, etc.)	Alzheimer's Orange County, Alzheimer's Association of Orange County, Council on Aging, Meals on Wheels – Orange County, Health Aging Center: Acacia, Community and Senior Centers, SoulRapha

St. Jude Medical Center cannot address all the significant community health needs by working alone. Improving community health requires collaboration across community stakeholders and with community engagement. Below outlines a list of community resources potentially available to address identified community needs.

Table_Apx 6. Community Resources Available to Address Significant Health Needs - St. Jude Medical Center

Significant Health Need Addressed	Organization or Program Addressing Significant Health Need
Behavioral health challenges and access to care (includes both mental health and substance use disorders)	Mariposa Women's Center; Seneca Family of Agencies; Western Youth Services, The Gary Center Substance Abuse Counseling System, Recovery Road, Families and Communities Together (FaCT) Family Resource Centers; Providence St. Joseph; NAMI; National Council on Mental Health; CSUF Interns; CalOptima, Be Well Orange County, Moving Forward Psychological Institute, Start Well
Affordable housing	Kennedy Commission; NeighborWorks; Habitat for Humanity; Mercy House; Jamboree Housing; YIMBY, Illumination Foundation, Families Forward, Family Solutions Collaborative, Orange County United Way, People for Housing OC
Culturally and linguistically concordant services	LGTBQ Center OC, Vital Access Care Foundation (Vietnamese), Korean Community Services (KCS), OMID Multicultural Institute for Development (Farsi, Arabic), Latino Health Access, CHIRLA, Good Hands Foundation
Access to health services/access to care	3B Wellness, KCS, Lestonnac Free Clinic, Anaheim Lighthouse, Brain Rehabilitation and Injury Network, OC HCA, St. Jude Neighborhood Health Centers
Lack of community involvement and engagement	Fullerton Collaborative
Access to safe, reliable, affordable transportation	OC Access, 211 Orange County, OCTA
Economic insecurity (lack of living wage jobs and unemployment)	Community Action Partnership, OC SSA
Food insecurity	Second Harvest; OC Food Access Coalition; Waste Not OC; UC Cooperative Extension; OC Health Care Agency – NEOP

Significant Health Need Addressed	Organization or Program Addressing Significant Health Need
Basic needs	Families and Communities Together (FaCT) Family Resource Centers
Homelessness	Kennedy Commission; NeighborWorks; Habitat for Humanity; Mercy House; Jamboree Housing; YIMBY, Illumination Foundation, City Net, Orange County United Way
Access to dental care	Healthy Smiles
Racism and discrimination	Groundswell, Unlimited Disabilities
Aging concerns (e.g., cognitive decline/dementia, mobility, etc.)	Alzheimer's Orange County, Alzheimer's Association of Orange County, Council on Aging, Meals on Wheels – Orange County, Community and Senior Centers, North Orange County Senior Services Collaborative; Caregiver Resource Center OC.

Appendix 4: Mission Hospital, St. Joseph Hospital, and St. Jude Medical Center Community Health Committees

Table_Apx 7. Mission Hospital Community Health Committee Members

Name	Title	Organization	Sector
Amy Buch	Resident		Resident
Israel Dominguez	Director of Economic & Workforce Development	Saddleback College	Education
Nicole Garcia	Director, CalAIM Community Outreach	CalOptima Health, A Public Agency	Health Care
Travers Ichinose	Research Analyst IV	Orange County Health Care Agency (Orange County's Public Health Agency), Health Promotion and Community Planning – Public Health Services Division	Public Health
Gila Jones	Board of Trustees	Capistrano Unified School District	Education
Claudia Magee	Director, Community Support and Development	Families Together of Orange County Community Health Center	Health Care
Sr. Herlinda Ramirez – Co Chair	Sisters of St Joseph of Orange	St Joseph of Orange	Faith-Based
Ginny Ripslinger – Chair	Healthcare Consultant	VLR Consulting	Health Care
Alaine Schauer	Director, Nursing	Providence Mission Hospital	Health Care

Table_Apx 8. St. Joseph Hospital Community Health Committee Members

Name	Title	Organization	Sector
Arianna Barrios	City of Orange Council Member	Orange City Council	Government
Christa Sheehan	Senior Director of Strategy and Advancement	Taller San Jose Hope Builders	Nonprofit
David Lugo	CEO	MOMS Orange County	Nonprofit
Gregory Scott	CEO, Community Partnerships and Services	Community Action Partnership of Orange County	Nonprofit
Iosefa Alofaituli	Executive Director and Co-founder	CIELO	Nonprofit
Jennifer Wang	Chief Operating Officer	Asian American Senior Citizen Services Center	Nonprofit
Brian Helleland	Chief Executive	St. Joseph Hospital	Health Care
Jonathan Hughes	Providence Senior Government Affairs Officer	Providence	Health Care
Jordan Abushawish	Senior Director, Federal and Local Government Affairs CalOptima	CalOptima	Government
Lisa Jenkins	President & CEO	Council on Aging- Southern California	Nonprofit
Mary Anne Foo	Executive Director	O.C. Asian & Pacific Islander Community Alliance, Inc. (OCAPICA)	Nonprofit

Monique Daviss	Executive Director	El Sol Science and Arts Academy	Education
Ron DiLuigi	Retired Hospital Executive	Retired	Healthcare
Ruben Smith	Partner	Alvarado Smith Law	Corporate
Sudeep Kukreja, MD	Neonatologist	CHOC Pediatrics	Healthcare

Table_Apx 9. St. Jude Medical Center Community Health Committee Members

Name	Title	Organization	Sector
Alison Garcia	Community member		
Dr. Jeffery Winston	Physician	Nvision Centers	Healthcare
Egleth Padilla-Nuncci	Community member	Center for Healthy Neighborhoods, Fullerton	Education
Feedy Mares	Community member	Providence St. Jude Ministry Board	
Hilda Sugarman	Board member	Fullerton School District	Education
Karen Freeman	Community member		
Ron DiLuigi	Community member		Healthcare
Rose Espinoza	Executive Director	Rosie's Garage	Social Services
Sr. Mary Rogers, CSJ, Chair		Sisters of St. Joseph of Orange	Faith/Religious
Rusty Kennedy	Community member		
Jordan Abushawish		CalOptima Health	Healthcare

Dr. Sueling Chen		Arborland Montessori Children's Academy	Education
Pooja Bhalla	CEO	Illumination Foundation	Housing
Dr. Vicky Calhoun		Fullerton Joint Union High School District	Education
Jose Trinidad Castanada	Council Member	City of Buena Park	Government
Carol Morrison	Community member		
Rhonda Shader	Council Member	City of Placentia	Government
Ofelia Hanson	Board Member	La Habra School District	Education