ST. JOSEPH HOSPITAL

FY18 - FY20 Community Benefit Plan/Implementation Strategy Report

St.JosephHealth
St. Joseph Hospital

To provide feedback about this *Community Benefit Plan/Implementation Strategy Report*, **email**
Martha.Shanahan@stjoe.org

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EXECUTIVE SUMMARY

St. Joseph Health, St. Joseph Hospital is an acute-care hospital founded in 1920, is located at 2700 Dolbeer Street in Eureka, California. It was the first hospital in the St. Joseph Health ministry. The facility has 138 licensed beds, 130 of which are currently available, and a campus that is approximately 11.5 acres in size. St. Joseph Hospital has a staff of more than 1150 and professional relationships with more than 140 local physicians. Major programs and services include cardiac care, critical care, diagnostic imaging, emergency medicine including a Level III Trauma designated hospital, which is the highest level emergency department in the area, cancer program and obstetrics including a Level II neonatal intensive care unit, as well as community-based programs focused on prevention, health promotion and community building.

FY18-FY20 CB Plan Priorities/Implementation Strategies
As a result of the findings of our FY17 Community Health Needs Assessment (CHNA) and through a prioritization process aligned with our mission, resources and hospital strategic plan, St. Joseph Hospital will focus on the following areas for its FY18-FY20 Community Benefit efforts:

- Housing
- Mental Health & Substance Abuse
- Food and Nutrition

Collaborating Organizations
St. Joseph Hospital believes in working collaboratively to solve community and health-related problems. The social and health problems our communities face are significant and complex; they are bigger than any one organization alone. Therefore, St. Joseph Hospital will partner with government entities, non-profit organizations, schools, the interfaith community and the business community in order to achieve the goals and strategies outlined in this plan.

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

MISSION, VISION, AND VALUES

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

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

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

INTRODUCTION – WHO WE ARE AND WHY WE EXIST

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

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ORGANIZATIONAL COMMITMENT

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

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

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

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

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

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

A charter approved in 2007 establishes the formulation of the St. Joseph Hospital Community Benefit Committee. The role of the Community Benefit Committee is to support the Board of Trustees in overseeing community benefit issues. The Committee acts in accordance with a Board-approved charter. The Community Benefit Committee is charged with developing

policies and programs that address identified needs in the service area particularly for underserved populations, overseeing development and implementation of the Community Health Needs Assessment and Community Benefit Plan/Implementation Strategy Reports, and overseeing and directing the Community Benefit activities.

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

Roles and Responsibilities

Senior Leadership
- CEO and other senior leaders are directly accountable for CB performance.

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

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

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

PLANNING FOR THE UNINSURED AND UNDERINSURED

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

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

COMMUNITY

Definition of Community Served

St. Joseph Hospital provides North Coast communities with access to advanced care and advanced caring. The hospital's service area extends from Crescent City in the north, Rio Dell in the south, Willow Creek/ Hoopa in the east and is bordered by the Pacific Ocean in the west. Our Hospital Total Service Area includes the cities and of Eureka, Arcata, Fortuna, Trinidad, Blue Lake, Ferndale, Rio Dell, Crescent City and the unincorporated communities of McKinleyville, Fields Landing, Bayside, Samoa, Hoopa, Willow Creek, Loleta, Klamath, Orick and Kneeland; as well as nine federally recognized tribes: Resighini Rancheria, Bear River Band of Rohnerville Rancheria, Big Lagoon Rancheria, Blue Lake Rancheria, Hoopa Valley Tribe, Karuk Tribe, Table Bluff Rancheria, Trinidad Rancheria and the Yurok Tribe. This includes a population of approximately 148,828 people.

Hospital Total Service Area

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

- PSA: 70% of discharges (excluding normal newborns)

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

The Primary Service Area ("PSA") is the geographic area from which the majority of the Hospital's patients originate. The Secondary Service Area ("SSA") is where an additional population of the Hospital's inpatients reside. The PSA is comprised of Eureka, Arcata, McKinleyville, Bayside, Samoa, Fields Landing, and Fortuna. The SSA is comprised of Crescent City, Klamath, Orick, Hoopa, Willow Creek, Trinidad, Blue Lake, Kneeland, Loleta, Ferndale and Rio Dell.

Table 1. Cities/ Communities and ZIP codes

Cities/ Communities	ZIP Codes	PSA or SSA
Eureka	95501, 95502, 95503	PSA
Arcata	95518, 95521	PSA
McKinleyville	95519	PSA
Bayside	95524	PSA
Samoa	95564	PSA
Fields Landing	95537	PSA
Fortuna	95540	PSA
Crescent City	95531, 95532	SSA
Klamath	95548	SSA
Orick	95555	SSA
Hoopa	95546	SSA
Willow Creek	95573	SSA
Trinidad	95570	SSA

Blue Lake	95525	SSA
Kneeland	95549	SSA
Loleta	95551	SSA
Ferndale	95536	SSA
Rio Dell	95562	SSA

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

**Figure 1. St. Joseph Hospital Total Service Area**
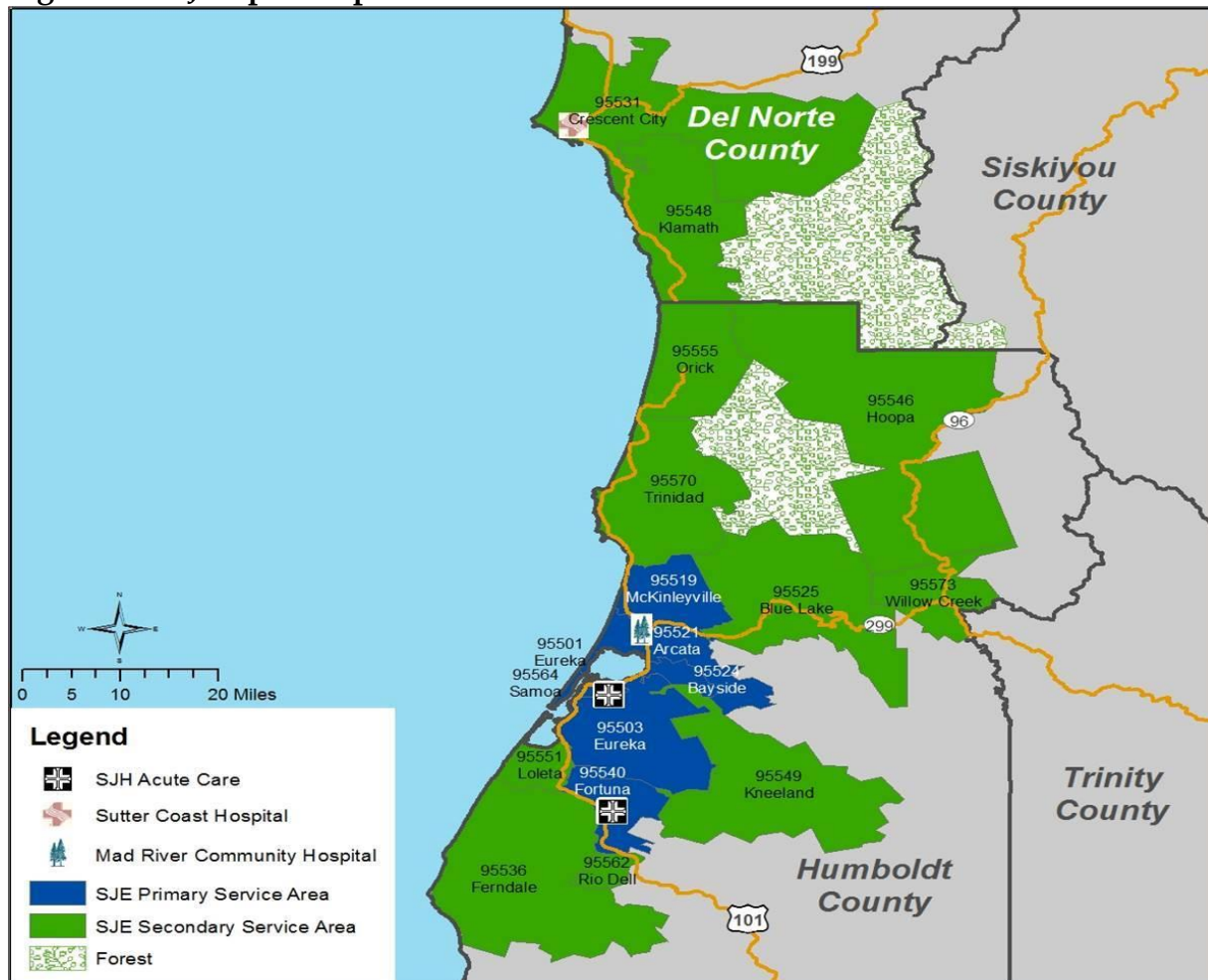
St. Joseph Hospital Eureka

Community Profile

The table and graph below provide basic demographic and socioeconomic information about the St. Joseph Hospital Eureka Service Area and how it compares to Humboldt and Del Norte Counties and the state of California. The Total Service Area (TSA) of St. Joseph Hospital Eureka includes approximately 150,000 people, with about 124,000 (84%) in Humboldt County. 90% of the population of both Humboldt and Del Norte Counties live in the TSA, so comparisons to county data are only of limited utility. In the TSA, median household income is much lower than California averages and percentages of those living in poverty are higher than California averages. There are more older adults and fewer children, and far more non-Latino Whites in the service area than in California.

Service Area Demographic Overview

Indicator	PSA	SSA	TSA	Humboldt County	Del Norte County	California
Total Population	104,955	43,873	148,828	138,332	27,153	38,986,171
Under Age 18	18.7%	20.9%	19.4%	19.1%	20.3%	23.6%
Age 65+	15.5%	16.6%	15.8%	16.0%	16.1%	13.2%
Speak only English at home	88.8%	87.8%	88.5%	89.9%	85.3%	56.2%
Do not speak English "very well"	3.8%	3.5%	3.7%	3.3%	4.6%	19.1%
Median Household Income	$40,256	$39,500	$40,053	$40,424	$37,618	$62,554
Households below 100% of FPL	12.1%	15.3%	13.0%	12.4%	17.2%	12.3%
Households below 200% FPL	30.2%	33.8%	31.3%	31.2%	36.4%	29.8%
Children living below 100% FPL	24.4%	26.4%	25.0%	23.4%	29.6%	22.7%
Older adults living below 100% FPL	6.4%	9.5%	7.4%	7.3%	11.6%	10.2%

Race/Ethnicity
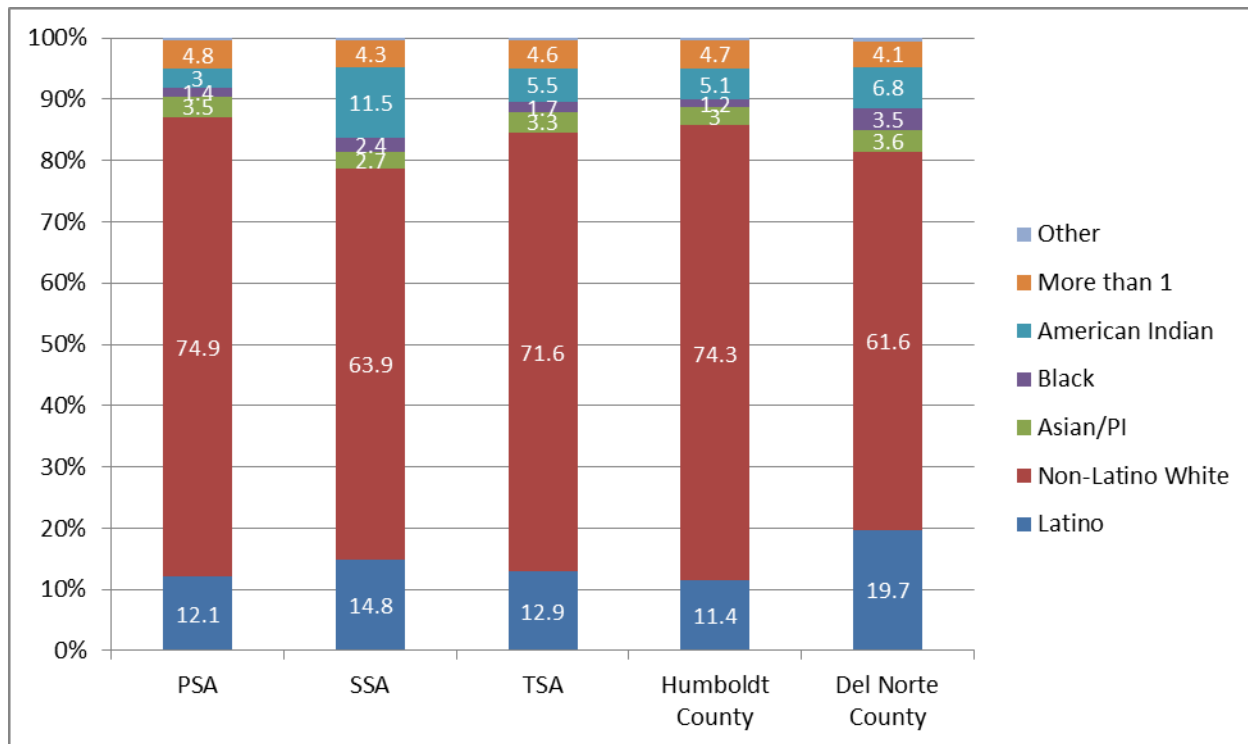
Community Need Index (Zip Code Level) Based on National Need

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

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

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

This objective measure is the combined effect of five socioeconomic barriers (income, culture, education, insurance and housing). A score of 1.0 indicates a zip code with the fewest socioeconomic barriers, while a score of 5.0 represents a zip code with the most socioeconomic barriers. Residents of communities with the highest CNI scores were shown to be twice as likely to experience preventable hospitalizations for manageable conditions such as ear infections,

pneumonia or congestive heart failure compared to communities with the lowest CNI scores. (*Ref* (*Roth R*, *Barsi E*., *Health Prog.* *2005 Jul-Aug; 86(4):32-8.)* The CNI is used to a draw attention to areas that need additional investigation so that health policy and planning experts can more strategically allocate resources.

For example, the ZIP code 95501 on the CNI map is scored 4.2, making it a High Need area.

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

**Figure 2. St. Joseph Hospital Community Need Index (Zip Code Level)**
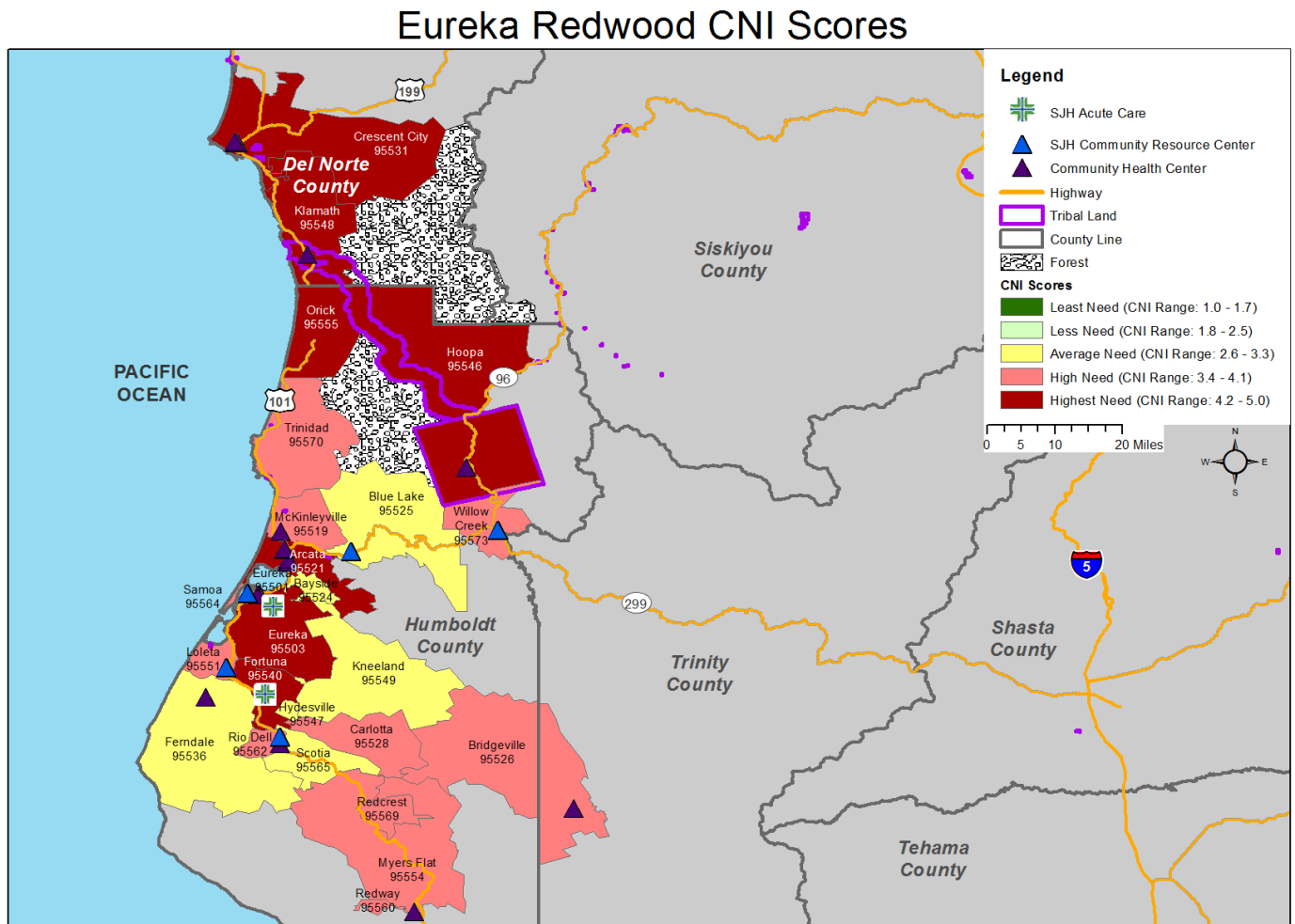
COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

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

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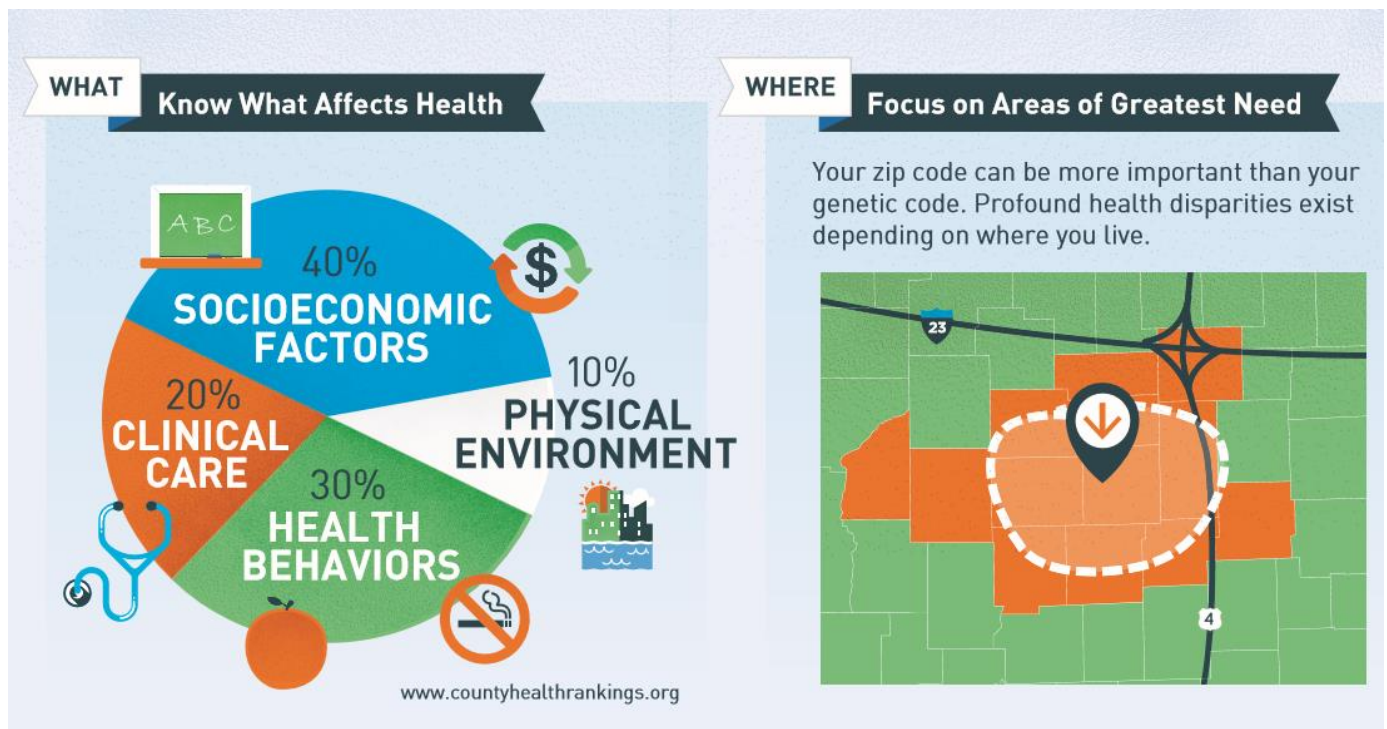
Examples of the types of information that was gathered, by health factor, are:

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

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

Health Behaviors – obesity[1], sugary drink consumption, physical exercise, smoking, and substance abuse

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

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

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

METHODOLOGY

Collaborative Partners

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

The California Center for Rural Policy (CCRP) fosters "Rural Research, for and by Rural Communities" to improve the health and well-being of rural people and environments. CCRP values a research approach partnering with rural people to address their priorities and to build upon community strengths. The center is a leader in innovative methods of rural research. Our exploration of the relationships between people and their environments is grounded in an ecological approach investigating the determinants of health and well-being. CCRP examines

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

the intersections between the health of individuals, the health of the economy and the health of the environment. CCRP assisted in the planning of the community input sessions, facilitated all focus groups and the forum, and aided in the reporting on their findings.

The Humboldt County Department of Health and Human Services – Public Health Branch has been working collaboratively with St. Joseph Hospital to align needs assessment process and implementation plans for the past four year. Non-profit hospitals and accredited public health agencies have similar requirements to periodically survey the health needs of their communities and craft comprehensive plans to address the prioritized significant health needs. Using a collective impact approach, St. Joseph Hospital and Public Health are working to deepen their partnership by sharing data and setting goals together. The resulting community-wide health improvement efforts are being branded *Live Well Humboldt*.

Community Partners:

St. Joseph Hospital Eureka partnered with the following community groups to recruit for and host the Focus Groups and Forum as well as provide local-level data specific to rural communities:

Multigenerational Center and the Fortuna Senior Center
Westside Community Improvement Association and the Jefferson Community Center
Humboldt Senior Resource Center
Table Bluff Rancheria
Betty Kwan Chinn Homeless Foundation and Day Center
Eureka Rescue Mission
Alcohol and Drug Care Services
Redwood Community Action Agency
Live Well Humboldt, Community Strategies Team
English Express
Humboldt Del-Norte Medical Society
Humboldt County Office of Education
LatinoNet and Humboldt *Promotores de Salud*

St. Joseph Hospital would like to express our gratitude to these partners for their assistance in reaching vulnerable populations and assisting with focus groups and the forum on short notice. As well as providing data that improved understanding of community need. Your partnership is deeply valued and appreciated.

Secondary Data/Publicly Available Data

Within the guiding health framework for the CHNA, publicly-available data was sought that would provide information about the communities (at the city and zip code level when available) and people within our service area. In addition, comparison data was gathered to show how the service area communities are faring compared to the county or state. Indicators were chosen if they were widely accepted as valid and appropriate measures[2] and would readily communicate the health needs of the service area. Preference was given to data that was obtained in the last 5 years and was available at the zip code level. The data sources used are highly regarded as reliable sources of data (e.g., ESRI Business Analyst Online, US Census Bureau American FactFinder, and California Health Interview Survey Neighborhood Edition). In total, 81 indicators were selected to describe the health needs in the hospital's service area. Appendix 2 includes a complete list of the indicators chosen, their sources, the year the data was collected, and details about how the information was gathered.

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

After the data was gathered, the zip code level data was compared to the Total Service area values and color coded light pink to dark red depending on how much worse a zip code area was compared to the TSA value. This made it easier to visualize the geographic areas with greater health needs. The criteria for color-coding the zip code level data is explained in the spreadsheets in Appendix 2.

Community Input

The process of collecting qualitative community input took three main forms: Community Resident Focus Groups, a Nonprofit and Government Stakeholder Focus Group, and a Community Forum. Each group was designed to capture the collected knowledge and opinions of people who live and work in the communities served by St. Joseph Hospital Eureka. We developed a protocol (noted in Appendix 3b) for each group to ensure consistency across individual focus groups, although the facilitators had some discretion on asking follow-up questions or probes as they saw fit. Invitation and recruitment procedures varied for each type of group. Appendix 3 includes a full report of the community input process and findings along with descriptions of the participants.

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

Resident Focus Groups

For Community Resident Focus Groups, Hospital Community Benefit staff, in collaboration with their Community Benefit Committees and the St. Joseph Health Community Partnerships Department, identified geographic areas where data suggested there were significant health, physical environment, and socioeconomic concerns. This process also identified the language needs of the community, which determined the language in which each focus group was conducted. Community Benefit staff then partnered with community-based organizations that serve those areas to recruit for and host the focus groups. Community Benefit staff developed an invitation list using their contacts - as well as contacts of the community-based organizations - and knowledge of the area. Transportation assistance was offered and participants were promised a small incentive for their time. A nourishing meal (lunch or dinner depending on the time of day) was provided and childcare was offered at the focus groups that included families. Two focus groups were conducted in English and one in Spanish. Two consultants staffed each focus group, serving as facilitators and note takers. These consultants were not directly affiliated with the ministry to ensure candor from the participants.

Nonprofit and Government Stakeholder Focus Group

For the Nonprofit and Government Stakeholder Focus Group, Community Benefit staff developed a list of leaders from organizations that serve diverse constituencies within the hospital's service area. Ministry staff sought to invite organizations with which they had existing relationships, but also used the focus group as an opportunity to build new relationships with stakeholders. Specific effort was made to reach out to stakeholders in non-health sectors, such as education and law enforcement. Participants were not given a monetary incentive for attendance, but a catered lunch was provided. As with the resident focus groups, this group was facilitated by outside consultants without a direct link to St. Joseph Health.

Resident Community Forum

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

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

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.

- Not all desired health-related data was available. As a result proxy measures were used when available. For example, there is limited community or zip code level data on the incidence of mental health, or many health behaviors such as substance use.
- Data that is gathered through interviews 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.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly (such as rates of uninsured) and the most recent data available is not a good reflection of the current state.
- Zip code areas are the smallest geographic regions for which many health outcomes and health behavior indicators are publicly available. It is recognized that even within zip codes, there can be populations that are disproportionately worse off. For example, within smaller geographic areas, such as census tracts, socio-economic data provides a more granular understanding of disparity at the neighborhood level. As previously mentioned, census tract health outcome and health behavior data was not publicly available to paint a complete picture of community level need.
- Data for zip codes with small populations (below 2000) is often unreliable, especially when the data is estimated from a small sample of the population. In the total service area, Bayside, Blue Lake, Fields Landing, Klamath, Kneeland, Loleta, Orick, Samoa, and Willow Creek each had fewer than 2,000 people.
- Information gathered during focus groups and community forums is dependent on who was invited and who showed up for the event. Efforts were made to include people who

could represent the broad interests of the community and/or were members of communities of greatest need.

- Fears about deportation kept many undocumented immigrants from participating in the focus groups and community forum and made it more difficult for their voice to be heard.

Process for gathering comments on previous CHNA

The previous Community Health Needs Assessment, completed in FY14, was made publically available on the St. Joseph Hospital website indicating that comments should be sent to the Director of Community Benefit. No comments were received.

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

Identification and Selection of Significant Health Needs

The matrix below shows the 13 health needs identified through the selection process, and their final prioritized scores. The check marks indicate each source of input and whether this issue was identified as a need by that input process.

Significant Health Need	Health Category	Total Rank Score	Community Data	Resident Focus Groups (FG)	Non-profit/ Govt. Stakeholder FG	Community Forum
Housing Concerns	Physical Environment	50.3	✓	✓	✓	✓
Mental Health	Health Outcome	50.0	✓	✓	✓	✓
Substance Abuse	Health Behavior	48.5	✓	✓	✓	✓
Food and Nutrition	Health Behavior	46.5	✓	✓		✓
Access to Resources	Clinical Care	44.0	✓	✓	✓	✓
Economic Insecurity	Socioeconomic	39.5	✓	✓	✓	✓
Insurance and Cost of Care	Clinical Care	39.0	✓	✓		✓
Smoking	Health Behavior	39.0	✓		✓	
Crime and Safety	Physical Environment	36.8	✓	✓		✓
Asthma	Health Outcome	35.0	✓			
Heart Disease	Health Outcome	34.5	✓			
Dental Care	Clinical Care	33.8		✓		✓
Homelessness	Socioeconomic	22.0*	✓	✓	✓	✓

Definitions:

Housing Concerns: Includes affordability, availability, overcrowding, and quality of housing as well as the condition of homelessness, its prevention, and its impact on individuals and communities. Indicator data shows this can be a problem across most of the service area. Housing was frequently discussed as a challenge in the community focus groups, was a major theme in the stakeholder group and received the highest number of votes in the community forum.

Mental Health: Covers all areas of emotional, behavioral, and social well-being for all ages. It includes issues of stress, depression, coping skills, as well as more serious health conditions such as mental illness and Adverse Childhood Experiences.

Substance Abuse: Pertains to the misuse of all drugs, including alcohol, marijuana, methamphetamines, opiates, prescription medication, and other legal or illegal substances. It does not encompass cigarette smoking, which was considered as a separate significant health need.

Food and Nutrition: Concerns about healthy eating habits, nutrition knowledge, and challenges of cost and availability of healthy options. It also includes concerns around food insecurity and hunger.

Access to Resources: Includes most barriers to accessing health care services and other necessary resources, such as transportation, a shortage of providers, particularly specialists, language barriers, and resources being unavailable outside of working hours.

Economic Insecurity: Identified as a root cause of other health issues, this issue covers the effects of poverty and economic challenges as well as difficulties around finding jobs that pay livable salaries.

Insurance and Cost of Care: Includes access to health care for those without insurance and those who have insurance, but for whom costs of premiums, co-pays, prescriptions, and other needs are excessively burdensome. It also encompasses issues around the complexities of the system and its navigation.

Smoking: The health behavior and effects of smoking cigarettes and other forms of tobacco use. It does not include marijuana use, which is included in substance abuse.

Crime and Safety: Encompasses the incidence of crime and violence as well as the fear of it, which prevents people from using open space or enjoying their community.

Asthma: Includes the treatment of and management of asthma.

Heart Disease: Encompasses the prevention of heart disease as well as its incidence and treatment.

Dental Care: Includes knowledge of dental health and the availability of providers and dental insurance, as well as the cost of services.

Homelessness: Homelessness was discussed both for its impact on the homeless but also on the community. *The internal work group opted not to score "Homelessness" as it was closely tied to Mental Health, Substance Abuse, and Housing, and not necessary a separate issue.

Community Health Needs Prioritized
St. Joseph Hospital Eureka will address the following priority areas as part of its FY18-FY20 CB Plan/Implementation Strategy Report:

- Housing Concerns
- Mental Health/Substance Abuse
- Food and Nutrition (as influenced by Economic Insecurity)

Housing Concerns was the highest ranked concern after Step 2 of the Prioritization process, and a major concern of the community and stakeholders. It was widely discussed in every focus group and housing received the most votes in the forum. Community members focused on the

lack of availability and poor quality of housing, the growing scope of the homelessness problem, and the interrelatedness of these issues to each other. The data shows that a majority of renters pay more than 30% of their income on rent, and this figure is much worse for some communities. The Community Benefit Committee discussed how affordable housing is an issue that affects all communities in our service area, but is a significant hardship for the more vulnerable members of our community such as seniors, persons with disabilities, single mothers with children and low-income families. Furthermore, the aging and sub-standard housing conditions create or exacerbate health problems. The Community Benefit Committee has a desire to address community-level, root causes of poor health and discussed how housing is one of the key social determinants of health.

Mental Health and Substance Abuse were combined by the Community Benefit Committee as the two areas are closely connected and often individuals have co-occurring or dual-diagnosis for mental illness and substance abuse. At the conclusion of the prioritization process, they were the second highest ranked concern. Both were strongly supported by the community process: Substance Abuse was the most widely discussed topic in focus groups, and Mental Health was discussed in each focus group and received the second highest number of votes in the community forum. Both issues were linked to many other concerns such as economic challenges, housing, homelessness, crime, and immigration. While data on mental health is difficult to obtain, 11% of adults in the Counties self-reported "serious psychological distress" compared to 8% for California. The suicidal ideation rate for adults in Humboldt County is 17% compared to 8% for the state as a whole, and per-capita youth suicide rates are much higher than the state. Substance abuse data shows the age-adjusted mortality rate due to unintentional overdoses in Humboldt County is more than double the state average, as is the per-capita number of all drug-related deaths. The rate of alcohol and drug use for teens is 42% for Humboldt County, 14 percentage points higher than California. Data on mental health and substance abuse in Del Norte County has limitations due to sample size but overall is similar to that of Humboldt.

Food and Nutrition, **as influenced by Economic Insecurity,** was a major issue in the community focus groups and the forum, as residents raised concerns about the cost, availability, and ease of preparing healthy food as well as a lack of supermarket availability and quality. Data about this issue is somewhat inconsistent. Obesity levels for the service area are only a percentage point higher than California averages (27% vs. 26%) and some measures of food insecurity for the service area are comparable to the state. However, Feeding America estimates have food insecurity in Del Norte and Humboldt Counties at 18% compared to a state rate of 14%. After the second step of prioritization, Food and Nutrition was the fourth ranked issue. The Community Benefit Committee had robust discussion around the root cause of food insecurity and how food insecurity can be seen as a function of economic insecurity. These two areas had equal number of votes and tied for the third highest ranked concern.

Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. We are committed to continue our Mission through core Community Benefit Programing (Care Transitions, Evergreen Lodge, Community Resource Centers, Paso a Paso and Healthy Kids Humboldt) and by funding other non-profits through our Care for the Poor Community Grants program managed by the St. Joseph Hospital Community Benefit Department.

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

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

While we could not prioritize all of the needs identified, we will be able to effect many of the needs by working on root cause. For example, **Heart Disease** is not a priority need, but we will impact this health outcome by focusing our efforts on promoting good nutrition and food security. **Dental Care** is not a prioritized need but St. Joseph Hospital is committed to working with partners on the multi-year Dental Transformation Grant our Public Health department received from the CA Department of Health Care Services. Additionally, St. Joseph Hospital does not have a program in place to directly prevent **Asthma** occurrence in our service area; however, we partner with several entities, including the public health department that do address asthma prevention. Furthermore, our efforts to improve the quality of housing in our service has the potential to impact asthma occurrence.

In addition, St. Joseph Hospital will collaborate with local organization(s) that address aforementioned community needs, to coordinate care and referral and address these unmet needs.

COMMUNITY BENEFIT PLAN

Summary of Community Benefit Planning Process

Evaluators from The Olin Group performed a rigorous review of the publicly-available data and community input to identify 12 significant health needs for St. Joseph Hospital Eureka.

The selection process began with the development of a general list of potential health needs, derived from a broad review of the indicator data, focus group findings, and literature around health concerns and social determinants of health. The goal of the selection process was to

analyze the wide variety and large quantity of information obtained through the quantitative and qualitative processes in a consistent manner. Each source of input was considered as follows:

- Quantitative Data: Weighting was based on how the service area compared to California and county averages and how individual cities and zip codes compared to the service area averages. Note that for some health needs, data was not readily available.
- Resident Focus Groups: Focus Group transcripts and notes were reviewed and considered both at the individual focus group level and collectively across focus groups. Weighting was related to how often and how extensively an issue was discussed by the participants.
- Stakeholder Focus Group: Weighting for the stakeholder group was based on how strongly the problem was discussed by the participants, and the extent of agreement among the participants about the problem.
- Community Resident Forum: The Community Forum was designed to measure the importance of an issue to attendees. The forum ended with "dot voting" on significant health issues allowing all participants to have a voice in indicating which issues were most important to them. Issues that received more votes were considered to be more important to the community.

In developing the list of significant health needs, the quantitative data was given equal weight to the community input. After reviewing and rating all the available information, the list of potential health needs was ranked from greatest to lowest need for the ministry and the top 12 were recommended by The Olin Group for further consideration.

Before the final selection of significant health needs, two reviews took place. First, The Olin Group reviewed the list to determine if there were needs that were identified as priorities through the community process but not highlighted by the data, or for which no data was available. In some cases, a significant health need may have been added to the list due to this review. In the second review, the Community Benefit Lead examined the list, using her ministry-specific knowledge to determine if the significant health needs should be consolidated or added. Once the review was completed, the list was finalized for prioritization.

Prioritization Process and Criteria

To rank order the list of significant health needs and ultimately select the three health needs to be addressed by St. Joseph Hospital Eureka, a four-step process was followed that incorporated the experience, expertise, and perspective of both internal and external stakeholders of the ministry. The criteria and rating scales can be found in Appendix 5.

Step 1: Using criteria that were developed in collaboration with the St. Joseph Health Community Partnerships Department and the Community Benefit Lead, The Olin Group Evaluation Team scored each health need on seven criteria.

- Seriousness of the Problem: The degree to which the problem leads to death, disability, and impairs one's quality of life
- Scope of the Problem 1: The number of people affected, as a percentage of the service area population
- Scope of the Problem 2: The difference between the percentage of people affected in the service area compared to regional and statewide percentages
- Health Disparities: The degree to which specific socioeconomic or demographic groups are affected by the problem, compared to the general population
- Importance to the Community: The extent to which participants in the community engagement process recognized and identified this as a problem
- Potential to Affect Multiple Health Issues: Whether or not this issue is a root cause, and the extent to which addressing it would affect multiple health issues
- Implications for Not Proceeding: The risks associated with exacerbation of the problem if it is not addressed at the earliest opportunity

Step 2: The Community Benefit Lead for St. Joseph Hospital Eureka and Redwood Memorial Hospital convened a working group of internal stakeholders to complete the second stage of prioritization. Before the process of prioritization began, the working group chose to combine "Housing Concerns" with "Homelessness" and rank them as a single combined item. This working group applied five criteria to each need.

- Sustainability of Impact: The degree to which the ministry's involvement over the next three years would add significant momentum or impact, which would remain even if funding or ministry emphasis on the issue were to cease.
- Opportunities for Coordination and Partnership: The likelihood that the ministry could be part of collaborative efforts to address the problem.
- Focus on Prevention: The existence of effective and feasible prevention strategies to address the issue.
- Existing Efforts on the Problem: The ability of the ministry to enhance existing efforts in the community.
- Organizational Competencies: The extent to which the ministry has or could develop the functional, technical, behavioral, and leadership competency skills to address the need.

Step 3: Two final criteria were considered by the Community Benefit Lead for each health need.

- Relevance to the Mission of St. Joseph Health: Is this area relevant to or aligned with the Mission of St. Joseph Health?
- Adherence to Ethical and Religious Directives: Does this area adhere to the Catholic Ethical and Religious Directives?

If the answer was "No" to either question, the health need was dropped from further consideration. None of the needs were dropped at this step.

Step 4: The final step of prioritization and selection was conducted by the St. Joseph Hospital Eureka and Redwood Memorial Hospital Community Benefit Committee, which reviewed the list of identified health needs rank-ordered by the results of the first three steps of the prioritization process. The Committee discussed each need and its relevance to the ministry, the potential for progress on the issue, and the potential role of the ministry in addressing the need. After extensive discussion, the Committee selected three priorities for inclusion in the plan.

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

1. **Initiative/Community Need being Addressed:** **Housing**

Goal (anticipated impact): Increase pathways to safe and affordable housing

Outcome Measure	Baseline	FY18 Target	FY20 Target
TBD	TBD	TBD	TBD

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY20 Target
1. Low income housing development	Number of projects	0	1	3
2. Medical Respite Program	Respite bed days (new measure: housing status of respite patients at discharge)	1500 Unknown	1750 TBD	1800 TBD
3. Community Building Initiatives (CBI)	Number of communities with a CBI project	1 completed 3 current	1 completed 3 current	4 completed
4. Evergreen Lodge	# of people served # of nights lodging	444 people 2941 nights	TBD	TBD

Evidence Based Sources: Prevention Institute, Preventing medical high utilization through improving the community conditions that shape health, i.e. the Social Determinants of Health https://www.preventioninstitute.org/projects/prevention-approach-medical-high-utilization, Center for Outcomes Research and Education (CORE): http://oregon.providence.org/our-services/c/center-for-outcomes-research-and-education-core/social-determinants-of-health/housing-and-health/, American Hospital Association

Key Community Partners: Builders, Providence Supportive Housing, Betty Kwan Chinn Homeless Foundation, Communities of Loleta, W. Eureka, Bridgeville and Peninsula, Redwood Community Action Agency, California Center for Rural Policy, Clean and Sober Houses, Alcohol and Drug Care Services, City and County Public Agencies

Resource Commitment: Operating budget, Care for the Poor funds, Care Transitions staff time, Community Benefit Operations staff time, SJH-HC BOT time

2. Initiative/Community Need being Addressed: Mental Health and Substance Abuse

Goal (anticipated impact): Improve health and advance health equity in the communities served by St. Joseph Hospital through a comprehensive set of approaches that include clinical services and also strategically addressing the upstream community determinants of health (physical/built environment, social/cultural environment, and economic environment).

Outcome Measure	Baseline	FY18 Target	FY20 Target
TBD	TBD	TBD	TBD

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY20 Target
1. Increased clinical services for mental health and substance abuse	a. Waterfront Recovery Services (WRS) metrics	No medical detox in Humboldt County	Open WRS, issue quarterly reports	Drug Medi-Cal funded, sustainable operations
	b. Counseling for Spanish speakers	One contract with LCSW	Maintain contract with LCSW	TBD
	c. Care Transitions Program	3 services lines, multidisciplinary team approach	Maintain	Expand
2. Accountable Community for Health	Fully functional ACH model	No ACH in Humboldt County	Meet FY18 targets per ACH plan	Meet 3 year targets per ACH plan
3. Engage a strategic and comprehensive local coalition of partners to address the upstream community determinants of health across the Spectrum of Prevention and the Adverse Childhood/Community Experiences and Resilience framework	# of partners engaged in this coalition	0	6	12
4. Stigma Reduction	May is MH Awareness Month	Participation	Continued Participation	Increased Participation
5. Build the Social/Cultural	a. Community Resource Centers	TBD	TBD	TBD

environment	(CRCs) b. Paso a Paso c. Community Building Initiatives (CBI) d. English Express			
6. Care for the Poor Community Grants	# number of grants $ amount invested	12 grants $131,000	TBD	RBD

Evidence Based Sources: The Well Being Trust, Providence St. Joseph Health, CA Each Mind Matters Campaign, Center for Disease Control and Prevention, Prevention Institute

Key Community Partners: Alcohol and Drug Care Services, Redwood Community Action Agency, City and County Public Agencies, Local Spanish-speaking counselors, North Coast Grant-making Partners (First 5 Humboldt, Humboldt Area Foundation, Smullin Foundation, McLean Foundation, Vesper Society, Humboldt Health Foundation, Footprint Foundation), Humboldt Network of Family Resource Centers, California Center for Rural Policy, North Coast Health Improvement and Information Network (NCHIIN)

Resource Commitment: Operating budget, Care for the Poor funds, Community Resource Center and Paso a Paso staff time, Community Benefit Operations staff time, Mental Health and Wellness Initiative grant funds from the Well Being Trust

3. **Initiative/Community Need being Addressed:** Food and Nutrition (as influenced by Economic Insecurity)

Goal (anticipated impact): Increase access to affordable and nutritious foods – with emphasis on locally sourced foods – throughout the county for low income families, children and seniors.

Outcome Measure	Baseline	FY18 Target	FY20 Target
TBD	TBD	TBD	TBD

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY20 Target
1. CalFresh Grant from DHHS *(outreach and enrollment)*	Number of CalFresh beneficiaries in Humboldt County	20,610 CalFresh beneficiaries (2017)	2% increase from baseline	3% increase from baseline
2. Community Resource Centers (CRCs) Food Security work	# of food security activities at the five SJH CRCs	N/A	TBD	TBD
3. Paso a Paso food distributions	# of people served by gleaning program	N/A	TBD	TBD
4. Advocate for policies and food system changes	# of policies and system changes advocated for	0	2	4
5. Increase local sourcing	a. Hospital farm direct purchasing b. Hospital CSA program with Shakefork Community Farm c. SSI market match with North Coast Growers Association d. Locally Delicious Farmer's fund	TBD	TBD	TBD
6. Care for the Poor Community Grants	# number of grants $ amount invested	13 grants $157,000	TBD	TBD
7. Food Security and Pantry survey	Complete survey use results for program development and/or policy change	Survey done in 2013, 2015, 2017	1 new program/policy	3 new programs/policies

8. HKH VITA program participation	# tax returns prepared $ refunded to low-income families	60 returns $105,073 refunded	TBD	TBD
9. Look for opportunities to partner with Economic Development entities	# of new partnerships	0	1	2

Evidence Based Sources: Centers for Disease Control and Prevention, American Hospital Association, United States Department of Agriculture

Key Community Partners: Department of Health and Human Services, Food for People, Community Alliance with Family Farmers, Humboldt Food Policy Council, North Coast Growers Association, Humboldt Network of Family Resource Centers, Locally Delicious, Shakefork Community Farm, Humboldt Senior Resource Center, St. Vincent de Paul, Betty Kwan Chinn Foundation, Eureka Rescue Mission, Redwood Community Action Agency, California Center for Rural Policy, Loleta Elementary School, Local Farmers

Resource Commitment: Operating budget, Care for the Poor funds, Community Resource Center, Paso a Paso and Healthy Kids Humboldt staff time, Community Benefit Operations staff time

Other Community Benefit Programs and Evaluation Plan

Initiative/Community Need Being Addressed:	Program Name	Description	Target Population (Low Income or Broader Community)
1. Access to Care	Physician Recruitment	Recruitment and retention efforts for primary and specialty care physicians and mid-level practitioners	Broader Community
2. Access to Care	Family Practice Residency Program	New residency program, in partnership with Open Door, to train ~6 family practice residents per year	Broader Community
3. Access to Care	Gardner Group	Insurance enrollment assistance for hospitalized patients	Broader Community
4. Support Services	Facility Use	Free meeting room space at the hospital for non-profits or other like-minded groups/organizations	Broader Community
5. Care Coordination	Sexual Assault Response Team (SART)	Multi-agency response effort to coordinator care post-sexual assault	Broader Community
6. Education	Intern programs for allied professionals	Interns are trained in multiple hospital departments including pharmacy, rehabilitation, physical therapy, occupational therapy, social work	Broader Community

Appendix

Definition of Terms

Community Benefit: An initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives:
   a. Improves access to health services;
   b. Enhances public health;
   c. Advances increased general knowledge; and/or
   d. Relieves government burden to improve health.
Community benefit includes both services to the poor and broader community.

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

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

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

Initiative: An initiative is an umbrella category under which a ministry organizes its key priority efforts. Each effort should be entered as a program in CBISA Online (Lyon Software). Please be sure to report on all your Key Community Benefit initiatives. If a ministry reports at the initiative level, the goal (anticipated impact), outcome measure, strategy and strategy

measure are reported at the initiative level. Be sure to list all the programs that are under the initiative. Note: All Community Benefit initiatives must submit financial and programmatic data in CBISA Online.

Program: A program is defined as a program or service provided to benefit the community (in alignment with guidelines) and entered in CBISA Online (Lyon Software). Please be sure to report on all community benefit programs. Note: All community benefit programs, defined as "programs", are required to include financial and programmatic data into CBISA Online.

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

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

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