# 2024 - 2026

## COMMUNITY HEALTH IMPROVEMENT PLAN

# St. Jude Medical Center

Fullerton, California


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

Providence

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# EXECUTIVE SUMMARY

Providence continues its Mission of service in Orange County through Providence St. Jude Medical Center (SJMC). SJMC is an acute-care hospital founded in 1957 and located in Fullerton, California. The hospital's service area is the entirety of North Orange County, including 1,690,000 people.

Providence St. Jude Medical Center dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of people experiencing social inequities and health disparities.

The Community Health Needs Assessment (CHNA) is an opportunity for Providence St. Jude Medical Center to engage the community every three years with the goal of better understanding community strengths and needs. The results of the CHNA are used to guide and inform efforts to better address the needs of the community. Through a mixed-methods approach, using quantitative and qualitative data, 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, and hospital utilization data. We also conducted listening sessions with community members and fielded a key informant survey to actively engage the community.

## Collaborating Organizations

The three Orange County hospitals, St. Jude Medical Center, St. Joseph Hospital Orange, and Mission Hospital collaborated on the CHIP report and its strategies to address priority areas. However, each hospital developed their own CHIP.

## Providence St. Jude Medical Center Community Health Improvement Plan Priorities

As a result of the findings of our 2023 CHNA and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, Providence St. Jude Medical Center will focus on the following areas for its 2024-2026 Community Benefit efforts:

### ACCESS TO CARE

Ensure access to care that is financially sustainable for vulnerable, underserved, and low-income communities.

### BEHAVIORAL HEALTH

Creating awareness and providing services addressing mental health and substance use disorders.

### HOMELESSNESS AND AFFORDABLE HOUSING

Support effective advocacy efforts on state and local level.

# INTRODUCTION

## Who We Are

| | |
|---|---|
| **Our Mission** | As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable. |
| **Our Vision** | Health for a Better World. |
| **Our Values** | Compassion — Dignity — Justice — Excellence — Integrity |

Providence St. Jude Medical Center is an acute-care hospital founded in 1957 and located in Fullerton, California. The hospital has 320 beds a staff of more than 2,496, and professional relationships with more than 649 physicians. Major programs and services offered to the community include the following: Cardiac, Orthopedics, Neurosurgery, Cancer, Perinatal, Rehabilitation and Digestive Services.

## Our Commitment to Community

Providence St. Jude Medical Center dedicates resources to improve the health and quality of life for the communities we serve. 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.

## Health Equity

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

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

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


## Planning for the Uninsured and Underinsured

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

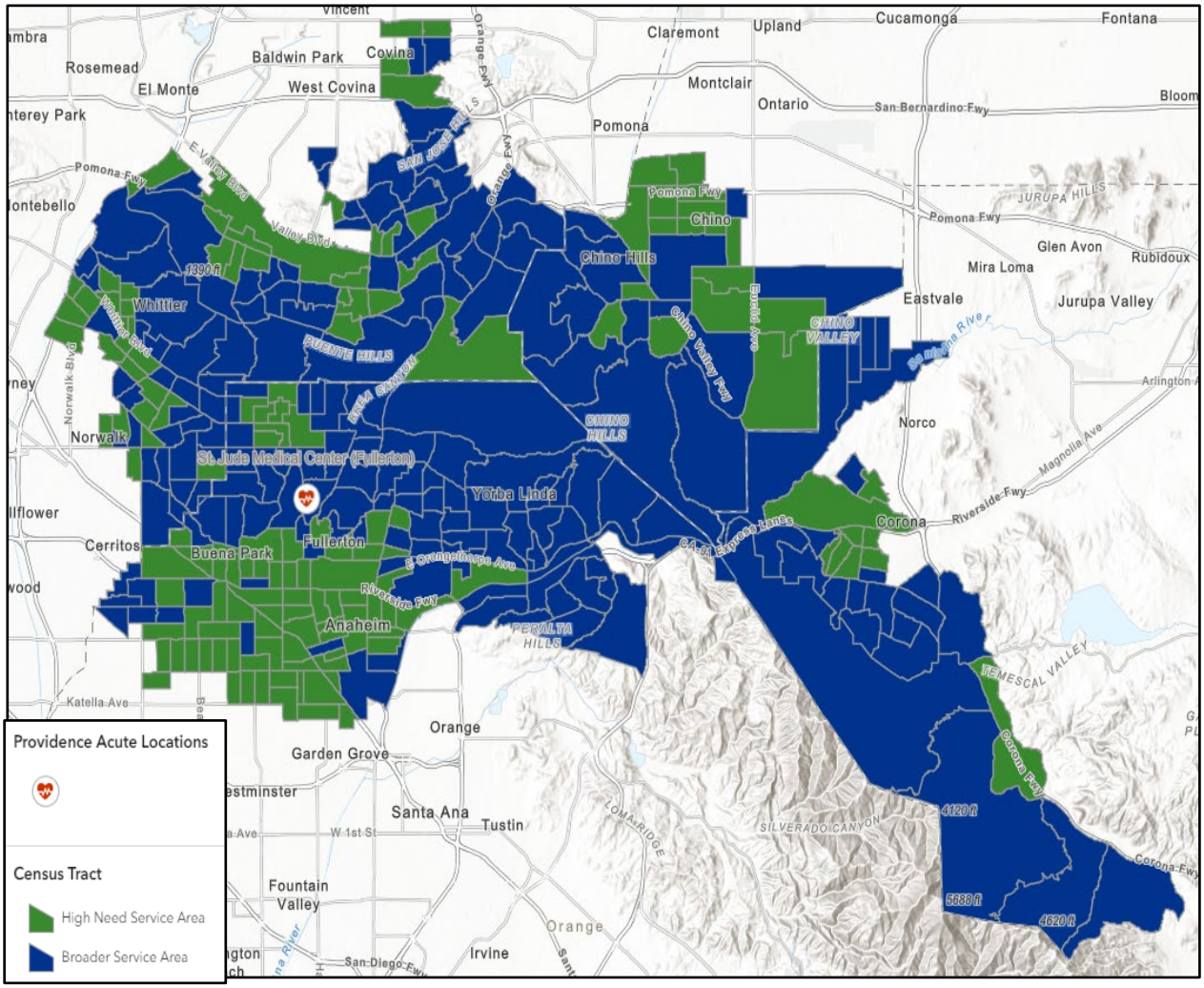
One way Providence St. Jude Medical Center informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain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

# OUR COMMUNITY

## Description of Community Served

Providence St. Jude Medical Center's service area is North Orange County and includes a population of approximately 1,690,000 people.

***Figure 2. St. Jude Medical Center Total Service Area***




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 North Orange County 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.[1]

## Community Demographics

The following demographics are from the 2021 American Community Survey, 5-year estimate.

### POPULATION AND AGE DEMOGRAPHICS

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, 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 1. 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

### POPULATION BY RACE AND ETHNICITY

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.

[1] 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)

## SOCIOECONOMIC INDICATORS

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

| Indicator | Broader Service Area | High Need Service Area | Total Service Area | ORANGE COUNTY |
|---|---|---|---|---|
| **Median Income**<br>Data Source: 2021 American Community Survey, 5-year estimate | $117,402 | $74,335 | $97,116 | $100,429 |

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.

**Full demographic and socioeconomic information for the service area can be found in the 2023 CHNA for St. Jude Medical Center.**

# COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

## Summary of Community Needs Assessment Process and Results

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

Knowing where to focus our resources starts with our Community Health Needs Assessment (CHNA), an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets, and opportunities. The results of the CHNA are used to guide and inform efforts to better address the needs of the community. Through a mixed-methods approach, using quantitative and qualitative data, 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, and hospital utilization data. We also conducted listening sessions with community members and fielded a key informant survey to actively engage the community.

The 2023 CHNA was approved by the SJO Community Health Committee on September 20, 2023.

## Significant Community Health Needs Prioritized

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 the 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*

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.

#### *AFFORDABLE HOUSING AND 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.

## Needs Beyond the Hospital's Service Program

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

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

The following community health needs identified in the ministry CHNA will not be addressed due to limited funds and capacity and to ensure a focused approach to the three CHIP priorities. An explanation is provided below:

1. **Culturally and linguistically concordant services:** While this was not selected as a priority issue, St. Jude Medical Center works to integrate culturally and linguistically concordant services in its community-based programming as well as provides interpreter services for multiple languages in its hospital-based settings.
2. **Access to safe, reliable transportation:** Although not identified as a top priority SJMC provides transportation support with taxi vouchers to vulnerable and low-income ED and inpatient population.
3. **Lack of community involvement and engagement:** Stakeholders and micro communities who participated in listening sessions identified a lack of involvement and engagement among some communities to address health disparities and inequities. Although this is not a priority identified, SJMC will prioritize community involvement and engagement in all key initiatives.
4. **Economic insecurity (lack of living wage jobs and unemployment):** While SJMC is not focusing on a specific initiative around economic insecurity, all strategies focus on the principles of health equity which can/will include issues around economic insecurity. In addition, our partnership with The Hub Family Resource Center in the Fullerton School District provides temporary financial support and access to social services that qualify families for financial assistance and job placement.
5. **Basic needs:** Although not identified as a selected priority, SJMC funds the pharmacy medication program by providing needed prescription medication to low-income and vulnerable patients upon discharge from the hospital. Additionally, St. Jude Medical Center provides access to clothing, shoes, and basic hygiene items to unhoused patients.
6. **Food insecurity:** Although not identified as a selected priority, SJMC will continue to address food insecurity through partnerships such as The Hub Family Resource Center in the Fullerton School District which provides food, temporary housing, and school attendance support.
7. **Access to dental care:** SJMC does not directly provide dental services, however we partner with local Federally Qualified Health Centers who offer this service.
8. **Racism and discrimination:** While SJMC is not focusing on a specific initiative around racism and discrimination all strategies focus on the principles of health equity which directly address racism and discrimination.
9. **Domestic violence, child abuse/neglect:** St. Jude Medical Center does not directly address domestic violence; however, we partner with community organizations who specialize in domestic violence and child abuse/neglect through our FQHC partner.

In addition, Providence St. Jude Medical Center will collaborate with local organizations that address the aforementioned community needs to coordinate care and referrals to address these unmet needs.

# COMMUNITY HEALTH IMPROVEMENT PLAN

## Summary of Community Health Improvement Planning Process

The local Community Health team worked with internal and external partners to develop strategies to respond to community needs.

The 2024-2026 CHIP was approved on February 14, 2024, and made publicly available no later than May 15, 2024.

## Addressing the Needs of the Community: 2024- 2026 Key Community Benefit Initiatives and Evaluation Plan

### COMMUNITY NEED ADDRESSED #1: ACCESS TO CARE

*Population Served*

Underserved, uninsured/underinsured communities in North Orange County

*Long-Term Goal(s)/ Vision*

1. To improve access to health care and preventive resources for people with low incomes and those uninsured by deploying programs to assist with navigating the health care system.
2. To ease the way for people to access appropriate and culturally responsive levels of care at the right time.

***Table 3. Strategies and Strategy Measures for Addressing lack of access to care***

| Strategy | Population Served | Strategy Measure | Baseline | 2026 Target |
|---|---|---|---|---|
| Ensure seamless transition to Medi-Cal/CalOptima | Newly Medi-Cal eligible FQHC patient population. | # of patients enrolled | Approximately 2,000 newly eligible patients in 2023. | 80-90% of patient population enrolled. |
| Open new Finamore Place clinic site in Anaheim | Low Income uninsured and underinsured persons | # of patients served | Clinic opens March-April 2024 | OB/GYN = 1,500 visit annually<br>Pediatrics = 1,951 visits annually<br>Optometry = 1,000 visits annually |

| | | | | |
|---|---|---|---|---|
| Support Avoidable ED Navigation Program to provide comprehensive intervention | Medi-Cal/CalOptima patients. | # of Avoidable ED visits<br># of PCP visits and Urgent Care visits | 65% reduced AED visits in first 90-days in 2023<br>48% increase in PCP visits in first 90-days in 2023<br>19% increase in Urgent Care visits in first 90-days in 2023 | 70%-75% reduced AED visits<br>55%-65% increase in PCP visits<br>25%-30% increase in Urgent Care visits |
| Increase access to health care for North and Central Orange County providing Medi-Cal outreach, enrollment, retention, and utilization services. | Uninsured undocumented population age 26-49 who are newly eligible for Medi-Cal | # of persons enrolled<br># of persons receiving outreach and education | Enrolled 958 persons<br>Provided outreach to 6,602 persons | 1,200 individuals enrolled in Medi-Cal and simultaneously enrolling in other programs to improve health and address SDoH annually. |
| Partner with TGR Foundation to promote health care workforce development | 11th and 12th grade high school students in the Unified Anaheim School District | # of students participating in the healthcare career pathways program | 125 students in 2023 | 200-300 students participate in the healthcare pathways program. |

*Evidence Based Sources*

- Health insurance enrollment outreach and support: https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/health-insurance-enrollment-outreach-support
- Federally qualified health centers (FQHCs): https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/federally-qualified-health-centers-fqhcs
- Strategies for expanding health insurance coverage in vulnerable populations - Healthy People 2030 | health.gov

*Resource Commitment*

$1M per year in operating support for all access to care initiatives in 2024-2026

*Key Community Partners*

St. Jude Neighborhood Health Centers; Heritage Medical Group; CalOptima/CalAIM; CHIOC; TGR Foundation

## COMMUNITY NEED ADDRESSED #2: BEHAVIORAL HEALTH (INCLUDING MENTAL HEALTH AND SUBSTANCE USE)

*Population Served*

Underserved communities living in North Orange County

*Long-Term Goal(s)/ Vision*

1. To ensure equitable access to high-quality, culturally responsive, and linguistically appropriate mental/behavioral health services, especially for populations who are on the margins and are low income.
2. Reduce mental health stigma in the community.

***Table 4. Strategies and Strategy Measures for Addressing Mental Health***

| Strategy | Population Served | Strategy Measure | Baseline | 2026 Target |
|---|---|---|---|---|
| Promote Each Mind Matters Campaign/Green Bench OC among community partners | Low-income communities with an emphasis in Latino and Vietnamese households. | # of residents active on the EMM & Green Bench OC social media sites<br>\# of new green benches installed in key/high traffic locations. | 4005 residents active in 2023<br>29 green benches since 2021 | 12,000 residents engaging in social media sites.<br>5-10 additional green benches installed. |
| Expand MAT Program in Emergency Department by promoting free Naloxone Program. | Patients with opioid use disorder | # of patients and/or community at large who receive Naloxone prescription in the ED. | 726 patients received MAT services in the ED. | 2,170 patients |
| Collaborate with partner FQHC to provide free psychiatry services | FQCH patients | # of patients who receive psychiatric evaluation and medication management. | 100 unique patients; 110 encounters | 300 unique patients;<br>325 encounters |

*Evidence Based Sources*

- Behavioral health primary care integration: https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/behavioral-health-primary-care-integration

*Resource Commitment*

$150,000-$200,000 per year for Each Mind Matters and other mental health strategies.

*Key Community Partners*

St. Joseph Hospital Orange, Mission Hospital, Westbound Communications, St. Jude Neighborhood Health Centers (FQHC).

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

*Population Served*

Unhoused people/communities and low-income residents in North Orange County

*Long-Term Goal(s)/ Vision*

Providence is a dedicated member of local coalitions to ensure coordination of homeless support services, including recuperative care, and that there are increased connections to supportive services for individuals experiencing homelessness.

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

| Strategy | Population Served | Strategy Measure | Baseline | 2026 Target |
|---|---|---|---|---|
| Support Homeless Navigation Program | Patients experiencing homelessness | Decrease the number of days patients experiencing homelessness are in the hospital beyond what is medically necessary without an appropriate place to discharge | 275 days in the hospital in 2023 | 150 days in the hospital |

| | | | | |
|---|---|---|---|---|
| Partner with Illumination Foundation to provide Recuperative Care. | Patients experiencing homelessness | # of patients that are referred to recuperative care post discharge and obtain access to primary care, behavioral health services, case management, and supportive housing services. | 7 patients referred | 10-14 patient referrals |
| Support United Way Eviction Diversion & Prevention Program | Families at risk for eviction | # of households that are assessed and receive an ecosystem of eviction prevention services. | 600 clients referred to program<br>347 clients utilized eviction prevention assessment tool<br>165 clients served with eviction diversion services | 1,800 clients referred to the program<br>500 clients utilized eviction prevention assessment tool<br>300 clients served with eviction diversion services |
| Support Homes for All, an advocacy training program to build community leaders' capacity in north and central OC to address immediate housing needs and advocate for increased production of | Persons living in rent-burdened census tracts | # of Community-based Organizations trained | 30 community members trained using curriculum<br>12 residents actively participate in community meetings on Housing Element compliance and submit public comments | Residents/low-income communities of color are equipped with information and advocacy tools that enable them to engage in city-level decision-making. |

| | | | | |
|---|---|---|---|---|
| affordable housing. | | | | |
| Support development of OC's first Affordable Housing Access website to empower residents and Housing Navigators in social service agencies seeking affordable housing opportunities. | Low-income residents trying to secure stable affordable housing | Website developed and deployed in English and Spanish. | New project | Affordable Housing Access website is available to provide vital information about existing affordable housing units, resident interest list, and empowering residents and housing navigators in social service agencies seeking affordable housing opportunities. |
| Create access point for the Fullerton School District's Hub Family Resource Center at Valencia Park Elementary School | Title 1 school-age children and their families experiencing housing insecurity | # of families that access McKinney-Vento Act resources including assistance with housing, food, health care, and mental health services | Since August 2023, a total of 60 families served | At least 400 families are helped with housing (temporary/permanent), clothing, food, health care, mental health services, hygiene products, and school supplies per year. |

*Evidence Based Sources*

- Best practices for community responses to unsheltered homelessness: http://www.evidenceonhomelessness.com/recent_highlights/series-of-briefs-offer-evidence-based-guidance-and-best-practices-for-community-responses-to-unsheltered-homelessness/

*Resource Commitment*

$800,000 is budgeted for 2024-2026 to support Homeless Navigation Program

*Key Community Partners*

Health Care Agency Orange County; Illumination Foundation; The Kennedy Commission; United Way OC; People For Housing; Fullerton School District

## Other Community Benefit Programs

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

| Initiative (Community Need Addressed) | Program Name | Description | Population Served (Low Income, Vulnerable or Broader Community) |
|---|---|---|---|
| Engaging community partners to address health disparities | Healthy Communities: Move More Eat Healthy | Technical assistance to support community collaboratives | Low-income |
| Lack of public transportation | Transportation Program | Provide non-emergency medical transportation | Low-income |
| Lack of access to medical services | Post Hospital Transition Care for Indigent Patients | Hospital costs incurred to take care of indigent patients, both the uninsured and underinsured – including long-term facility, homecare, hospice, mental health, ambulance fees and taxicab vouchers among others | Low-income |
| Lack of support services for frail elderly | Senior Services | Information and referrals, support groups, classes, Caring Neighbors Volunteer Program | Low-income |
| Access to Care | Rehab Community Reintegration | Provides recreational, exercise, communication, and other groups for individuals with a disability to assist in their re-entry into the community | Broader community; people with disabilities |

| | | | |
|---|---|---|---|
| Support for family caregivers overwhelmed with needs of person they are caring | Family Caregiver Support Program/Orange Caregiver Resource Center | Partnership to provide family caregivers with assessment, advice for developing a respite program, referrals, education, legal and support services that assist them in their role as a caregiver | Broader Community |
| Coordination of services for traumatic brain injury patient population | St. Jude Brain Injury Network | Provide case management, support services to assist adult survivors of traumatic brain injury with assistance in vocational, housing, health and financial needs | Low-income |
| Food Insecurity | Meals on Wheels Food Finders | Special diets for home delivery and food donation | Broader Community |
| Neuro Rehab | Neuro Rehab Continuum | Inpatient and Outpatient rehab | Broader Community |

# 2024- 2026 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Community Health Committee of the hospital on February 14, 2024. The final report was made widely available by May 15, 2024.

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3/25/2024

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

Sister Mary L Rogers 3/13/24

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