La Amistad Dental Clinic Orange, California
Dr. Van, Dental Director and Dental Assistant providing preventive dental services

St. Joseph Hospital

Fiscal Year 2015 COMMUNITY BENEFIT REPORT

PROGRESS ON FY15 - FY17 CB PLAN/IMPLEMENTATION STRATEGY REPORT

St.JosephHealth
St. Joseph Hospital
A member of the St.Joseph Hoag Health alliance

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[1] Non-financial summary of accomplishments are referred to in SB 697 as non-quantifiable benefits.

EXECUTIVE SUMMARY

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

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

In FY15, community benefit investments totaled **$78,328,695**. This included services to the poor, vulnerable and at risk populations as well as for the broader community. Unpaid costs to Medicare totaled $64,243,956.

Overview of Community Needs and Assets Assessment

Summary of Community Needs Assessment Process

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

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

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

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

Community Plan Priorities/Implementation Strategies

The following information provides a brief summary of accomplishments associated with each of the Community Benefit Initiatives for FY15:

- **Initiative #1:** Access to Health Care
    - In the summer of 2014, Dr. Rich Afable, Regional Executive Vice President of Southern California, convened the three southern California Federally Qualified Health Center (FQHC) clinics to begin discussing ways in which we could build a network of care for serving the underserved/uninsured in Orange County. Out of that meeting, Dr. Afable requested that St. Jude Neighborhood Health Center (SJNHC) explore the potential for merging SJO's La Amistad Family Health Center/Puente a la Salud Mobile Community Clinics and SJNHC to ensure long term sustainability. Shortly after that meeting, SJO VP of Mission Integration, St. Jude Medical Center VP of Healthy Communities and SJNHC leadership met to discuss possible options and outline a clear path to bringing both clinics together. After a period of due diligence by the hospitals and the clinic, a decision was made unanimously to move forward with the merger. On May 1, 2015, La Amistad Family Health merged with SJNHC. La Amistad is now under SJNHC's tax ID and licensure. SJO has committed to continuing its financial support of La Amistad and Puente a la Salud by dedicating its Care For The Poor funds to the clinic. In addition, SJO has signed an affiliation agreement as well as a service agreement with SJNHC which further outlines the ongoing support it will continue to provide La Amistad and Puente a la Salud. This regional effort has resulted in administrative efficiencies, shared policies and best practices and increased financial stability for the clinics. Most importantly and a clear tangible outcome of this regional effort is that today, SJNHC with La Amistad as an additional clinic site are the **largest safety net providers** for the uninsured among community clinics in Orange County.
    - The La Amistad Family Health Center and Puente a la Salud Mobile clinics served 6,913 patients which was a 12% increase over last fiscal year. In addition, 2,736 new patients selected SJO Community Clinics as their medical home.
    - We formed relationships with over seven groups of SJO specialists who agreed to see our clinic patient.

  - The clinic's process improvements efforts resulted in re-organizing patient flow, staff shifts and scheduling changes as well as implementing the clinic's first ever Call Center.

- **Initiative #2:** Chronic Disease Management
  - The total number of La Amistad diabetic patients who were "uncontrolled" decreased from 536 to 466 571 of 861 (66%) clinic diabetic patients of patients received diabetic eye exam.
  - The clinic's EHR system was completed and received Meaningful Use Certification. The EHR contains best practice clinical standards of care for chronic disease management.

- **Initiative #3:** Mental Health
  - A depression baseline was established. The data determined that 47% of diabetic patients screened were Moderate, Moderate Severe, and Severe risk for depression.
  - The clinic Health Educator developed a list of 9 different referrals to local mental health counseling resources. The list was offered to patients who scored Moderate during the screening. All patients screened were offered a follow up appointment with their clinic Provider.
  - Southern California Regional SHJ Ministries secured funding to provide Telehealth Psychiatry Services for underserved clinic patient population. *So. California Regional Ministries secured funding to provide Telehealth Psychiatry Services for underserved clinic patient population.*

INTRODUCTION

Who We Are and Why We Exist

As a ministry founded by the Sisters of St. Joseph of Orange, SJO lives out the tradition and vision of community engagement set out hundreds of years ago. The Sisters of St. Joseph of Orange trace their roots back to 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.

Mission, Vision and Values and Strategic Direction

Our Mission

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

Our Vision

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

Our Values

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

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

Strategic Direction

As we move into the future, St. Joseph Hospital is committed to furthering our mission and vision while transforming healthcare to a system that is health-promoting and preventive,

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

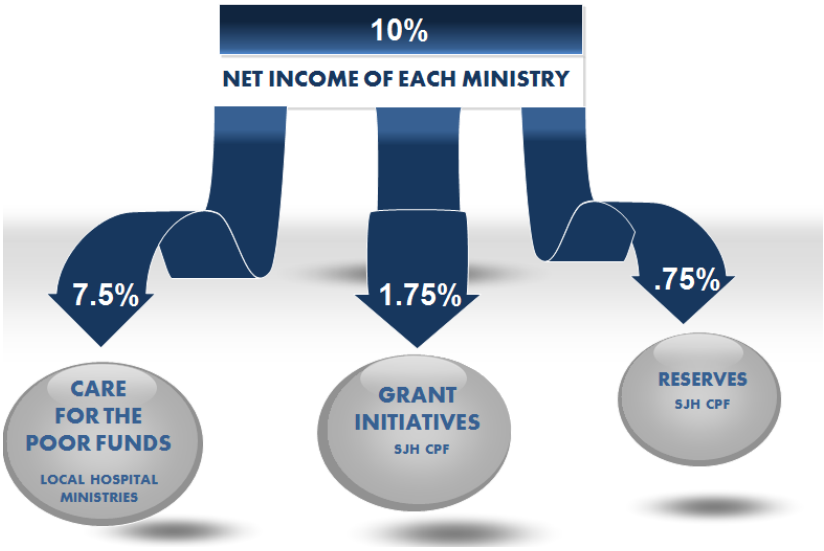
In FY15, community benefit investments totaled **$78,328,695**. This included services to the poor, vulnerable and at risk populations as well as for the broader community. Unpaid costs to Medicare totaled $64,243,956.

ORGANIZATIONAL COMMITMENT

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

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

Figure 1. Fund distribution



Each year St. Joseph Hospital allocates 10% of its net income (excluding unrealized gains and losses) to the St. Joseph Health Community Partnership Fund. (See Figure 1). 7.5% of the contributions are used to support local hospital Care for the Poor programs. 1.75% is used to support SJH Community Partnership Fund grant initiatives. The remaining .75% is designated toward reserves, which helps ensure the Fund's ability to sustain programs into the future that assist low-income and underserved populations.

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

Community Benefit Governance Structure

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

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

A charter approved in 2007 establishes the formulation of the St. Joseph Hospital Community Benefit Committee. The role of the Community Benefit Committee is to support the Board of Trustees in overseeing community benefit issues. The Committee acts in accordance with a Board-approved charter. The Community Benefit Committee is charged with developing policies and programs that address identified needs in the service area particularly for underserved populations, overseeing development and implementation of the Community Health Needs Assessment and Community Benefit Plan/Implementation Strategy Reports, and overseeing and directing the Community Benefit activities.

The Community Benefit Committee has a minimum of eight members including three members of the Board of Trustees. Current membership includes 5 members of the Board of Trustees and 7 community members. A majority of members have knowledge and experience with the populations most likely to have disproportionate unmet health needs. The Community Benefit Committee generally meets bimonthly.

Roles and Responsibilities

Senior Leadership

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

Community Benefit Committee (CBC)

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

Community Benefit (CB) Department

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

Local Community

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

PLANNING FOR THE UNINSURED AND UNDERINSURED

Patient Financial Assistance Program

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 (FAP)** that provides free or discounted services to eligible patients. In FY15, St. Joseph Hospital, provided $5,409,141 in charity care and 9,250 encounters.

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 his/her bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible.

Medicaid and Other Means-Tested Government Programs

St. Joseph Hospital provides access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California, and other means-tested government programs. In FY15, St. Joseph Hospital, provided $65,553,081 in Medicaid and recorded a unpaid cost of other means-tested government programs net benefit of ($41,147) due to prior year settlement and reconciliation of old MSI accounts.

COMMUNITY

Defining the Community

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

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

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

Hospital Total Service Area

The community served by the Hospital is defined based on the geographic origins of the Hospital's inpatients. The Hospital Total Service Area is 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 Anaheim, Garden Grove, Midway City, Orange, Santa Ana, Tustin, Villa Park and Westminster. The SSA is comprised of Buena Park, Corona, Costa Mesa, Cypress, Foothill Ranch, Fountain Valley, Fullerton, Huntington Beach, Irvine, and Lake Forest.

Table1. Cities and ZIP codes

Cities	ZIP codes
Anaheim	92801, 92802, 92804, 92805, 92806, 92807, 92808
Garden Grove	92840, 92841, 92843, 92844, 92845
Midway City	92655
Orange	92865, 92866, 92867, 92868, 92869
Santa Ana	92701, 92703, 92704, 92705, 92706, 92707
Tustin	92780, 92782
Villa Park	92861
Westminster	92683
Buena Park	90620, 90621
Corona	92879, 92880, 92882, 92883
Costa Mesa	92626, 92627
Cypress	90630
Foothill Ranch	92610
Fountain Valley	92708

Fullerton	92831, 92833
Huntington Beach	92646, 92647, 92648, 92649
Irvine	92602, 92603, 92604, 92605, 92606, 92612, 92614, 9267, 92618, 92620
Lake Forest	92630

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

Figure 1. St. Joseph Hospital Total Service Area

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

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

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

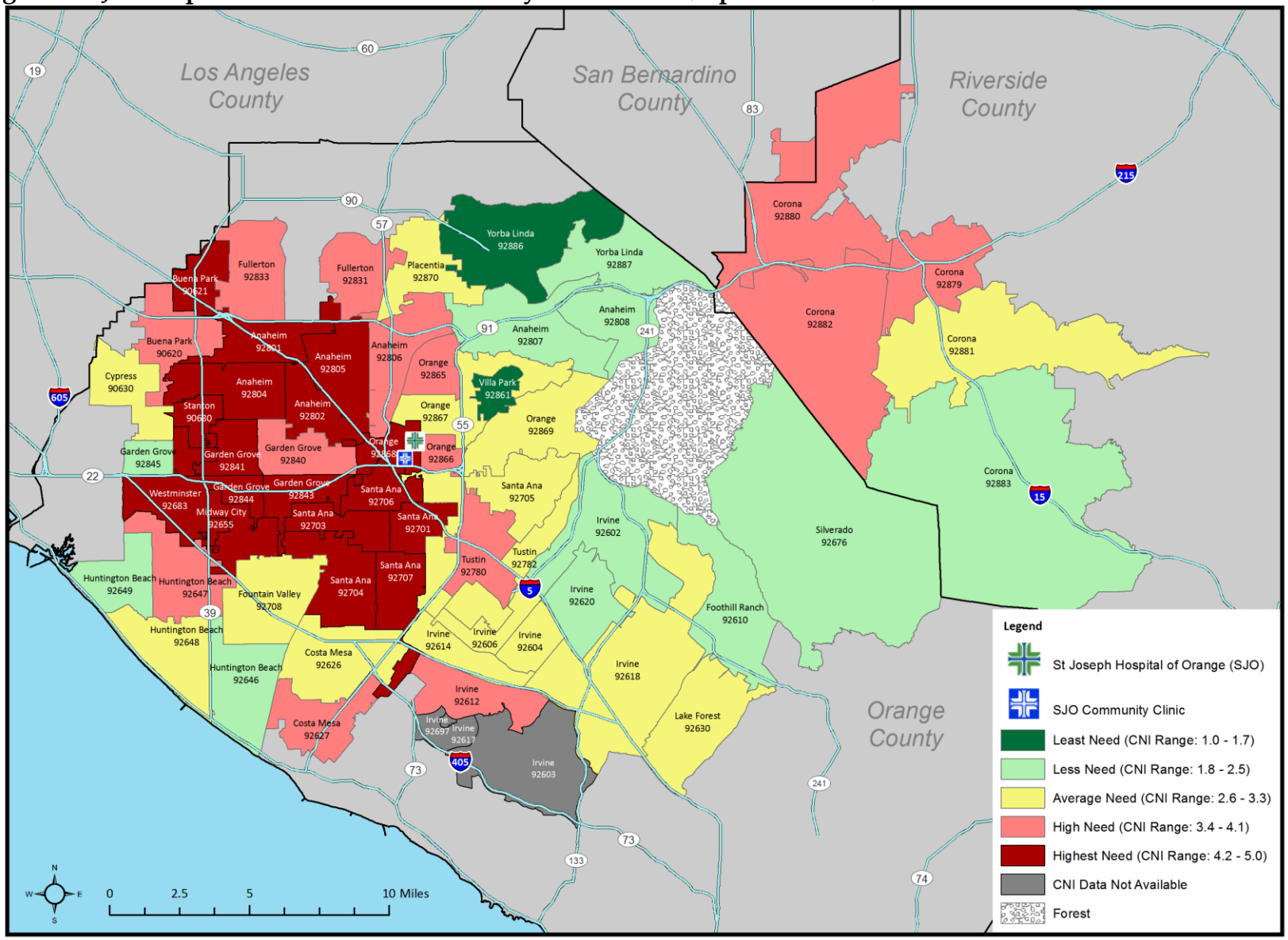
- Income Barriers (Elder poverty, child poverty and single parent poverty)
- Culture Barriers (non-Caucasian limited English);
- Educational Barriers (% population without HS diploma);
- Insurance Barriers (Insurance, unemployed and uninsured);
- Housing Barriers (Housing, renting percentage).

This objective measure is the combined effect of five socioeconomic barriers (income, culture, education, insurance and housing). A score of 1.0 indicates a zip code with the fewest socioeconomic barriers, while a score of 5.0 represents a zip code with the most socioeconomic barriers. Residents of communities with the highest CNI scores were shown to be twice as likely to experience preventable hospitalizations for manageable conditions such as ear infections, pneumonia or congestive heart failure compared to communities with the lowest CNI scores. (*Ref (Roth R, Barsi E., Health Prog. 2005 Jul-Aug; 86(4):32-8.)* The CNI is used to 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 92703 on the CNI map is scored 5.0, making it a High Need community.

Figure 2 (following page) 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. SJO Hospital Service Area Community Need Index (Zip Code Level)



Map represents HTSA (Hospital Total Service Area).
Prepared by the St Joseph Health Strategic Services Department, September 2013.
Source: Dignity Health.

Intercity Hardship Index (Block group level) Based Geographic Need

The Intercity Hardship Index (IHI) was developed in 1976 by the Urban and Metropolitan Studies Program of the Nelson A. Rockefeller Institute of Government to reflect the economic condition of cities and allow comparison across cities and across time. The IHI ranges from 0-100, with a higher number indicating greater hardship. The IHI was used by St. Joseph Health to identify block groups with the greatest need.

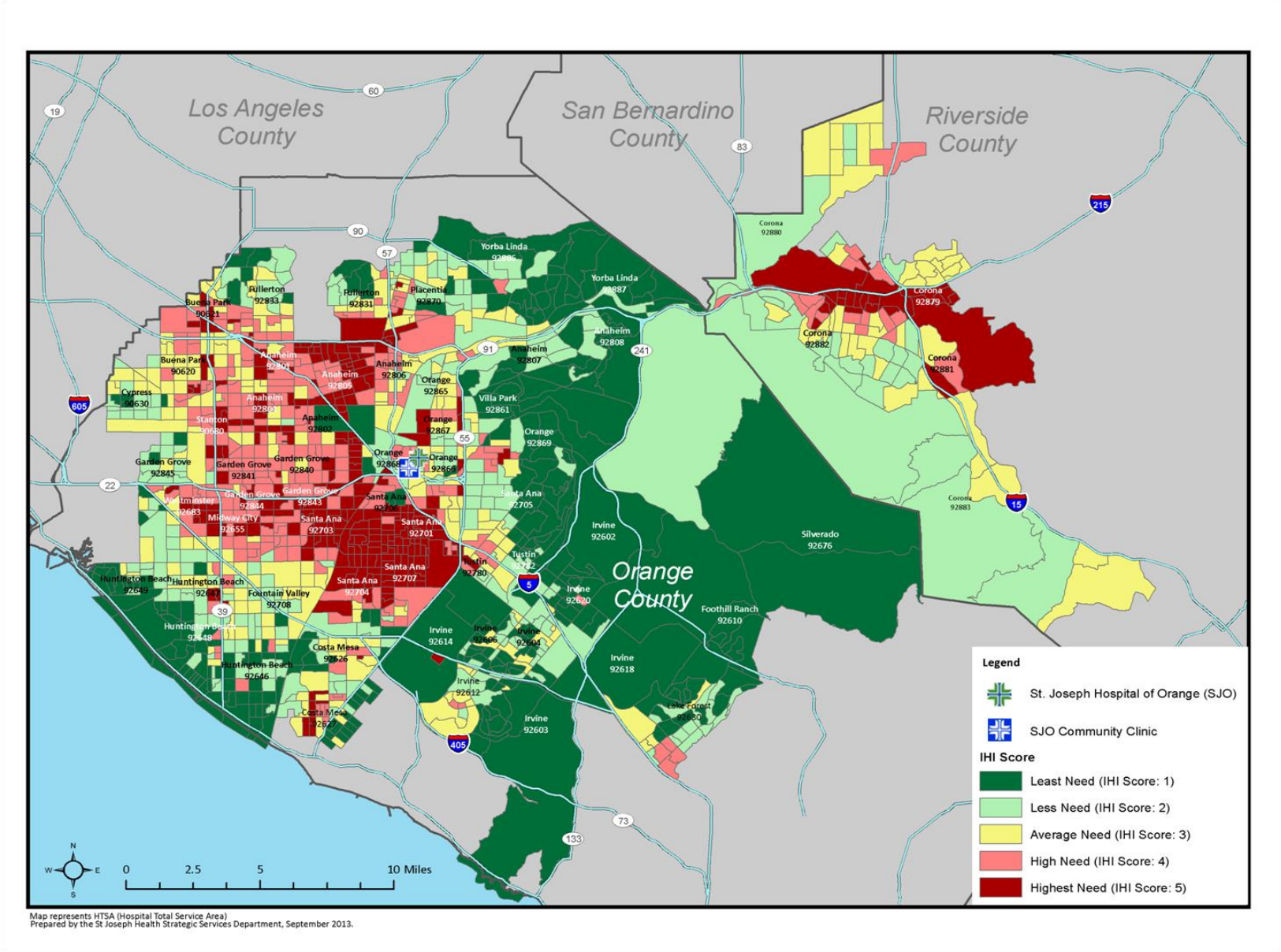
The IHI combines six key social determinants that are often associated with health outcomes:

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

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

Figure 3 (see following page) depicts the **Intercity Hardship Index** for the hospital's geographic service area and demonstrates *relative need*.

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



COMMUNITY NEEDS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

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

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

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

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

Primary Data

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

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

Focus Groups – A total of 54 community members participated in five focus groups about health needs and quality of life issues in the St. Joseph Hospital service area. The transcripts of four focus groups (40 participants) that were conducted in May 2012 for The Cambodian

Family, a local nonprofit organization, were analyzed for this assessment. Two of the focus groups were conducted in Spanish, and two in Khmer. All four asked about health and quality of life challenges in the Santa Ana area. A fifth focus group was conducted in October 2013. This focus group consisted of 14 clients of the St. Joseph Hospital Diabetes Management Program and was conducted in Spanish.

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

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

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

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 DUHN Communities

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

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

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

DUHN Group and Key Community Needs and Assets Summary Table

DUHN Population Group or Community	Key Community Needs	Key Community Assets

Garden Grove – 92843, 92844	• Higher rates of families where Spanish is the primary language at home
	• Higher rates of families with someone age 25+ not having a HS diploma
	• Higher number of Households with more than 7 people
	• Higher number of Households living below the poverty level
	• Higher number of female heads of household
	Utilizing IHI and CNI to identify areas with disproportionate unmet health needs, the zip codes listed reflect areas with
	• Higher rates unemployment
	• Higher rates of dependency
	• Lower rates of education attainment
	• Lower per capita income levels
	• Higher rates of crowded housing (> 7 persons per household)
	• Higher rates of poverty
	• Higher rates of limited English proficient individuals
	• Higher rates of unemployed and uninsured
		• County of Orange Health Care Agency
		• Community-based Organizations
		  ○ Healthy Smiles
		  ○ Orange County Asian and Pacific Islander Community Alliance (OCAPICA)
		  ○ Orange County Korean American Health Information Education Center (OCKAHIEC)
		  ○ MOMS Orange County

Santa Ana – 92701, 92704, 92707	• Higher rates of families where Spanish is the primary language at home
	• Higher rates of families with someone age 25+ not having a HS diploma
	• Higher number of households with more than 7 people
	• Higher number of households living below the poverty level
		• County of Orange Health Care Agency
		• Community-based Organizations
		  ○ Latino Health Access
		  ○ Kidworks
		  ○ MOMS Orange County
		  ○ The Cambodian Family
		  ○ Delhi Center
		  ○ Corbin Family Resource Center
		  ○ Taller San Jose

	• Higher number of female heads of household Utilizing IHI and CNI to identify areas with disproportionate unmet health needs, the zip codes listed reflect areas with • Higher rates Unemployment • Higher rates of dependency • Lower rates of education attainment • Lower per capita Income levels • Higher rates of crowded housing (> 7 persons per household) • Higher rates of poverty • Higher rates of limited English proficient individuals Higher rates of unemployed and uninsured	• Community Clinics/Health Centers o AltaMed (3 clinics) o Birth Choice Health Center o Clinica CHOC Para Ninos o Kaiser Permanente Harbor MacArthur Clinic o Puente a la Salud Mobile Community Clinics o Serve the People Health Center o SOS-El Sol Wellness Center o UCI Santa Ana
Midway City - 92655	• Higher rates of families where Spanish is the primary language at home • Higher rates of families with someone age 25+ not having a HS diploma • Higher number of households with more than 7 people • Higher number of households living below the poverty level • Higher number of Female heads of household Utilizing IHI and CNI to identify areas with disproportionate unmet health needs, the zip codes listed reflect areas with • Higher rates unemployment • Higher rates of dependency • Lower rates of education attainment • Lower per capita income levels • Higher rates of crowded housing (> 7 persons per household) • Higher rates of poverty • Higher rates of limited	• County of Orange Health Care Agency • Community-based Organizations o MOMS Orange County

	English proficient individuals Higher rates of unemployed and uninsured	

Anaheim – 92801, 92805	Utilizing IHI and CNI to identify areas with disproportionate unmet health needs, the zip codes listed reflect areas with
	• Higher rates unemployment
	• Higher rates of dependency
	• Lower rates of education attainment
	• Lower per capita income levels
	• Higher rates of crowded housing (> 7 persons per household)
	• Higher rates of poverty
	• Higher rates of limited English proficient individuals
	Higher rates of unemployed and uninsured
		• County of Orange Health Care Agency
		• Community-based Organizations
		  ○ Boys and Girls Club
		  ○ Anaheim Harbor Family Resource Center
		  ○ MOMS Orange County
		• Community Clinics/ Health Centers
		  ○ Alta Med (2 clinics)
		  ○ Puente a la Salud Mobile Community Clinics
		  ○ UCI Family Health Center-Anaheim

PRIORITY COMMUNITY HEALTH NEEDS

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

Top Eight Concerns

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

Seven Additional Concerns:

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

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 community benefit programs and by funding other non-profits through our Care for the Poor Program managed by St. Joseph Hospital.

Furthermore, St. Joseph Health, 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, resources to meet the identified needs of underserved communities through St. Joseph Health communities.

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

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

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

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

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

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

COMMUNITY BENEFIT PLANNING PROCESS

Summary of Community Benefit Planning Process

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

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

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

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

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

- Access to Health Care
- Chronic Disease
- Mental Health

ST. JOSEPH HOSPITAL
FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY15 Accomplishments

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

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

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

Outcome Measure	Baseline	FY15 Target	FY15 Result
Number of new patients who select SJO Community Clinics as their medical home.	1,900 new (additional) patients in FY14	2,280 new patients	2,097 new patients

Strategy(ies)	Strategy Measure	Baseline	FY15 Target	FY15 Result
Increase # of patients served by 20%.	Number of unique patients served at SJO Community Clinics	6,186 patients in FY14	7,423 patients	6,913 patients; A 12% increase in # of patients served.
Increase availability of Specialty Care providers.	Number of specialists who accept patient referrals	Current specialists accepting patients: 2-5	6-8 specialty groups	New specialists accepting patient referrals: 35 Orthopedic Surgeons from Hoag Orthopedic Institute Group- Irvine

				& Orange Site, Gastroenterologist, General Surgeon, OBGYN, Thoracic Surgeon, Endocrinologist and Plastic Surgeon.
Implement performance improvement plan throughout clinic departments.	Percentage of process improvement initiatives/events implemented	5 Process Improvement events executed	Process Improvement event outcomes result in effective, efficient, productive and sustained systemic changes	Process improvements resulted in re-organizing patient flow, staff shifts and scheduling changes as well as implementing the clinic's first ever Call Center.

Key Community Partners: Coalition of Orange County Health Centers, Family Resource Centers and CalOptima

FY15 Accomplishments: The strategy to increase 20% of patients served fell short by 8%. A number of unforeseen challenges impacted our ability to reach our goal. First, La Amistad Family Health Center patients who had Medical Services for the Indigent (MSI) as their health insurance began to transition over to CalOptima. CalOptima assured SJO Director of Contracts that this population would seemly transition over. Unfortunately this did not take place. Many of our MSI patients received automatic assignments to a different clinic medical homes. Even though our Business Office staff assisted many of these patients in navigating the process with CalOptima (Orange County's Medi-Cal insurance product), not all were successful. Of those who successfully transitioned over, after 30 days, they were re-assigned to another medical home because they now had CalOptima Direct. In addition, during the fiscal year, SJO made the decision that La Amistad Family Health Center and Puente a la Salud Mobile Clinics would merge with St. Jude Neighborhood Health Center. One of the most critical changes that took place was the conversion of the Patient Management System and the Electronic Health Record (EHR). The conversion caused a decrease in productivity which impacted the clinic during the last 2½ months of the fiscal year. One of the most successful outcomes of the fiscal year was the creation and implementation of the clinics's Call Center. All calls requesting appointments and/or information for La Amistad and Puente a la Salud now are routed to one phone number. The Call Center is staffed by two full time employees.

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

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

Outcome Measure	Baseline	FY15 Target	FY15 Result
Number of chronic disease patients with improved clinical values	536 uncontrolled diabetics (47%) 604 controlled diabetics (53%)	44% uncontrolled diabetics 56% controlled diabetics	466 uncontrolled diabetics (44%) 547 controlled diabetics (52%)

Strategy(ies)	Strategy Measure	Baseline	FY15 Target	FY15 Result
Decrease A1C by one percentage point	Number of diagnosed diabetic patients that decrease their A1C by one percentage point from baseline	536 patients with uncontrolled diabetes	500 patients with uncontrolled diabetes	466 patients with uncontrolled diabetes
Increase number of patients who receive diabetic eye exam by 10%	Number of patients who receive diabetic eye exam	657 of 961 (68%) of patients received diabetic eye exam	722 patients receive diabetic eye exam	571 of 861 (66%) patients of patients received diabetic eye exam.
Implement best practice standards of care for community clinic chronic disease management	System/platform in place in enhanced EHR to track and monitor implementation of best practice standards	Started the building of grant funded enhanced EHR	System/platform developed and implemented	EHR system was completed and received Meaning Use Certification. EHR contains best practice clinical standards of care for chronic disease management.

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

FY15 Accomplishments: During the transition of clinic patients from MSI to CalOptima, the Vision Mobile Clinic lost approximately. 86 patients. The Vision Mobile Clinic was able to bill for MSI visits. However, because CalOptima patients have coverage for vision services through Vision Services Plan (VSP) and the Vision Mobile Clinic is not currently a VSP provider, we could no longer see those patients. CalOptima patients (formerly MSI patients on the Vision Mobile Clinic) had to be referred to an outside VSP provider. VSP does not credential mobile clinics at this time but are considering changing their process to include mobile clinics.

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

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

Outcome Measure	Baseline	FY15 Target	FY15 Result
Number of persons who are screened for depression	None	Establish "at risk" for depression baseline	313 persons screened for depression

Strategy(ies)	Strategy Measure	Baseline	FY15 Target	FY15 Result
Integrate behavioral health screening into primary care services	Number of targeted (diabetic population) behavioral health screening consistently being used at La Amistad Family Health Center	None	Establish "at risk" for depression baseline	Baseline determined that 47% of diabetic patients screened were Moderate, Moderate Severe, and Severe risk for depression
Coordinate referral sources with partners	Number of established creditable community resources for referrals	None	A list of local resources for behavioral health services	We've compiled a list of 9 different referrals to local mental health counseling resources. The list is provided to patients upon request. It is also provided to

				patients who take depression assessment and score "Moderate" or above.
Participate in County collaborative efforts	Develop regional behavioral health initiative to address identified goals	None	Implement at least 1 of 3 regional goals to provide access to behavioral health services onsite	So. California Regional Ministries secured funding to provide Telehealth Psychiatry Services for underserved clinic patient population.

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

FY15 Accomplishments: St. Jude Medical Center, Mission Hospital, Hoag Hospital and St. Joseph Hospital have entered into a collaborative partnership to address the unmet need for behavioral health services for the most underserved population in Orange County. The Regional telepsychiatry project is a pilot program that would provide low income patients served by the ministries with medication management through a Psychiatrist as well as care coordination to ensure continuum of care through the community clinics. Assessment and counseling will be provided at clinics where available or referred out to the new OC Health Care Agency Behavioral Health Services.

Other Community Benefit

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

Initiative (community need being addressed):	Program	Description	FY15 Accomplishments
Access to Dental	La Amistad and Puente a la Salud Dental Services	Provide mobile and fixed comprehensive dental services for adults and children.	4,516 encounters
Access to Vision	Puente a la Salud Vision Services	Provide mobile vision services for adults and children.	1,948 encounters
Access to Health Screening	Puente a la Salud Mobile Cardiovascular Screening Program	Provide cardiovascular screenings and follow up for adults.	1,565 encounters
	Taller San Jose Pre-employment Screening Program	Provide pre-employment drug screening and vaccines to teens and young adults.	163 encounters
	Laboratory Services	Provide various lab tests to Lestonnac Free Clinic patients.	27,328 labs provided
	Women's Heart Center	Provide cardiovascular screenings to women.	102 encounters
Postpartum Depression	Postpartum Depression Comprehensive Services	Provide screening and treatment to women referred.	232 encounters and 121 unduplicated patients
Food Insecurity	Meals On Wheels Program	Provide meals to seniors and disabled persons.	10,320 encounters and 5,160 unduplicated persons
	Waste Not OC Program	Provides food donations from the hospital cafeteria to food bank for the homeless	3,602 meals and 4.322 pounds of food
Access to Rx	Pharmacy Meds Program	Provide needed Rx upon discharge.	451 prescriptions provided
Postpartum follow up	Mother Baby Assessment Center	Provide physical and psycho-social assessment of mother and baby.	5,438 encounters and 3,070 unduplicated patients

FY15 Community Benefit Investment

In FY15 St. Joseph Hospital invested a total of $1,828,428 Care for the Poor dollars in FY15 in key community benefit programs. SJO received a prior year, July 1, 2013 to December 31, 2013 settlement of $41,146.64 for the Orange County indigent program Medical Services for the Indigent (known as MSI). With MSI transitioning to CalOptima (Orange County's Medi-Cal product), SJO reconciled remaining MSI accounts.

FY15 COMMUNITY BENEFIT INVESTMENT
ST. JOSEPH HOSPITAL
(ending June 30, 2015)

CA Senate Bill (SB) 697 Categories	Community Benefit Program & Services[2]	Net Benefit
Medical Care Services for Vulnerable[3] Populations	Financial Assistance Program (FAP) (Traditional Charity Care-at cost)	$5,409,141
	Unpaid cost of Medicaid[4]	$65,553,081
	Unpaid cost of other means-tested government programs	$(41,147)
Other benefits for Vulnerable Populations	Community Benefit Operations	$0
	Community Health Improvements Services	$122,779
	Cash and in-kind contributions for community benefit	$921,449
	Community Building	$0
	Subsidized Health Services	$3,256,910
	Total Community Benefit for the Vulnerable	$75,222,213
Other benefits for the Broader Community	Community Benefit Operations	$513,455
	Community Health Improvements Services	$2,219,829
	Cash and in-kind contributions for community benefit	$0
	Community Building	$0
	Subsidized Health Services	$ 236,615
Health Professions Education, Training and Health Research	Health Professions Education, Training & Health Research	$136,583
	Total Community Benefit for the Broader Community	$3,106,482
	TOTAL COMMUNITY BENEFIT *(excluding Medicare)*	$78,328,695
Medical Care Services for the Broader Community	Unpaid cost to Medicare[5] ***(not included in CB total)***	$64,243,956

[2] Catholic Health Association-USA Community Benefit Content Categories, including Community Building.
[3] CA SB697: "Vulnerable Populations" means any population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medicaid (referred to as Medi-Cal in California), Medicare, California Children's Services Program, or county indigent programs. For SJH, we exclude Medicare as part of Community Benefit total and only include it below the line for SB697 reporting purposes.
[4] Accounts for Hospital Fee. The pledge/grant (separate from the quality assurance fee) is reported in Cash and In-kind Contributions for other vulnerable populations.
[5] Unpaid cost of Medicare is calculated using our cost accounting system. In Schedule H, we use the Medicare cost report.

Telling Our Community Benefit Story: Non-Financial[6] Summary of Accomplishments

SJO's Executive and Management Team members lent their expertise, time and talent to outside organizations committed to delivering healthcare excellence and healthy communities.

The following lists all Board membership participation and volunteer work.

- *Chair for the Southern California region of Hospital Association of Southern California*
- *Board of Trustees member for Taller San Jose*
- *Western University Advisory Board member and California State University, Fullerton Advisory Board member*
- *California Hospital Patient Safety Organization Board member*
- *Southern California Association for Healthcare Risk Management Board member*
- *Children's Health Initiative of Orange County Advisory Committee member*
- *El Sol/SOS Wellness Center Advisory Committee*
- *Orange County Coalition of Community Health Centers member*
- *Bethany House Board member*
- *Casa Teresa Board member*
- *CNI Career Network Institute Advisory Board member*
- *California State University, Fullerton Nursing Advisory Board member*
- *Sigma Theta Tau Nursing Honor Society Board member*
- *Leadership Orange Executive Committee member*
- *Chairman of Health Associates Federal Credit Union Board member*
- *National Philanthropy Day Committee*
- *Association of Fundraising Professionals, Orange County Board member*
- *National Renal Administrators Association Board member*
- *National Kidney Foundation Public Policy Committee*
- *Association for the Advancement of Medical Instrumentation- Board member Water Treatment and Dialysis Equipment*
- *Kidney Care Partners Advocacy Committee*
- *Orange County of the Association for Clinical Laboratory Management*
- *Pet Therapy Program volunteer*
- *No One Dies Alone Program volunteer*
- *Volunteer Advisory Board member*
- *Mock interviewer volunteer for Taller San Jose*
- *National Kidney Foundation Council of Nephrology Nurses & Technicians Executive Committee Board member*
- *Renal Disease and Detoxification Committee*
- *Home Care Applications Committee*
- *Fistula First Breakthrough Initiative*
- *County of Orange Health Care Agency Dialysis Advisor*
- *Focus Orange County volunteer*
- *Endoscopy and Surgery Center staff volunteer for Access OC (free surgeries for the uninsured)*
- *Association of Fundraising Professionals Orange County Board member*
- *Advisory Council, State of California, Breast and Cervical Cancer Chair*
- *American Liver Foundation Greater LA and Orange County Medical Advisory Board*
- *Physician Engagement Team Member, American Cancer Society, California Division*

[6] Non-financial summary of accomplishments are referred to in CA Senate Bill 697 as non-quantifiable benefits.