ST. JOSEPH HEALTH MINISTRY, ST. JUDE

FY15 – 17 Community Benefit Plan/ Implementation Strategy Report

St. Joseph Health, St. Joseph Health Ministry

St. Joseph Health
St. Jude Medical Center
St. Jude Heritage Medical Group

TABLE OF CONTENTS

EXECUTIVE SUMMARY

St. Joseph Health, St. Jude Medical Center (referred to in this document as the Medical Center) is located in 101 E. Valencia Mesa Drive, Fullerton, CA 92835. The facility has 329 licensed beds with centers of excellence in Cardiac, Oncology, Orthopedics, Rehabilitation, and Women and Children's Services. The Medical Center's 2,865 employees and 740 medical staff are committed to striving for sacred encounters, perfect care and healthiest communities. St. Jude Heritage Healthcare is a not-for-profit medical practice foundation with 866 employees and 150 physicians in partnership with the Medical Center serving over 250,000 residents in North Orange County and neighboring areas.

The community benefits service area of St. Jude Medical Center (SJMC CBSA) and its integrated medical practice foundation St. Jude Heritage Healthcare includes the following cities of North Orange County: Fullerton, Brea, Placentia, Buena Park, La Habra and Yorba Linda. This service area with a population of 443,813 represents communities of wealth and poverty, working class communities and middle class areas. While the average household income in the service area is almost $71,521, there are several neighborhoods where the household income is half of the average. The service area is one of great ethnic diversity. Hispanics make up over one-third of the population and Asian-Pacific Islanders are 16 percent of the population. In many neighborhoods the majority of the community is Hispanic and Spanish is the primary language spoken at home. The neighborhoods where the Medical Center's community benefit programs focus are those that are lower in income and more ethnically diverse (DUHN – Disproportionate Unmet Health Needs neighborhoods).

In response to identified unmet health-related needs in the community needs assessment, during FY15-17 St. Jude Medical Center will focus on access to medical care for the underserved; obesity; behavioral health; and infant and child health for the broader and underserved disadvantaged members of the surrounding community.

Access to medical care for the underserved remains a critical need as there will be an estimated 300,000 uninsured persons in Orange County after health care reform is fully implemented. Our partnership with St. Jude Neighborhood Health Centers will continue to be our major focus of this initiative, as will our on-going charity care and our expanded participation in CalOptima, the county organized MediCal managed care plan. We will expand our efforts on obesity prevention by focusing on the home, community and school environments of low-income children and their families. Our work in behavioral health will support both the countywide initiative and our health system regional plan. Our efforts in infant and child health will focus on increasing immunization rates and childhood obesity prevention.

Due to the fast pace at which the community and health care industry change, St. Jude Medical Center anticipates that implementation strategies may evolve and therefore, a flexible approach is best suited for the development of its response to the St. Jude Medical Center Community Health Needs Assessment (CHNA). On an annual basis St. Jude Medical Center 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.

In 1986, St. Joseph Health created a plan and began an effort to further its commitment to neighbors in need. With a vision of reaching beyond the walls of health care facilities and transcending traditional efforts of providing financial assistance for those in need of acute care services, St. Joseph Health

System created the St. Joseph Health Community Partnership Fund (formerly known as the St. Joseph Health System Foundation) to improve the health of low-income individuals residing in local communities.

Each year St. Jude Medical Center allocates 10% of its net income (net realized gains and losses) to the St. Joseph Health Community Partnership Fund. 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. Jude Medical Center 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 California hospitals' service areas.

INTRODUCTION – WHO WE ARE AND WHY WE EXIST

As a ministry founded by the Sisters of St. Joseph of Orange, St. Jude Medical Center lives out the tradition and 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 names Jean-Pierre Medaille. He 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 Sisters of St. Joseph went 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, 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.

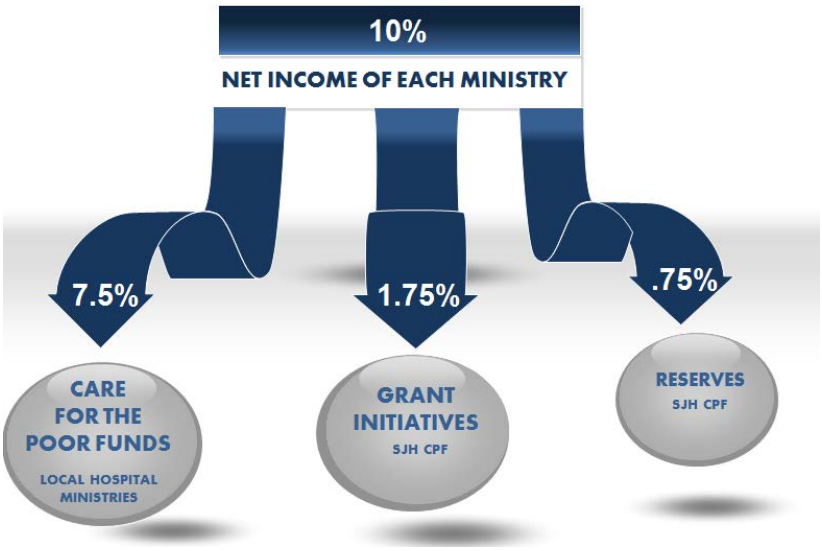
St. Jude Medical Center has been meeting the health and quality of life needs of North Orange County as part of St. Joseph Health Ministry since 1957. Serving the communities of Fullerton, Brea, Buena Park, La Habra, Placentia, Yorba Linda and the surrounding areas, St. Jude Medical Center is a 329 acute care hospital that provides quality care in the areas of cardiac care, oncology, orthopedics, general surgery, rehabilitation, perinatal services, critical care, diagnostic imaging and emergency medicine. St. Jude Heritage Healthcare has been a partner since 1995. With the Medical Center's 2,865 employees and 740 medical staff realizing the mission, St. Jude Medical Center is one of the largest employers in the region. Together we are committed to increasing access to the most vulnerable through our charity care and community clinics, improving the health of our community through prevention and disease management programs and working in collaboration with others to serve all residents in North Orange County with a special focus on those living in poverty.

Strategic Direction

As we move into the future, St. Jude Medical Center 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, St. Jude Medical Center, and St. Jude Heritage are strategically focused on two key areas to which the Community Benefit Plan strongly align: population health management and network of care.

ORGANIZATIONAL COMMITMENT

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 the economically poor and underserved.



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Community Benefit Governance and Management Structure

St. Jude Medical Center demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation, and collaboration. The Vice President of Healthy Communities, the Vice President of Mission Integration, and the SJMC Community Benefit Committee of the Board of Trustees are responsible for coordinating implementation of California Senate Bill 697 provisions as well as provide the opportunity for community leaders, internal hospital Executive Management Team members, physicians, and other staff to work together in planning and carrying out the Community Benefit Plan.

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

A charter approved in 2007 establishes the formulation of the St. Jude Medical Center 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 CB Committee has a minimum of eight members including three members of the Board of Trustees. Current membership includes five members of the Board of Trustees and 11 community members. A majority of members have knowledge and experience with the populations most likely to have disproportionate unmet health needs. Committee generally meets quarterly.

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 (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 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.

Community

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

COMMUNITY

Community Served

St. Jude Medical Center provides parts of Orange, Riverside, Los Angeles and San Bernardino counties with access to advanced care and advanced caring. The hospital's total service area extends from Walnut and Chino Hills in the north, Anaheim in the south, Corona in the east and Whittier and La Mirada in the west. Our Hospital Total Service Area includes the cities of Anaheim, Brea, Buena Park, Chino, Chino Hills, Corona, Diamond Bar, Fullerton, Hacienda Heights, La Habra, La Mirada, Placentia, Walnut, Whittier and Yorba Linda. This includes a population of approximately 1.61 million people, which is similar to the prior assessment. This population is ethnically diverse with 44.5% Hispanic and 19.3% Asian-Pacific Islander, youthful with 25.9% of the population under 17 years of age, and with both wealth and poverty with 8.4% of households living below the federal poverty level. This area has some of the most densely population neighborhoods in California.
The Medical Center has defined a Community Benefit Service Area since it began developing community benefit plans more than fifteen years ago that focuses on the cities nearest the hospital, including Fullerton, Brea, La Habra, Placentia, Buena Park and Yorba Linda. The CBSA includes two areas designated as Medically Underserved Populations – one in south Fullerton and the other in La Habra. For a complete copy of St. Jude Medical Center's FY14 CHNA click here: www.stjudemedicalcenter.org.

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 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

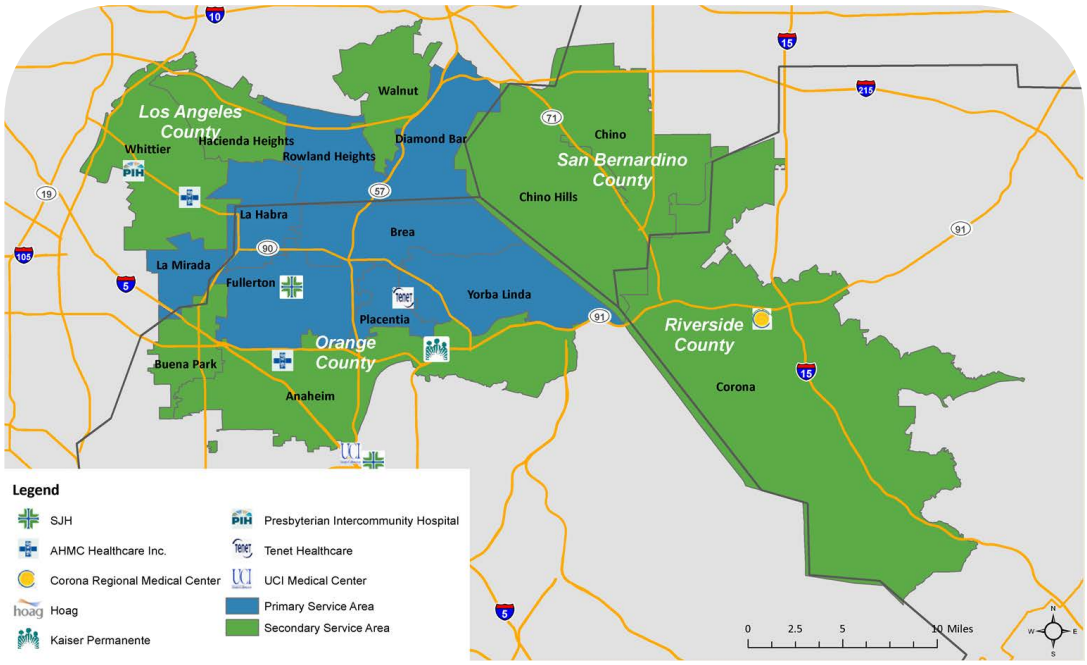
The Primary Service Area ("PSA") is the geographic area from which the majority of the Hospital's patients originate. The Secondary Service Area ("SSA") is where an additional fifteen percent of the population of the Hospital's inpatients reside. The PSA is comprised of Fullerton, Brea, La Habra, La Mirada, Diamond Bar, Rowland Heights, and Yorba Linda. The SSA is comprised of another 8 cities including Walnut, Whittier, Hacienda Heights, Buena Park, Anaheim, Chino Hills, Chino and Corona.

Table 1. Cities and ZIP codes in Community Benefit Service Area

Cities	ZIP codes
Brea	92821,92823
Buena Park	90620,90621
Fullerton	92831,92832,92833,92834,92835
La Habra	90631
Placentia	92870
Yorba Linda	92886,92887

Figure 1 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. Jude Medical Center Total Service Area



The geographic area of focus in our community needs assessment and plan includes the six cities in our Community Benefit Service Area (CBSA) of Brea, Buena Park, Fullerton, La Habra, Placentia, and Yorba Linda.

Table 2 shows that there are wide disparities in economic indicators within the SJMC CBSA. Buena Park has the lowest median household income and the highest unemployment rate. Within each city, except Yorba Linda, there are neighborhoods that have a higher percentage of disproportionate unmet health needs populations.

City	Population	Unemployment Rate	Median HH Income	% below FPL	% HH Renting
Brea	39,638	6.6%	$ 72,824	5.6%	34.2%
Buena Park	80,795	11.9%	$ 61,094	10.2%	44.6%
Fullerton	133,771	10.7%	$ 63,219	11.3%	44.7%
La Habra	68,506	10.8%	$ 64,700	12.4%	44.8%
Placentia	52,308	8.5%	$ 79,194	10.4%	33.9%
Yorba Linda	68,795	6.4%	$113,560	2.5%	17.3%
Total	443,813	9.15%	$ 90,918	8.73%	36.6%

Table 2. Sociodemographic characteristics of communities in SJMC CBSA; Source: U.S. Census Bureau, 2010.

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 92832 on the CNI map is scored 4.4, making it and zip code 90620 at 4.4 the High Need communities in our CBSA.

Figure 2 depicts the Community Need Index for the hospital's geographic service area based on national need. It also shows the location of the Hospital and the affiliated community clinic.

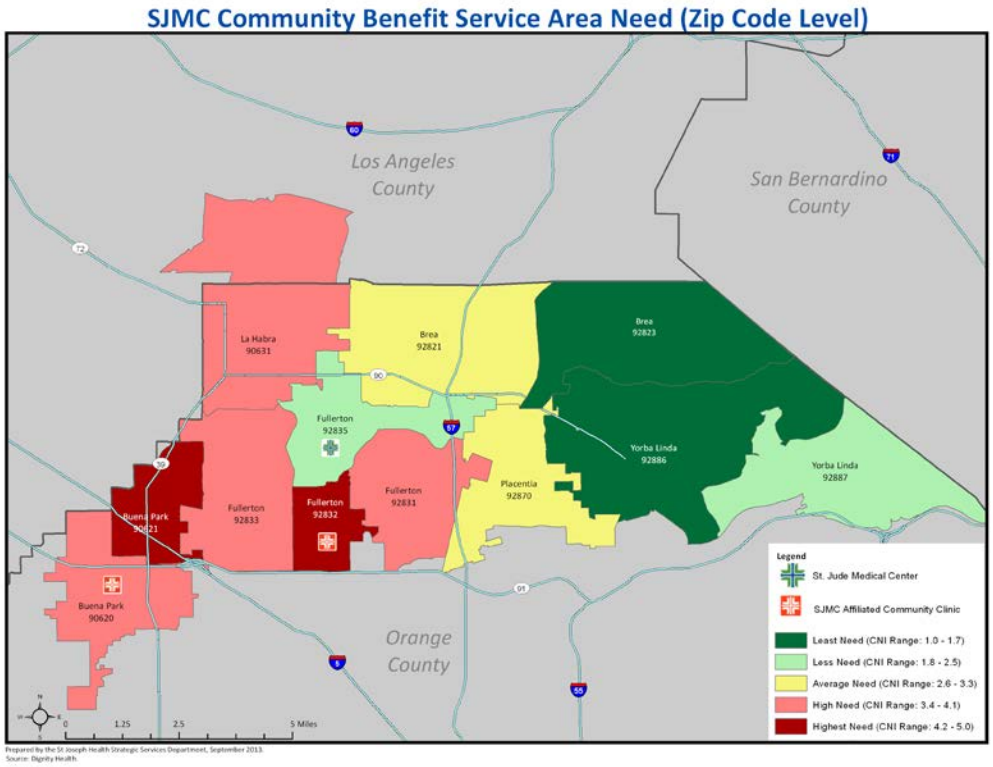


Figure 2. Community Need Index Map.

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.

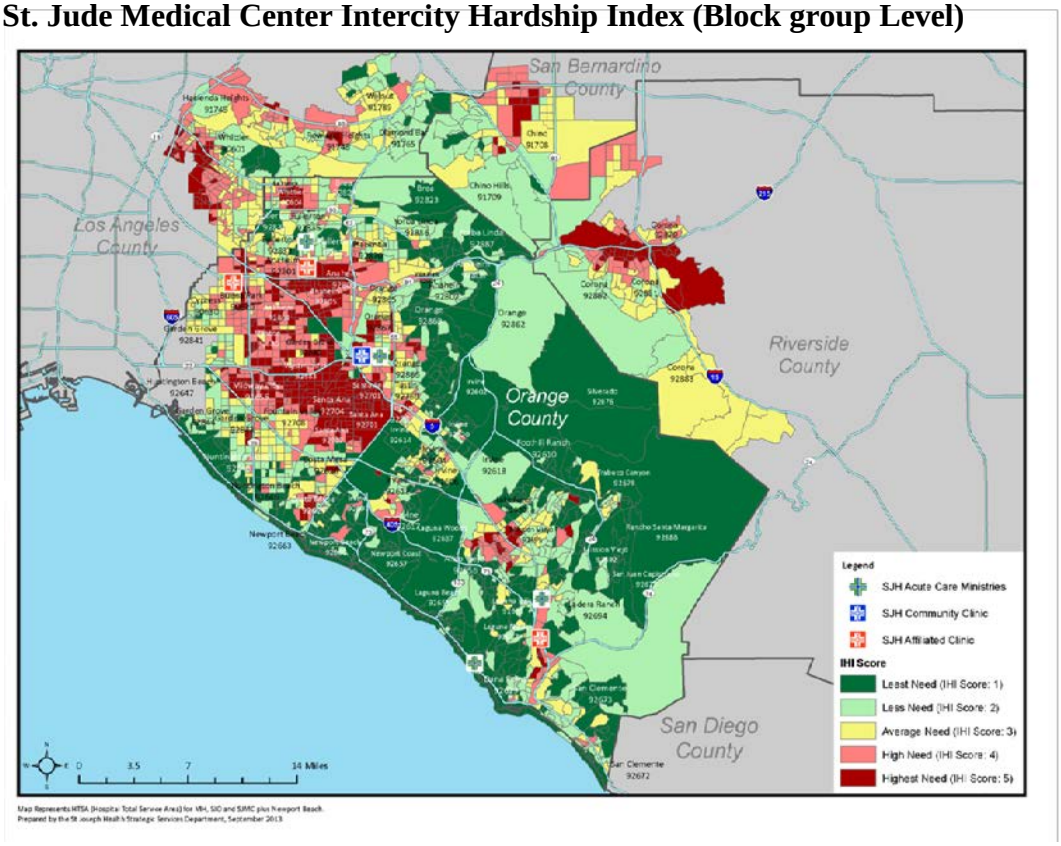
The IHI combines six key social determinants that are often associated with health outcomes:

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 Placentia, La Habra and Fullerton.

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

Figure 3. St. Jude Medical Center Intercity Hardship Index (Block group Level)



COMMUNITY NEEDS AND ASSESSMENT PROCESS RESULTS

Summary of the Community Needs and Assets Assessment Process

St. Jude Medical Center completed a needs assessment in FY 2014. This Community Health Assessment is a follow-up to the study conducted in 2007 and our 2010 Assessment. It is a systematic, data-driven approach to determining the health status, behaviors and lifestyles of residents in our Community Benefit Service Area (CBSA). This Community Health Assessment serves as a tool toward reaching three basic goals:

1. To improve community residents' self-reported health status, functional health, and overall quality of life.
2. To reduce the health disparities among residents.
3. To increase accessibility to preventive services for all community residents.

The process utilized in the community health needs assessment is outlined in Figure 4.

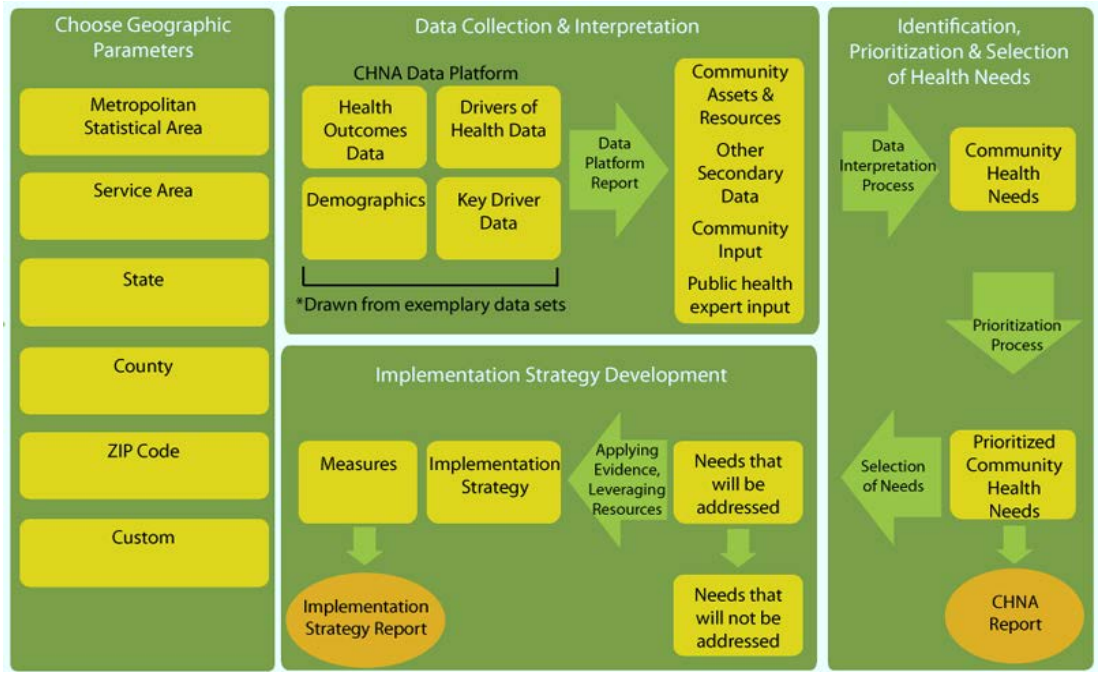


Figure 4. Process utilized in conducting the needs and assets assessment.

The assessment incorporates primary source data conducted by Professional Research Consultants, Inc. (PRC) in 2012 with comparison data from 2007, census data, community need index data, and intercity hardship data. In addition, qualitative obtained through a key informant survey of community based organizations, foundations, health advocates, community clinics, local political/policy leaders, public health organizations, and other hospitals.

A variety of existing (secondary) data sources were consulted to complement the research quality of this Community Health Assessment, including but not limited to: the 2010 U.S. Census, Orange County Healthy People Healthy Places Report, the Centers for Disease Control and Prevention (CDC), Orange County Health Needs Assessment Data, and key informant surveys and focus groups (involving community members, community leaders, public health experts, key stakeholders, low-income residents in North Orange County). National and statewide risk factor data were used as an additional benchmark against which to compare local findings. Data sources include: Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), National Health and Nutrition Examination Survey (NHANES), and California Departments of Health Services. The assessment also included consideration of existing assets available in the community to address health needs.

Identification and Selection of DUHN Communities

Communities with Disproportionate Unmet Health-Related 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. Table 3 lists the groups and identified community needs and assets.

Table 3. DUHN Group and Key Community Needs and Assets Summary Table.

DUHN Population Group or Community zip code or block group	Key Community Needs	Key Community Assets[1]
Adults lacking medical insurance in CBSA	Access to primary health care Access to specialty care	St. Jude Neighborhood Health Center St. Jude Heritage Healthcare Local community clinics Access OC
Overweight and obese children and adults in CBSA	Increased physical activity in schools. Safe places for recreation. Healthy school meals. Accessible healthy foods. Obesity treatment programs. Public policies promoting heath	Fullerton, Placentia, Buena Park, La Habra Collaboratives Healthy Weight Initiative School District Wellness Councils Network for a Healthy California Dairy Council Orange County Department of Education
Persons with Mental Illness and Substance Abuse Disorders	Lack of treatment programs for those without insurance Stigma of conditions Lack of 24 hour multi-service center for mentally ill homeless	Orange County Behavioral Health Services St. Jude Community Care Navigator Initiative National Alliance for Mentally Ill St. Joseph Health Orange County Region Behavioral Task Force Pathways of Hope Mercy House WTLC Western Youth Services CalOptima Behavioral Health
Infant and Children	Lack of teen pregnancy prevention programs in Latino communities Lack of robust immunization program for children Lack of obesity prevention and treatment programs for children	St. Jude Neighborhood Health Centers St. Jude Heritage Healthcare Local Community Clinics La Habra Collaborative Teen Pregnancy Prevention Programs CalOptima Obesity Prevention programs Healthy Weight Initiative
Low Income High Need Areas in Fullerton, Buena Park, Placentia and La Habra	Jobs Immigration Reform Gang Prevention Programs	Community Collaboratives CalGrip Program OCCCO Community Clinics
Homeless Population	Lack of 24 hour 7 day per week multi-service shelter Lack of rapid re-housing programs	Pathways of Hope Mercy House WTLC Fullerton Homeless Task Force

Prioritized Community Health Needs

The list below summarizes the prioritized community health needs identified through the FY14 Community Health Needs Assessment Process:

- Diabetes
- Cardiac Health
- Obesity
- Access to Medical Care
- Immigration Reform
- Asthma
- Older Adult Health
- Behavioral health
- Access to Dental Care
- Safety
- Homeless Services
- Infant and Child Health
- Income Inequality

COMMUNITY BENEFIT PLAN

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.

Priorities were identified by stakeholder groups' surveyed, low-income residents who participated in focus groups, and data collected by the county. Additionally, social determinants were included in the list of priorities for review by the Medical Center Community Benefit Committee. The Orange County Health Care Agency has identified obesity and diabetes, older adult services, infant and child health, and behavioral health as their top priorities for planning. The low-income resident focus groups identified hypertension, obesity, diabetes, access to medical care, homelessness, and safety as priority areas. The stakeholder surveys identified access to medical and dental care, obesity, homeless, gang prevention, and teen pregnancy as priorities. This information was provided to the Committee who ranked the identified issues based on the criteria recommended by the Catholic Health Association and approved by the Medical Center Community Benefit Committee.

Table 3. Issues identified in the CHNA, as ranked by the Community Benefit Committee.

Need	Ranking
Diabetes	31***
Cardiac Health	30
Obesity	30***
Access to Medical Care	29**
Immigration Reform	27
Asthma	26
Older Adult Health	26
Behavioral health	26**
Access to Dental Care	26
Safety	25
Homeless Services	24**
Infant and Child Health	23
Income Inequality	23

*Two of three groups rated as important. **All three groups rated as important. Red: Top priorities chosen for FY15-17.

Under this ranking system each of the health issues were ranked by Community Benefit staff as "Low" (1 point), "Medium" (2 points), or "High" (3 points) – with "High" indicating most need or most

resources and "Low" indicating less need or less resources (see Table 4 – 5 on the next page). For Time Commitment and Degree of Controversy, these criteria were scored with "Low" being 3 points and "High" being 1 point. Income inequality and immigration were included in the priorities since both are major underlying causes of poor health outcomes in our community. The Robert Wood Johnson Foundation also recently recommended that non-medical, social determinants of health be included within hospitals' priorities and plans.

Table 4. Community Benefit Ranking System

Criteria	Diabetes	Obesity	Access to Medical Care	Access to Dental Care	Homeless Services	Older Adult Health	Income Inequality	Immigration reform
Relevancy to mission	Hi	Hi	Hi	Hi	Hi	Hi	Hi	Hi
Scope of problem	Hi	Hi	Hi	Hi	Med	Med	Med	Hi
Seriousness of problem	Hi	Hi	Hi	Hi	Hi	Med	Hi	Hi
Health Disparities	Hi	Hi	Hi	Hi	Hi	Hi	Hi	Hi
Effectiveness of interventions	Med	Med	Med	Hi	Med	Med	Med	Med
Economic feasibility	Med	Med	Med	Low	Med	Low	Low	Med
Importance to community	Hi	Hi	Med	Low	Med	Low	Low	Med
Time Commitment*	Hi	Hi	Hi	Hi	Hi	Hi	Hi	Hi
Degree of controversy*	Low	Med	Med	Low	Hi	Low	Hi	Hi
Existing efforts on problem	Med	Med	Med	Low	Med	Hi	Med	Med
Implications for not proceeding	Hi	Hi	Hi	Med	Med	Med	Hi	Hi
Sustainability likely	Hi	Hi	Hi	Med	Low	Hi	Low	Med
Total Points	**31**	**30**	**29**	**26**	**24**	**26**	**23**	**27**

Table 5. Community Benefit Ranking System cont'd

Criteria	Behavioral Health	Cardiac Health	Asthma	Infant/Child	Safety	Older Adult Health
Relevancy to mission	Hi	Hi	Hi	Hi	Hi	Hi
Scope of problem	Hi	Hi	Med	Low	Med	Med
Seriousness of problem	Hi	Hi	Med	Low	Med	Med
Health Disparities	Hi	Hi	Hi	Med	Hi	Hi
Effectiveness of interventions	Hi	Hi	Hi	Hi	Med	Med
Economic feasibility	Med	Med	Med	Med	Low	Low
Importance to community	Med	Low	Low	Low	Low	Low
Time Commitment*	Hi	Med	High	Med	Hi	Hi
Degree of controversy*	Med	Low	Low	Low	Low	Low
Existing efforts on problem	Low	Med	Med	Med	Med	Hi
Implications for not proceeding with problem	Med	Hi	Med	Med	Med	Med
Sustainability likely	Low	Med	Med	Med	Hi	Hi
Total Points	**26**	**30**	**26**	**23**	**25**	**26**

The St. Jude Medical Center's Board of Trustees Community Benefit Committee selected the following priorities for the FY 15-17 Community Benefit Strategy and Implementation Plan:

1. **Medical Care for the Underserved**
2. **Obesity**
3. **Behavioral Health**
4. **Infant and Child Health**

Addressing the Needs of the Community: FY15 – FY17 Key Community Benefit Plan

IMPROVING MEDICAL ACCESS TO THE UNDERSERVED

Initiative (community need being addressed): The FY14 CHNA shows a significant number of uninsured in the CBSA. 18.7% of adults in the CBSA do not have insurance, and there are over 47,000 people with CalOptima.

Goal (anticipated impact): Expand access to care for the underserved in our CBSA

Outcome Measure	***Baseline***	***FY15 Target***	***FY17 Target***
Number of persons served	20,022 patients	21,658 patients	25,000 patients
Strategy(ies)	***Strategy Measure***	***Baseline***	***FY15 Target***
1. Provide grant and in-kind support to the SJNHC	Number of unique patients served at SJNHC	4,507 patients	5,662 patients
2. Provide charity care for uninsured patients	Number of uninsured patients provided charity care at SJMC	14,884 patients	13,396 patients
3. Provide subsidy for specialists in ER to serve uninsured patients	Number of uninsured patients provided subsidized care by specialists in ER	631 patients	600 patients*
4. Hospital and Heritage to participate as CalOptima Network	Number of CalOptima patients care for by integrated delivery systems (IDS) in new Heritage CalOptima network	0 patients	1,500 patients

*This number is lower than the FY15 target due to the expected number of uninsured gaining insurance coverage through Covered California.

Key Community Partners: St. Jude Neighborhood Health Center, St. Jude Heritage HealthCare, CalOptima, SJMC Medical Staff, City of Fullerton, Fullerton School District

HEALTHY WEIGHT/OBESITY REDUCTION & PREVENTION

Initiative (community need being addressed): FY 14 CHNA showed that 60.9 percent of adults and 30 percent of children are overweight or obese in the CBSA.

Goal (anticipated impact): Increase the percentage of 5th, 7th, and 9th graders in targeted schools within our CBSA; strengthen city, school, and organizational policies that promote healthy lifestyles

Outcome Measure	***Baseline***	***FY15 Target***	***FY17 Target***
Percentage of 5th, 7th, and 9th graders in Healthy Fitness Zone	2013 Fitnessgram scores for body composition	5 percent increase from baseline in each targeted school	15 percent increase of children in Healthy Fitness Zone from baseline in each targeted school
Strategy(ies)	***Strategy Measure***	***Baseline***	***FY15 Target***
1. Increase the percentage of healthy weight children at target schools	Number of schools with percentage of 5th, 7th, and 9th grade children attending Title I schools in target neighborhoods whose body composition are in the Healthy Fitness Zone on the Fitnessgram	Current scores will be baseline	50 percent of targeted schools achieving a 5 percent increase in percentage of children who are in the Healthy Fitness Zone for body composition
2. Engage four school districts in implementing policies that promote a healthy lifestyle	Number of active Wellness Councils; number of new policies or administrative rules that strengthen the Wellness Policy	3 Active Wellness Councils; 0 updated Wellness Policies	4 Active Wellness Councils; 2 updated Wellness Policies
3. Partner with four targeted cities to enhance their level of commitment in HEAL or Let's Move	Number of HEAL cities that achieve Active or Fit City recognition and/or number of Let's Move Cities that meet all recommended criteria	0 HEAL cities that achieve Active or Fit recognition or Let's Move-recognized cities	2 HEAL cities that achieve Active or Fit recognition or Let's Move-recognized cities

Key Community Partners: Fullerton Collaborative, Buena Park Collaborative, La Habra Collaborative, Placentia Families First Collaborative, Alliance for a Healthy Orange County, Fullerton School District, Buena Park School District, Placentia-Yorba Linda School District, La Habra School District, UC Cooperative Extension, Cities of Fullerton, Buena Park, Placentia and La Habra

BEHAVIORAL HEALTH

Initiative (community need being addressed): FY14 CHNA shows that 31.9% of 11th graders reported alcohol use in past month, and 20.5% of 11th graders reported drug use in past month. Additionally, in 2012, the SJMC established a full-time social worker to work with the homeless population that access the ED. These individuals served had 369 ED visits with 41 having more than 10 visits during this 10-month period. 31% of the patients seen in the Emergency Department had mental health issues, and 24% had substance abuse issues. The top mental health issues were post-traumatic stress disorder, depression, and anxiety.

Goal (anticipated impact): Improve behavioral health in low-income populations though prevention and access

Outcome Measure	***Baseline***	***FY15 Target***	***FY17 Target***
Number of patients served	0 patients	2000 patients	5000 patients
Strategy(ies)	***Strategy Measure***	***Baseline***	***FY15 Target***
1. Integrate behavioral health services at St. Jude Heritage and SJNHC	Number of targeted behavioral health screenings consistently being used at SJNHC	0 screenings	1 screening
2. Develop and implement programs within targeted school districts to enhance management of children with behavioral problems	Number of targeted school districts that are developing/implementing programs to enhance management of children with behavioral problems	1 school district	2 school districts
3. Address the needs of homeless patients with mental health and substance abuse problems	Continuation of community care navigation	203 homeless patients served with mental health or substance abuse problems	Percent homeless patients with mental health and substance abuse issues able to be connected to services

Key Community Partners: St. Jude Neighborhood Health Center, Fullerton Police Department, Illumination Foundation, School Districts, St. Jude Heritage Healthcare

INFANT & CHILD HEALTH

Initiative (community need being addressed): The percentage of children aged two and under in the SJMC CBSA immunized with dTAP and MMR vaccines are currently far below Healthy People 2020 goals. Only 48 percent of children received dTAP vaccines at Heritage North; 36 percent of children received dTAP vaccines at SJNHC; and 67 percent of children received dTAP vaccines at Heritage Central. At Heritage North, 86 percent of children aged two and under were MMR-immunized versus only 73 percent at the SJNHC. In addition, the percentage of infants receiving late or no pre-natal care was approximately 10 – 15 percent in many areas in the CBSA.

Goal (anticipated impact): Enhance infant and child health through improved pre-natal care and immunization rates.

Outcome Measure	***Baseline***	***FY15 Target***	***FY17 Target***
Percent of children ages 2 and under receiving dTAP and MMR immunizations at SJNHC and St. Jude Heritage	dTAP immunization rate: - Heritage North: 48% - SJNHC: 36% MMR immunization rate: - Heritage North: 86% - SJNHC: 73%	dTAP immunization rate: - Heritage North: 55% - SJNHC: 45% MMR immunization rate: - Heritage North: 90% - SJNHC: 80%	dTAP immunization rate: - Heritage North: 80% - SJNHC: 80% MMR immunization rate: - Heritage North: 90% - SJNHC: 90%
Strategy(ies)	***Strategy Measure***	***Baseline***	***FY15 Target***
1. Strengthen the recall/reminder system for immunizations	System in place to effectively reminder and recall patients for immunizations	None	System developed and implemented
2. Track reasons why parents are refusing immunizations and develop plan to address these reasons	Tracking system in place and data available	None	Tracking system developed and implemented
3. Evaluate the effectiveness and the delivery of educational materials and improve where needed	Evaluation of educational materials available	None	Evaluation available

Key Community Partners: St. Jude Neighborhood Health Center; St. Jude Heritage Healthcare

PLANNING FOR THE UNINSURED AND UNDERINSURED

Financial Assistance Program

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. Jude Medical Center, as a ministry of St. Joseph Health System, has a **Patient Financial Assistance Program**[1] that provides free or discounted services to eligible patients.

This program provides fully discounted services for families whose income is at or below 200 percent of the Federal Poverty Level (FPL) and discounted services for those families between 201 – 500 percent of the FPL. In addition, other factors used in determining eligibility for patient financial assistance include: income level, asset level, and medical indigence. There are certain very vulnerable populations that are automatically deemed eligible for charity care, including St. Jude Community Clinic and St. Jude Heritage Access Program patients. Hospital and Heritage staff members are educated about this policy during new employee hire and continuing staff training. Extensive efforts are made to educate patients about the Financial Assistance Program, including signs posted in prominent locations, brochures provided to uninsured patients, and on our hospital website.

One way that St. Jude Medical Center informs the public of the Patient Financial Assistance Program 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.

Medicaid and Other Local Means-Tested Government Programs

St. Jude Medical Center and St. Jude Heritage Healthcare provides access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California, and other local means-tested government programs.

[1] *Information about St. Jude Medical Center's Financial Assistance Program is available at http://www.stjudemedicalcenter.org/For-Patients/Patient-Financial-Assistance-Program.aspx*

Other Community Benefit

In addition to the preceding priority areas, St. Jude Medical Center 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	Target Population (Low Income or Broader community)
1. Access to care	Cancer Center Community Program	Provide care navigation, social work services, and support groups to cancer patients	Low-income
2. Engaging community partners to address health disparities	Healthy Communities	Technical assistance to support community collaboratives	Low-income
3. Lack of public transportation	Transportation Program	Provide non-emergency medical transportation	Low-income
4. Lack of access to medical services	Post-Hospital Transition Care for Indigent Patients	The hospital incurs various costs to take care of indigent patients, both the uninsured and underinsured – including: long-term facility fees, homecare fees, hospice fees, mental health fees, taxicab vouchers, and ambulance fees among others	Low-income
5. Lack of support services for frail elderly	Senior Services	Information and referrals, support groups, classes, Caring Neighbors volunteer program	Low-income
6. Lack of specialty care for uninsured	Super Surgery Saturday	Assist high-risk and vulnerable hospital patients in transition to home setting with goal of avoiding re-admissions	Low-income
7. Need for professional nursing staff in the community	Health Education Professions – Nursing, Rehabilitation, and Ancillary	Clinical rotations for nursing and rehabilitation students in med-surg, critical care, OB, OR, leadership, and community health; clinical rotations for ancillary students in respiratory, labs, imaging	Broader community
8. Access to care	ER Medical Staff – Payments for Care of Uninsured ER patients	The hospital pays, under the Measure H program, medical staff members to care for patients who are uninsured	Low-income

Initiative (community need being addressed):	Program	Description	Target Population (Low Income or Broader community)
9. Access to care	Rehab Community Reintegration for Broader Community	Provides recreational, exercise, communication, and other groups for individuals with ad disability to assist in their re-entry into the community	Broader community; people with disabilities
10. Need for patient/family education	Rehab Community Program Follow-Up	Nurse follow-ups with patients post-discharge	Broader community
11. Reduce number of re-admissions	Post-Hospital Transition Care for Indigent Patients	The hospital incurs various costs to take care of indigent patients, both the uninsured and underinsured. These costs include long-term facility fees, homecare fees, hospice fees, mental health fees, taxi cab vouchers, and ambulance fees among others	Low-income
12. Lack of resources for uninsured population	Community Care Navigation	Identification and intervention to assist the homeless and underserved population	Low-income
13. Lack of mildly-ill child care services	Healthy Steps – TAPP Program	Provides mildly ill child care center and support to pregnant teens and teen moms who attend the La Sierra High School	Low-income
14. 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
15. 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
16. Need for education and health screenings	Community Education & Health Fairs	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

Needs Beyond the Hospital's Service Program

Although 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 Program.

The table below describes the community health needs identified through the St. Joseph Health, St. Jude Medical Center CHNA that the hospital plans to address as well as those it does not plan to address.

Table 6.

Community Health Needs Identified thru CHNA	Hospital Plans to Address Need
Cardiac Health	No
Diabetes	No
Obesity	Yes
Access to Medical Care	Yes
Immigration Reform	No
Asthma	No
Older Adult Services	No
Behavioral Health	Yes
Access to Dental Care	No
Safety	No
Homeless Services	No
Infant and Child Health Services	Yes
Income Inequality	No

The indicated health needs are not being addressed directly through a St. Joseph Health, St. Jude Medical Center initiative or program because they are already addressed by local non-profit organizations that have the resources and expertise: Cardiac Health, Diabetes, Immigration Reform, Asthma, Older Adult Services, Access to Dental Care, Safety, Homeless Services, Income Inequality. Cardiac health and diabetes were not selected because the Committee selected obesity which underlies these conditions and if addressed will have an impact on this. Also, cardiac health outcomes improved between 2007 and 2012 according to the PRC survey. Asthma also showed an improvement over the two surveys. Older adult services, homelessness, access to dental care and safety are being addressed by other groups in the community. The Committee chose not to address immigration reform and income inequality, as these are state and national issues that the Medical Center does not have the expertise or ability to impact.

St. Joseph Health, St. Jude Medical Center will collaborate with local organizations that address aforementioned community needs, to coordinate care and referral and address these unmet needs. Specifically, we will collaborate with the following organizations to coordinate referrals and efforts: American Diabetes Association for Diabetes, American Heart Association for Cardiac Health, OCCCO for immigration reform, American Lung Association for asthma, Orange County Older Adults Collaborative for Older Adult Services, Coalition of Community Health Centers for dental care; CalGrip programs for safety, and the Fullerton Homeless Task Force and its members for homeless services.

Furthermore, St. Joseph Health, St. Jude Medical Center 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, resources to meet the identified needs of underserved communities throughout St. Joseph Health California hospitals' service areas.

Governance Approval

This Community Benefit Plan/Implementation Strategy Report was approved at the April 24, 2014 meeting of the St. Joseph Health Community Benefit Committee of the Board of Trustees.

Donald Bittner, MD, Chairman of Community Benefit Committee

4-24-14
Date