ST. JUDE MEDICAL CENTER

FY18 - FY20 Community Benefit Plan/Implementation Strategy Report

St. Joseph Health
St. Jude Medical Center
A member of the St. Joseph Hoag Health alliance

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EXECUTIVE SUMMARY

St. Joseph Health, St. Jude Medical Center, an acute-care hospital founded in 1957, is located in Fullerton, California. It became a member of St. Joseph Health in September 1983. The facility has 320 licensed beds, all of which are currently available, and a campus that is approximately 40 acres in size. St. Jude Medical Center has a staff of more than 2,575 people and professional relationships with more than 652 local physicians. Major programs and services include cardiac care, stroke/neuro, orthopedics, rehabilitation, oncology, emergency medicine and obstetrics.

In response to identified unmet health-related needs in the community needs assessment, during FY18-FY20, St. Jude Medical Center will focus on access to health care for the uninsured and underinsured, mental health (including substance abuse) and obesity (including food and nutrition, lack of exercise and walkability) for the broader and underserved members of the surrounding community.

There were no collaborating organizations on the development of this plan.

FY18-FY20 CB Plan Priorities/Implementation Strategies

As a result of the findings of our FY17 Community Health Needs Assessment (CHNA) and through a prioritization process aligned with our mission, resources and hospital strategic plan, St. Jude Medical Center will focus on the following areas for its FY18-FY20 Community Benefit efforts:

- Obesity (including Food and Nutrition, Lack of Exercise and Walkability)
- Mental Health (including Substance Abuse)
- Access to care for the Uninsured and Underinsured

In addition, the Medical Center will partner with our sister St. Joseph Hoag Health ministries on a regional priority on education equity to address income inequality.

MISSION, VISION, AND VALUES

Our Mission

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

Our Vision

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

Our Values

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

INTRODUCTION – WHO WE ARE AND WHY WE EXIST

As a ministry founded by the Sisters of St. Joseph of Orange, St. Jude Medical Center 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.

St. Joseph Health, St. Jude Medical Center has been meeting the health and quality of life needs of the local community for over 60 years. Serving the communities of Anaheim, Brea, Buena Park, Chino, Chino Hills, Diamond Bar, Fullerton, Hacienda Heights, La Habra, La Mirada, Placentia, Rowland Heights, Walnut, Whittier, and Yorba Linda, St. Jude Medical Center is an acute care hospital that provides quality care in the areas of Stroke/Neuro/ Ortho/Cardio Perinatal/Oncology/and Rehabilitation. With over 2,575 employees committed to realizing the mission, St. Jude Medical Center is one of the largest employers in the region.

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.

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

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

Furthermore, St. 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 hospitals' service areas.

Community Benefit Governance and Management Structure
St. Jude Medical Center 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 Vice President of Healthy Communities 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. 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 Community Benefit Committee has a minimum of eight members including three members of the Board of Trustees. Current membership includes 3 members of the Board of Trustees and 20 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 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 of Community Benefit (ASACB) Five Core Principles. It includes diverse community stakeholders. Trustee members on CBC serve as 'board level champions'.
- The committee provides recommendations to the Board of Trustees regarding budget, program targeting and program continuation or revision.

Community Benefit (CB) Department

- Manages CB efforts and coordination between CB and Finance departments on reporting and planning.
- Manages data collection, program tracking tools and evaluation.
- Develops specific outreach strategies to access identified 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

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 has a **Patient Financial Assistance Program (FAP)** that provides free or discounted services to eligible patients.

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

COMMUNITY

Definition of Community Served

St. Jude Medical Center provides North Orange County and parts of Los Angeles, Riverside, and San Bernardino counties' communities with access to advanced care and advanced caring. The hospital's service area extends from Walnut in the north, Anaheim in the south, Corona in the east and Buena Park in the west. Our Hospital Total Service Area includes the cities of Anaheim, Brea, Buena Park, Chino, Chino Hills, Diamond Bar, Fullerton, Hacienda Heights, La Habra, La Mirada, Placentia, Rowland Heights, Walnut, Whittier, and Yorba Linda This includes a population of approximately 1.35 million people, an increase of 8% of from the prior assessment.

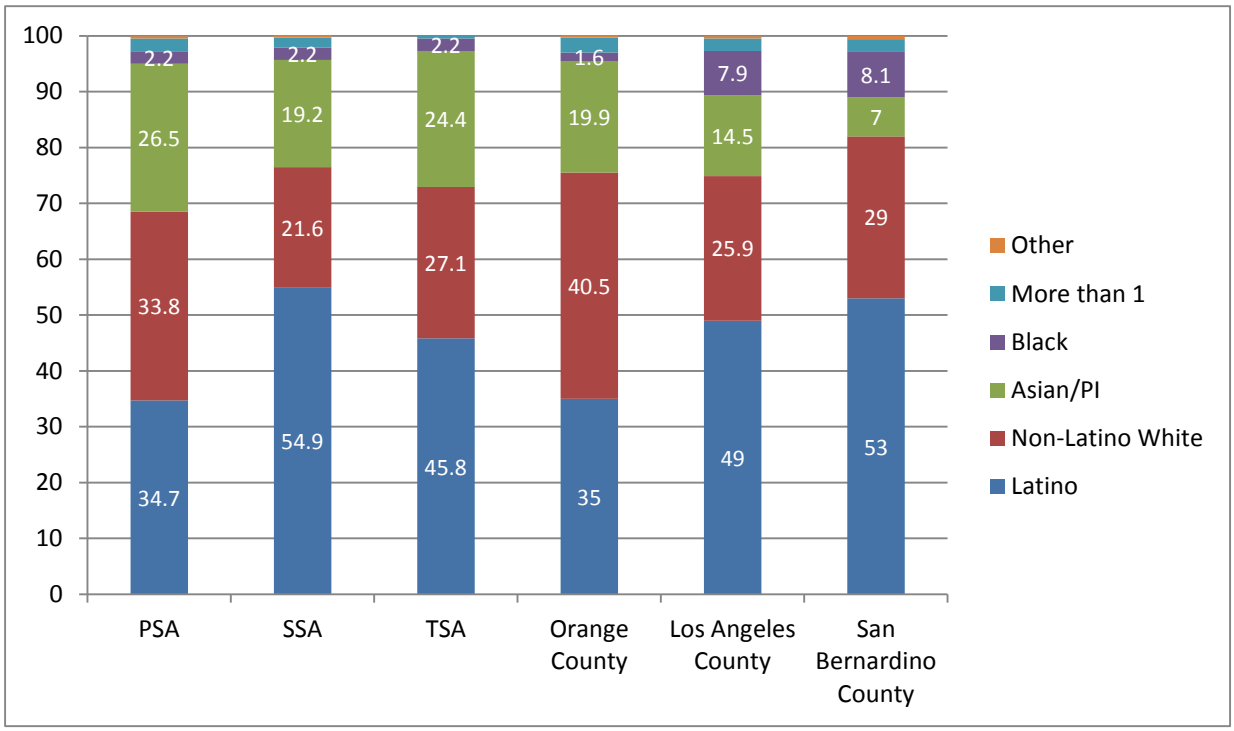
Community Profile

The table and graph below provide basic demographic and socioeconomic information about the St. Jude Medical Center Service Area and how it compares to Orange County, Los Angeles County, San Bernardino County, and the state of California. While 62% of the Total Service Area (TSA) population resides in Orange County, 32% lives in Los Angeles County and 6% is in San Bernardino County. However, most comparisons of the TSA will be made to Orange County because the areas in Los Angeles and San Bernardino Counties are adjacent to Orange County and more similar to it than their own home counties.

The TSA of St. Jude Medical Center has over 1.3 million people, with a median income of just over $73,000. Compared to Orange County, the TSA has more people who do not speak English "very well" and fewer people who speak only English at home, as well as slightly higher rates of poverty. The TSA, like Orange County, has no majority race or ethnicity. The Secondary Service Area (SSA), which includes the entirety of Anaheim and Whittier as well as some smaller cities, has more children and fewer older adults than the Primary Service Area (PSA) and is socioeconomically worse off than the PSA, with lower incomes and higher rates of poverty. Over half of the population of the SSA is Latino and 24% of the SSA reported that they did not speak English "very well."

Indicator	PSA	SSA	TSA	Orange County	Los Angeles County	San Bernardino County	California
Total Population	609,863	739,348	1,349,211	3,172,848	10,147,765	2,118,866	38,986,171
Under Age 18	21.7%	24.5%	23.2%	22.9%	23.1%	27.0%	23.6%
Age 65+	14.3%	11.8%	12.9%	13.5%	12.4%	10.5%	13.2%
Speak only English at home	53.4%	42.5%	47.4%	54.4%	43.2%	58.9%	56.2%
Do not speak English "very well"	21.1%	23.5%	22.4%	20.6%	25.8%	16.2%	19.1%
Median Household Income	$78,307	$68,010	$73,166	$78,612	$57,190	$55,726	$62,554
Households below 100% of FPL	8.0%	10.8%	9.5%	9.2%	14.6%	15.3%	12.3%
Households below 200% FPL	21.9%	28.5%	25.4%	23.5%	35.2%	36.0%	29.8%
Children living below 100% FPL	15.1%	19.6%	17.7%	17.6%	26.0%	26.4%	22.7%
Older adults living below 100% FPL	8.5%	10.1%	9.3%	8.7%	13.4%	11.5%	10.2%

Race/Ethnicity



Race/Ethnicity data is based on self-reported responses in accordance with US Census categories.

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

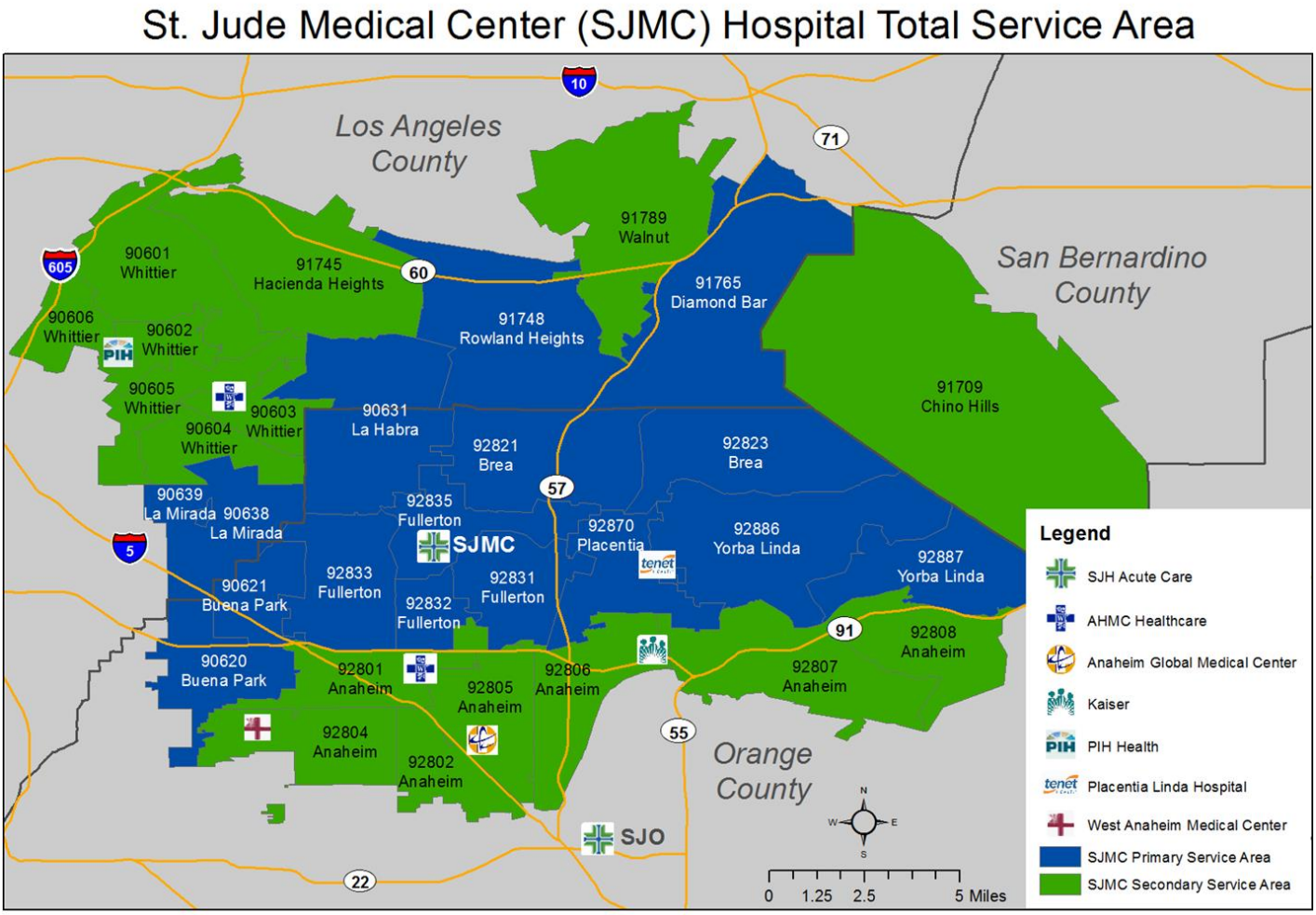
The Primary Service Area ("PSA") is the geographic area from which the majority of the Hospital's patients originate. The Secondary Service Area ("SSA") is where an additional population of the Hospital's inpatients reside. The PSA is comprised of Brea, Diamond Bar, Fullerton, La Habra, La Mirada, Placentia,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

Table 1. Cities and ZIP codes

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

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

Figure 1. St. Jude Medical Center Hospital Total Service Area



Map represents Hospital Total Service Area (HTSA). The Primary Service Area (PSA) comprises 70% of total discharges (excluding normal newborns). The Secondary Service Area (SSA) comprises 71% - 85% of total discharges (excluding normal newborns). The HTSA combines the PSA and the SSA. Includes zip codes for continuity. Cities are placed in either PSA or SSA, but not both. SJO = St. Joseph Hospital of Orange.
Prepared by the St. Joseph Health Strategic Services Department, April 2016.

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.

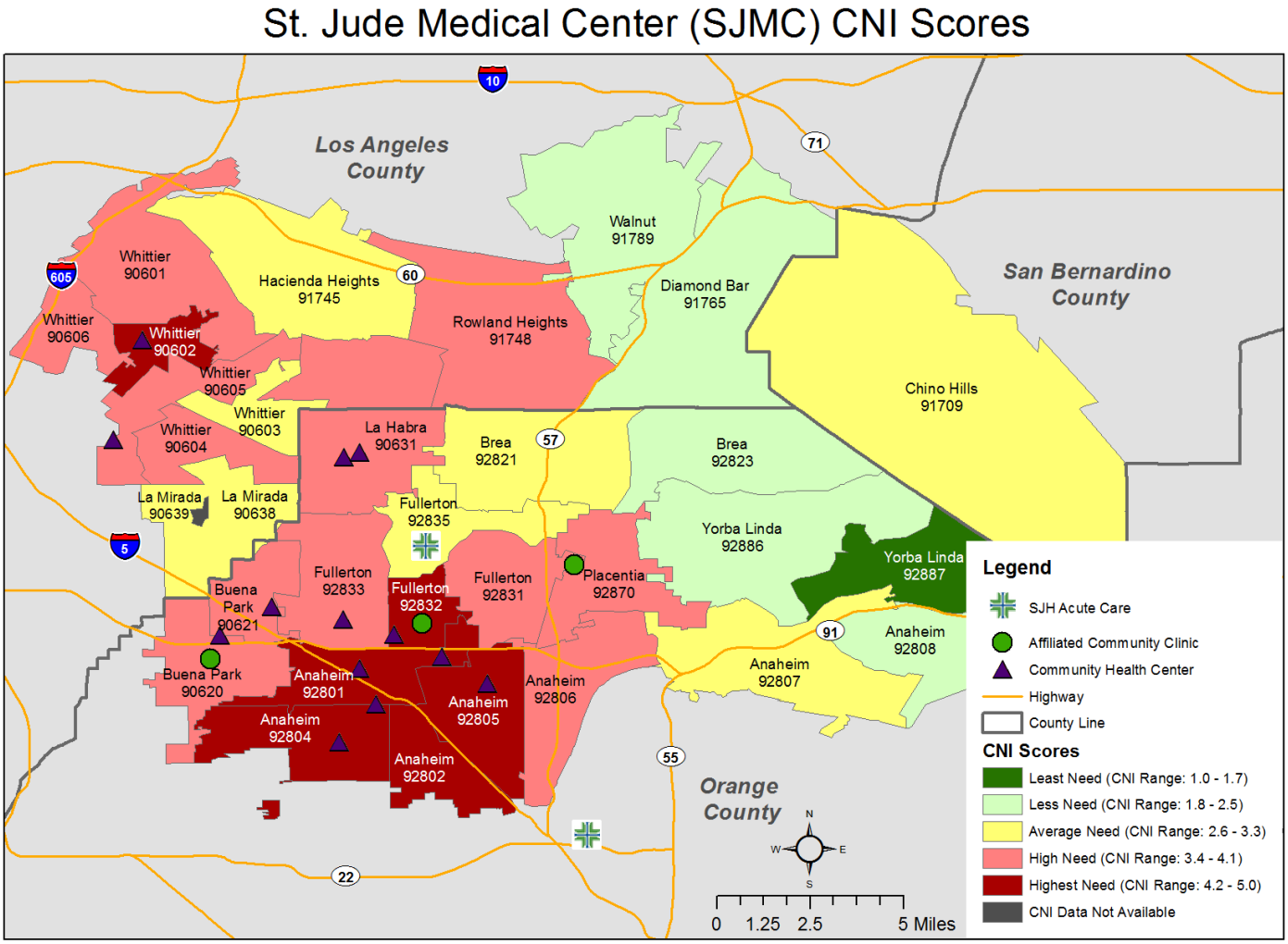
CNI aggregates five socioeconomic indicators that contribute to health disparity (also known as barriers):

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 4.2, making it a High Need community. Within zip codes that may score average or better there may be very high need block groups, such as the Whitten neighborhood in Placentia.
Figure 2 (below) depicts the Community Need Index for the ***hospital's geographic service area based on national need***. It also shows the location of the Hospital as well as the other hospitals in the area that are a part of St. Joseph Health.

Figure 2. St. Jude Medical Center Community Need Index (Zip Code Level)

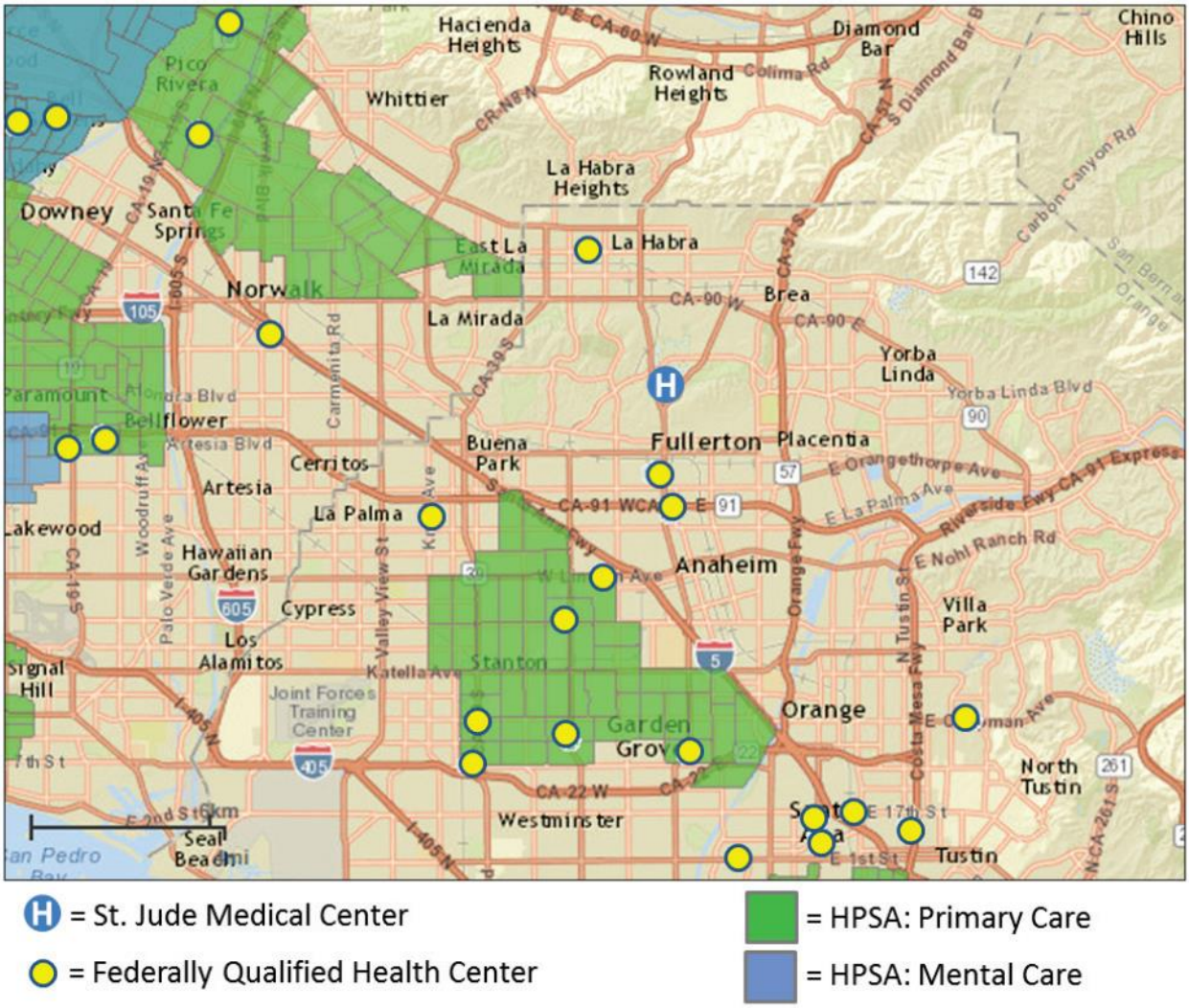


Sources: Dignity Health Community Need Index (cni.chw-interactive.org), 2015 (accessed March 2016); The Coalition of Orange County Community Health Centers (coccc.org); Community Clinic Association of Los Angeles County (ccalac.org) (accessed Sept. 2016). Prepared by the St. Joseph Health Strategic Services Department, April 2016.

Health Professions Shortage Area – Mental, Dental, Other

The Federal Health Resources and Services Administration designate Health Professional Shortage Areas as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). Although St. Jude Medical Center is not located in a shortage area, large portions of the service area to the South are designated as shortage areas. The map below depicts these shortage areas relative to St. Jude Medical Center's location.

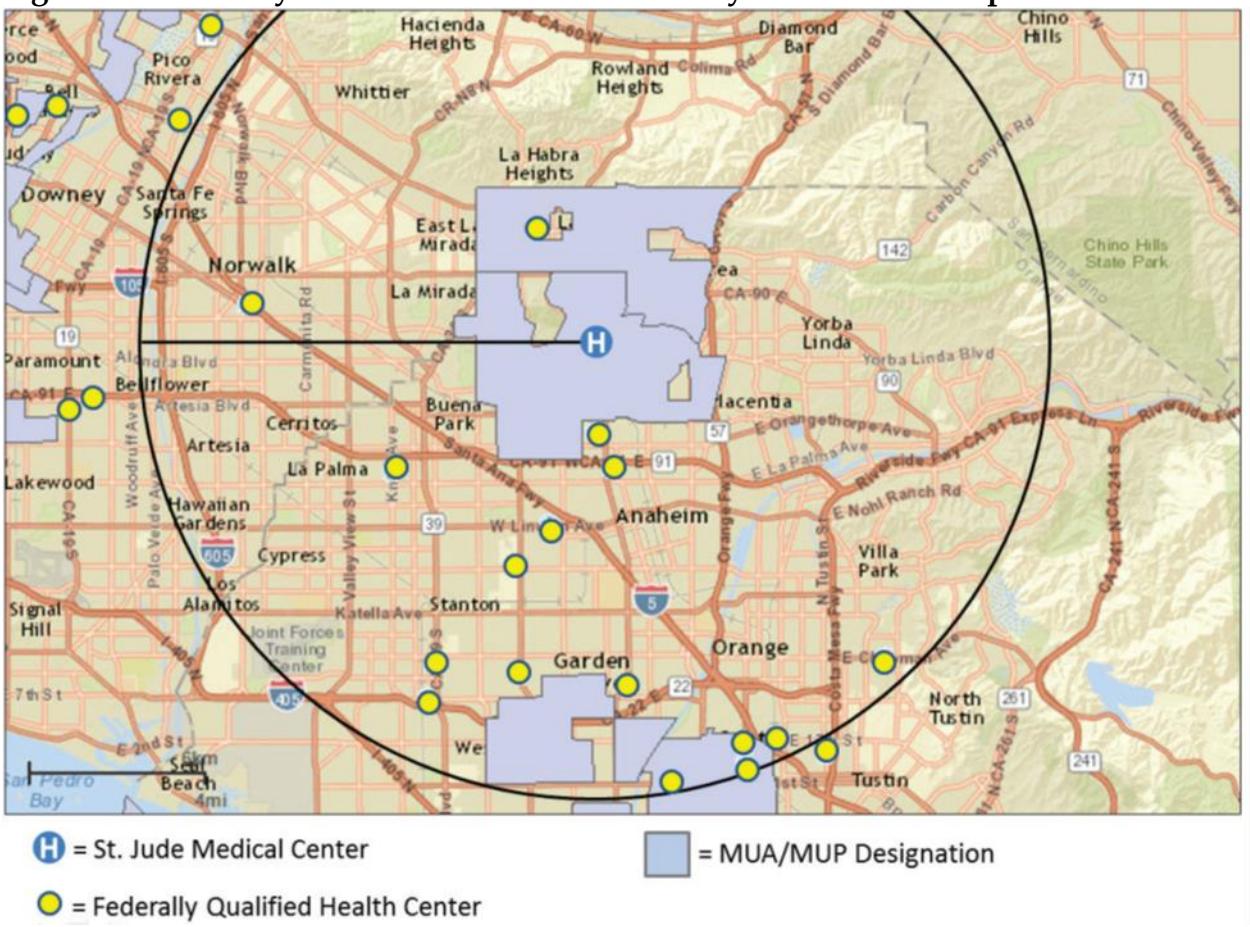
Figure 3: Health Professional Shortage Areas



Medically Underserved Area/Medically Underserved Populations

Medically Underserved Areas and Medically Underserved Populations are defined by the Federal Government to include areas or population groups that demonstrate a shortage of healthcare services. This designation process was originally established to assist the government in allocating community health center grant funds to the areas of greatest need. Medically Underserved Areas are identified by calculating a composite index of need indicators compiled and compared with national averages to determine an area's level of medical "under service." Medically Underserved Populations are identified based on documentation of unusual local conditions that result in access barriers to medical services. Medically Underserved Areas and Medically Underserved Populations are permanently set, and no renewal process is necessary. The map below depicts the Medically Underserved Areas/Medically Underserved Populations within a 30 mile radius from St. Jude Medical Center.

Figure 4: Medically Underserved Areas/ Medically Underserved Populations



COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs, Assets, Assessment Process and Results

The CHNA process was guided by the fundamental understanding that much of a person's health is determined by the conditions in which they live. In gathering information on the communities served by the hospital, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, health behaviors, and the availability of clinical care. In addition, we recognized that where people live tells us a lot about their health and health needs, and that there can be pockets within counties and cities where the conditions for supporting health are substantially worse than nearby areas. To the extent possible, we gathered information at the zip code level to show the disparities in health and the social determinants of health that occur within the hospital service area. Within the guiding health framework for the CHNA, publicly-available data was sought that would provide information about the communities and people within our service area. In addition, comparison data was gathered to show how the service area communities are faring compared to the county or state. Indicators were chosen if they were widely accepted as valid and

appropriate measures and would readily communicate the health needs of the service area. Preference was given to data that was obtained in the last 5 years and was available at the zip code level. The data sources used are highly regarded as reliable sources of data (e.g., ESRI Business Analyst Online, US Census Bureau American FactFinder, and California Health Interview Survey). In total, 81 indicators were selected to describe the health needs in the hospital's service area. Appendix 2 includes a complete list of the indicators chosen, their sources, the year the data was collected, and details about how the information was gathered.

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

After the data was gathered, the zip code level data was compared to the Total Service Area values and color coded light pink to dark red depending on how much worse a zip code area was compared to the TSA value. This made it easier to visualize the geographic areas with greater health needs.

The process of collecting qualitative community input took two main forms: Community Resident Focus Groups and a Nonprofit and Government Stakeholder Focus Group. Each type of focus group was designed to capture the collected knowledge and opinions of people who live and work in the communities served by St. Jude Medical Center. For Community Resident Groups, Community Benefit staff, in collaboration with their committees and the system office, identified geographic areas where data suggested there were significant health, physical environment, and socioeconomic concerns. This process also identified the language needs of the community, which determined the language in which each focus group was conducted. Community Benefit staff then partnered with community-based organizations that serve those areas to recruit for and host the focus groups. The community-based organization developed an invitation list using their contacts and knowledge of the area, and participants were promised a small incentive for their time. Two consultants staffed each focus group, serving as facilitators and note takers. These consultants were not directly affiliated with the ministry to ensure candor from the participants. For the Nonprofit and Government Stakeholder Focus Group, Community Benefit staff developed a list of leaders from organizations that serve diverse constituencies within the hospital's service area. Ministry staff sought to invite organizations with which they had existing relationships, but also used the focus group as an opportunity to build new relationships with stakeholders. Participants were not given a monetary incentive for attendance. As with the resident focus groups, this group was facilitated by outside consultants without a direct link to St. Joseph Health.

The Olin Group served as the lead consultant in the CHNA process, coordinating the quantitative and qualitative data collection processes and assisting in the prioritization and selection of health needs. St. Jude Medical Center partnered with Habitat for Humanity, Korean Community Services and the La Habra Family Resource Center to obtain focus group information.

St. Jude Medical Center held 3 Community Resident Focus Groups in three different cities of its Primary Service Area. Two focus groups were conducted in Spanish and one in Korean to ensure that people who face more challenges with having their voices heard could participate in the community input process. A total of 52 individuals participated in the Community Resident Focus Groups. Most participants understood the benefits of healthy eating and connected it to the development of obesity and diabetes. However, they shared their challenges in eating a healthy diet. Healthy, organic foods are more expensive than fast, processed foods. Children learn at an early age to prefer processed foods (like chicken nuggets at school), even when they are given healthy foods at home. Fast food eateries, donut shops, and food trucks that sell junk food are abundant in low-income neighborhoods. Food banks and churches often give out expired, dented canned goods and overripe produce that cannot be used and has to be thrown out. The Korean group also noted that food banks have mostly Western food, not Asian food. Obesity, especially in children, was a concern among focus group participants. They cited the availability of sodas and sweetened juices, diets high in fat, and lack of exercise as contributing to the incidence of obesity. Participants in both La Habra and Fullerton noted that there are too few jobs in the community so people have to travel long distances to find work. Fullerton participants also talked about how difficult it is for undocumented immigrants to get hired. The effects of low incomes and poverty are felt in a variety of ways. It affects access to quality housing and healthy food. It affects the ability to pay for dental and health care, and causes stress as people try to make ends meet. Housing was a major concern at the La Habra and Fullerton focus groups. The primary concern was apartments that are not maintained. They cited instances of mold, dirt, dust, old carpets, insect and rodent infestations, and neighbors who use marijuana and tobacco. The challenges around immigration status that are faced by the undocumented community were discussed at the La Habra and Fullerton focus groups. Stress and fear of arrest and deportation has grown considerably since November 2016. The Korean focus group participants mentioned that they often face language barriers at health care appointments and need translators, who are not always available. Stress was mentioned at all of the focus groups as a contributor to poor mental health. Among the causes of stress, participants cited low incomes, the high cost of housing, unemployment, undocumented status, and cultural issues. Participants at La Habra and Fullerton described widespread problems

with excessive alcohol consumption throughout the community and specifically at apartments and parks. The use and sale of drugs was linked to crime and gangs. The stakeholders covered a wide range of topics during the 80-minute focus group, demonstrating their understanding of the social determinants of health and their impact on the communities served by St. Jude Medical Center. There were 8 participants representing various community organizations and government entities They also understood how intertwined the issues are, explaining, for example, how the high cost of living and low incomes are connected to crowded living conditions and landlords who do not take care of rental properties, which contribute to stress, safety, and trauma issues.

Identification and Selection of Significant Health Needs

The graphic below depicts both how the compiled data and community input were analyzed to generate the list of significant health needs, as well as the prioritization process that allowed the selection of three significant health needs around which St. Jude Medical Center will build its implementation plan.

	Generating List of Significant Health Needs	Prioritization Step 1	Prioritization Step 2	Prioritization Step 3	Prioritization Step 4
Who	**2 external raters**	**2 external raters**	**Community Benefit Lead and internal Work group**	**Community Benefit Lead**	**Community Benefit Committee**
What	A comprehensive review of data & community input	Apply the following criteria per significant health need	Apply the following criteria per significant health need	Review through two filters	Review List of issues and narrow to 1-3 priority areas for FY18-FY20 CB Plan/ Implementation Strategy investment
Criteria	All sources were analyzed for severity of the problem and level of community concern.	1. Seriousness of the problem 2. Scope of the problem – # of people affected 3. Scope of the problem –compared to other areas 4. Health disparities among population groups 5. Importance to the community 6. Potential to affect multiple health issues (root cause) 7. Implications for not proceeding	1. Sustainability of impact 2. Opportunities for coordination/ partnership 3. Focus on prevention 4. Existing efforts on the problem 5. Organizational competencies	1. Is it aligned with the Mission of St. Joseph Health? 2. Does it adhere to the Catholic Ethical and Religious Directives?	1. Is the health need relevant to the ministry? 2. Is there potential to make meaningful progress on the issue? 3. Is there a meaningful role for the ministry on this issue? 4. Where do we want to invest our time and resources over the next three years?
Scale	**Multiple**	**1-5 scale**	**1-5 scale**	**Yes or No**	**CB Committee Dialogue**

The matrix below shows the 16 health needs identified through the selection process and their scores after the first three steps of the prioritization process. The check marks indicate each source of input and whether this issue was identified as a need by that input process.

Significant Health Need	Health Category	Total Rank Score	Community Data	Resident Focus Group	Non-profit/ Govt. Stakeholder FG
Mental Health	Health Outcome	47.4	✓	✓	✓
Obesity	Health Behavior	47.0	✓	✓	✓
Access to care for the Uninsured	Clinical Care	45.2	✓	✓	
Housing	Physical Environment	45.0	✓	✓	✓
Food and Nutrition	Socioeconomic	44.5	✓	✓	✓
Diabetes	Health Outcome	44.4	✓	✓	✓
Lack of Exercise	Health Behavior	43.7	✓	✓	✓
Walkability	Physical Environment	43.0		✓	✓
Drug Abuse	Health Behavior	40.8	✓	✓	✓
Parks	Physical Environment	40.3	✓	✓	✓
Poverty	Socioeconomic	36.7	✓	✓	✓
Immigration Status	Socioeconomic	36.3	✓	✓	✓
Jobs and Salaries	Socioeconomic	35.5	✓	✓	✓
Crime and Gangs	Physical Environment	35.2		✓	✓
Language Barriers	Socioeconomic	32.2	✓	✓	✓
Long Commutes	Physical Environment	28.5	✓	✓	

Definitions:

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

Obesity: Primarily defined as the health condition in which individuals are sufficiently overweight as to have detrimental effects on their overall health. This does not include issues of exercise or food choices, which are listed as separate issues.

Access to Care for the Uninsured: Providing access to health care for those without insurance.

Housing: Includes affordability, overcrowding, and quality of housing.

Food and Nutrition: Concerns about healthy eating habits, nutrition knowledge, and challenges of cost and availability of healthy options.

Diabetes: Specifically focused on the health condition of diabetes, and awareness and prevention of it.

Lack of Exercise: Includes issues around access to safe places to exercise and people not having enough time to exercise, or choosing not to.

Walkability: The lack of walkable areas and streets, including the lack of sidewalks, crosswalks, and street lights, as well as concerns about safety due to crime, speeding cars, and loose dogs.

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

Parks: Issues around a shortage of parks, or existing parks being poorly maintained, inaccessible, or unsafe.

Poverty: Poverty can have a detrimental effect on the health of low income individuals and families, and serve as a root cause of several other issues.

Immigration Status: Individuals who are or are connected to undocumented immigrants feel afraid and stressed, which affects their health. They also may not be able to access necessary health services or resources.

Jobs and Salaries: A root cause of other health issues, this covers difficulties around finding jobs that pay livable salaries and are close to home.

Crime and Gangs: Encompasses the incidence of crime, gang activity, and violence as well as the fear of it, which prevent people from using open spaces or enjoying their community.

Language Barriers: The challenges with accessing services and feeling welcomed that are faced by non-English speakers.

Long Commutes: Lengthy commutes can cause stress, increase the risk of accidents, reduce air quality, and take time away from healthier pursuits such as exercise or preparing healthier food.

Community Health Needs Prioritized

St. Jude Medical Center will address the following priority areas as part of its FY18-FY20 CB Plan/Implementation Strategy Report:

- Mental Health (including Substance Abuse): Implement innovative solutions and partnerships that eliminate the stigma of mental illness and ease access to care, build resilience in children, teens, families, and seniors, reduce suffering from depression, anxiety, and social isolation, curtail substance abuse and create hope for people with serious and persistent mental illness.

- Increase access to health care: provide support to affiliated community health center and other programs, increasing access to care for the underserved.
- Obesity (including Food and Nutrition, Lack of Exercise and Walkability): Implement policy, system, and environmental changes that make the healthy choice the easy choice in low income neighborhoods in North Orange County.

Mental Health and Substance Abuse were combined by the Community Benefit Committee. At the conclusion of Step 3 of the prioritization process, mental health was the highest ranked concern and substance abuse was ranked ninth. Both concerns were raised by community residents and stakeholders during the community input process, where they spoke in particular about stress due to low incomes, the high cost of living, crime, and immigration status. Data on mental health and substance abuse is difficult to obtain and often only at the county level. The emergency room utilization rate due to mental illness across Orange County is 59.2 per 10,000 inhabitants, compared to rates of 85.6, 98.9, and 130.2 in three zip codes of Anaheim. Data from the California Health Interview Survey-Neighborhood Edition shows high rates of serious psychological distress in Whittier (as high as 10.9%), although the rate for the TSA (7.4%) is below the state average (8.1%). The percentage of adults reporting binge or heavy drinking in Orange County is 19.5% compared to 17.2% throughout California. Mental health and substance abuse were combined as one priority to reflect both the approach of the regional and system wide Institutes for Mental Health and Wellness. Mental health and substance abuse were selected by the Committee as a priority because of the high score based on need and the regional and system-wide focus of this issue.

Access to Care for the Uninsured and Underinsured was the third highest ranked health need after the first three steps of the prioritization process. Participants at the community focus groups mentioned that undocumented immigrants are unable to purchase health insurance and the high cost of living affects the ability to pay for health care. In 2014, the TSA had a slightly higher rate of uninsured adults than Orange County (20.5% compared to 19.4%) and six zip codes had rates at or above 25% (in Buena Park, Whittier, and Anaheim). Orange County also had higher rates of uninsured children than California (5.3% compared to 3.2%), with rates in eight zip code areas over 6%. More updated data is not currently available, and while insurance rates have likely improved since then, these geographic areas are likely still below average. The Committee selected this need because of its high ranking and due to the uncertainty of the ACA and MediCal expansion at the federal level.

Obesity (Food and Nutrition, Lack of Exercise and Walkability) was the second highest ranked health need after the first three steps of the prioritization process; Food and Nutrition was ranked fifth. These were combined as food and nutrition, lack of exercise and walkability are viewed as strategies to address obesity. Rates of overweight children and obese adults in the TSA are higher than Orange County rates for all age groups. For example, 27% of teenagers

are overweight or obese in the TSA compared to 21% in Orange County. In some zip codes in the SSA, the rates are over 40% (all in Whittier). Similarly, the rate of obesity in adults is 22% in the TSA and over 25% in nine zip code areas (primarily in Whittier and Anaheim), compared to 18% in Orange County. 8% of people in the TSA reported low-income food insecurity, compared to 7% in Orange County. Rates of food insecurity were at or above 10% in 12 zip code areas, including parts of Buena Park, Fullerton, Whittier, and Anaheim. Community members recognized that obesity is prevalent in their neighborhoods and associated it with challenges to affording healthy food, easy access to less healthy processed and fast foods, and lack of safe places to exercise in their neighborhoods. The Committee selected Obesity as a top priority because of its prevalence, particularly in low income communities and its impact on health status.

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

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 by partnering with other organizations who may meet the needs beyond our programs and by funding other non-profits through our Care for the Poor program managed by the St. Jude Medical Center.

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

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

Homelessness Services: While St. Jude Medical Center has not prioritized homelessness as a top priority based on the CHNA, it is an increasing challenge in our community and the Medical Center has made investments to address this. The Medical Center has implemented a Community Care Navigation program which provides two social workers who work with homeless patients who come to the Emergency Department and the hospital and follow them in the community to connect them to resources. The Medical Center has a partnership with

Pathways of Hope for bridge housing, a contract with Illumination Foundation for recuperative care, and is a funded partner in the Whole Person Care Initiative and the Street to Home Initiative.

Diabetes: St. Jude Medical Center has chosen to address the increase in diabetes prevalence by focusing on obesity. The Vice President, Healthy Communities serves as President of the Orange County American Diabetes Association Community Leadership Board and helps lead the Diabetes Work Group of the Orange County Health Improvement Plan.

Poverty: While St. Jude Medical Center has not selected poverty as a top priority, the majority of its community benefit programs are targeted to the low income population. The Medical Center partners with Orange County Community Action Partnership, the county anti-poverty agency on several initiatives.

Immigration Status: While the Medical Center has not selected immigration status as a top priority, advocacy efforts to provide a path to citizenship are supported.

Jobs and Salaries: The Medical Center has a policy of a just living wage and in that way serves as a role model for other organizations in the community.

Crime and Gangs: The declining crime rate has not made this a priority but the Medical Center actively participates in five local city collaboratives that focus on the needs of at-risk youth with a goal to reduce gang involvement and crime.

Language Barriers: The Medical Center has a robust interpreter services department and policy. Several of the collaboratives that the Medical Center supports are focused on literacy issues.

Long Commutes: The Vice President, Healthy Communities leads the Alliance for a Healthy Orange County which has as a priority increasing the use of active transportation. The Medical Center's Move More Eat Healthy campaign encourages the creation of walkable mixed use communities.

COMMUNITY BENEFIT PLAN

Summary of Community Benefit Planning Process

The FY18-20 Community Benefit Strategy/Implementation Plan was developed in response to findings from the FY17 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.

The plan was developed in alignment with the Orange County Health Improvement Plan, which is developed under the leadership of the Orange County Public Health division. Key priorities in the Medical Center Plan are included in the county-wide plan. The Medical Center's Vice President, Healthy Communities serves on the Steering Committee of the Orange County Health Improvement Partnership which oversees the plan.

Selection Criteria and Process

Evaluators from The Olin Group performed a rigorous review of the publicly-available data and community input to identify 16 significant health needs for St Jude Medical Center.

The selection process began with the development of a general list of potential health needs, derived from a broad review of the indicator data, focus group findings, and literature around health concerns and social determinants of health. The goal of the selection process was to analyze the wide variety and large quantity of information obtained through the quantitative and qualitative processes in a consistent manner. Each source of input was considered as follows:

- Quantitative Data: Weighting was based on how the service area compared to California and county averages and how individual cities and zip codes compared to the service area averages. Note that for some health needs, data was not readily available.
- Resident Focus Groups: Focus Group transcripts and notes were reviewed and considered both at the individual focus group level and collectively across focus groups. Weighting was related to how often and how extensively an issue was discussed by the participants.
- Stakeholder Focus Group: Weighting for the stakeholder group was based on how strongly the problem was discussed by the participants and the extent of agreement among the participants about the problem.

In developing the list of significant health needs, the quantitative data was given equal weight to the community input. After reviewing and rating all the available information, the list of potential health needs was ranked from greatest to lowest need for the ministry and the top 16 were recommended by The Olin Group for further consideration.

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

Prioritization Process and Criteria

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

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

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

Step 2: The Community Benefit Lead for St. Jude Medical Center convened a working group of stakeholders to complete the second stage of prioritization. This working group applied 4 criteria to each need.

- Sustainability of Impact: The degree to which the ministry's involvement over the next 3 years would add significant momentum or impact, which would remain even if funding or ministry emphasis on the issue were to cease.
- Opportunities for Coordination and Partnership: The likelihood that the ministry could be part of collaborative efforts to address the problem.
- Focus on Prevention: The existence of effective and feasible prevention strategies to address the issue.
- Existing Efforts on the Problem: The ability of the ministry to enhance existing efforts in the community.

The Community Benefit Staff participating in the working group also considered a fifth criterion:

- Organizational Competencies: The extent to which the ministry has or could develop the functional, technical, behavioral, and leadership competency skills to address the need.

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

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

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

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

Once the priorities were identified, Community Benefit staff drafted goals, outcome measures, strategies and targets that were reviewed and refined by the Community Benefit Committee. Every effort was made to incorporate evidenced-based, best practice or promising practice strategies, as well as build on existing efforts in the community. The proposed plan was presented to the Community Benefit Committee for final approval.

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

1. **Initiative/Community Need being Addressed:** Access to Mental Health Services for Underserved Persons

Goal (anticipated impact): Increased access to quality mental health services for low income persons

Outcome Measure	Baseline	FY18 Target	FY20 Target
Number of mental health prevention and treatment encounters provided by programs supported by SJMC	2,465	8,615	9,225

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY20 Target
1.Implement chemical dependency care navigation program	# of encounters provided chemical dependency assessment and intervention	0	1000	1500
2.Collaborate with at least 3 school districts to enhance mental health prevention/treatment	# of student mental health encounters	519	1000	1500
3.Improve the quality of care provided at SJNHC and St. Jude Senior Services for clients experiencing depression	# of patients whose baseline PHQ 9 is greater than 10 who improve by one level	0	25	75
4.Reduce the stigma of mental health issues in North Orange County	# of persons who have made a promise to discuss mental health	0	500	1000
5.Improve integration of primary care and mental health services	# of mental health clinicians FTE integrated into North Orange County primary care and clinic practices # of encounters provided	1.25 1838	2.5 3500	3.5 5000
Increase connection of homeless population with mental health and substance use services	# of homeless patients in Community Care Navigation program connected to mental health or substance use services	108	125	150

1. **Initiative/Community Need being Addressed:** Access to Mental Health Services for Underserved Persons (Continued)

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY20 Target
Engage a strategic and comprehensive local coalition of partners to address the upstream community determinants of mental health across the Spectrum of Prevention and the Adverse Community Experience and Resilience framework	# of partners engaged in upstream mental health improvement efforts	0	8	12
Advocate for policies and system changes that improve the community determinants of mental health including changes to address substance use	# of policies and system changes advocated for	0	3	6

Evidenced Based Sources: United States Substance Abuse and Mental Health Services Administration National Registry of Evidenced Based Programs and Practices www.samhsa.gov/nrepp; Healthy People 2020 Evidenced Based Resources. www.healthypeople2020.

Key Community Partners: Fullerton Police Department, La Habra Police Department, CityNet, Pathways of Hope, Mercy House, Illumination Foundation, St. Jude Neighborhood Health Centers, Hoag Hospital, St. Joseph Heritage HealthCare, NAMI, OC Behavioral Health.

Resource Commitment: In FY18, $400,000 has been budgeted for this initiative. In addition, advocacy efforts will be undertaken for this initiative.

2. Initiative/Community Need being Addressed: Access to Care for the Underserved

Goal (anticipated impact): Increase access to health care for the underserved

Outcome Measure	Baseline	FY18 Target	FY20 Target
# of medical, dental and mental health visits provided to the underserved in our community	23,878	23,878	38,000

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY20 Target
1.Implement expansion of SJNHC Fullerton site	# of visits at SJNHC Fullerton sites	23,878	23,878	30,000
2.Implement Anaheim site of SJNHC	# of visits at Anaheim site	0	0	8,000
3.Expand access to urgent care and specialty services to uninsured	# of new urgent care and specialty visits provided to uninsured at new sites	0	TBD	TBD
4.Support policy initiatives that promote continued access to health insurance	Uninsured rate in North Orange County	7%	7%	7%
5. Implement systematic approach to collection of social determinant of health data at affiliated clinics.	Social Determinant data collected at affiliated clinic	No data collected	System to collect data implemented	Data utilized to identify gaps in services

Evidenced Based Sources: Healthy People 2020 Evidenced Based Resources www.healthypeople2020.gov.

Key Community Partners: St. Jude Neighborhood Health Centers, City of Fullerton, Fullerton School District, Anaheim City School District, Community Health Centers

Resource Commitment: In FY18, over $3.7 million has been budgeted for this initiative. In addition, advocacy efforts will be undertaken for this initiative.

3. **Initiative/Community Need being Addressed:** Obesity (including Food and Nutrition, Physical Activity and Walkability)

Goal (anticipated impact): Increase the percentage of healthy weight persons in our community benefit service area; Strengthen city, school and organizational policies that promote healthy lifestyles

Outcome Measure	Baseline	FY18 Target	FY20 Target
Per Cent of schools which show an increased percentage of 5th, 7th and 9th graders in the Healthy Fitness Zone for body composition	43%	50%	60%

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY20 Target
1. 1.Acheive at least bronze level designation for Alliance for Healthier Schools or US Healthier Schools	# of schools that register and achieve bronze, silver or gold status for Alliance for Healthier Schools or US Healthier Challenge	0	6	12
2. 2.Target cities implement at least 1 strategy in Bicycle Master Plan or Completes Street Plan	# of strategies implemented in each city	0	1 in each city	2 in each city
3. 3. Promote outdoor fitness center utilization in low income parks	Per Cent increase in utilization of outdoor exercise equipment as measured by a sample of parks at random times	0	10%	20%
4. Complete school walkability/bike assessments and implement plans to increase walking and bicycling to target schools	# of schools that have completed walk/bike audits and developed plans to address gaps	2	5	10
5. Engage low income	# of goals low income	15.788	16,000	18,000

residents in establishing personal goals	residents in targeted communities established and follows up to identify percentage of those who achieve their goals.			
6. Increase resident engagement in policies related to physical activity, the built environment and nutrition through Resident Leadership Academy.	Number of residents engaged in advocacy work related to active transportation, nutrition and the built environment	16	24	32

Evidenced Based Sources: U.S. Centers for Disease Control Recommended Community Strategies and Measurements to Prevent Obesity in the United States **www.cdc.gov.**

Key Community Partners: Community Action Partnership, Second Harvest, Cities of Fullerton, Buena Park, La Habra and Placentia, city collaboratives, Fullerton School District, Placentia Yorba Linda School District, Buena Park School District, La Habra Elementary School District, Fullerton Joint Union High School District, California State University Fullerton, Fullerton College

Resource Commitment: In FY18, the Medical Center has budgeted $1 million for this initiative. In addition, advocacy efforts will be undertaken.

4. Regional Initiative/Community Need being Addressed: Income inequality addressed through Education.
Goal (anticipated impact): Reduce the education achievement gap in the schools

Outcome Measure	Baseline	FY18 Target	FY20 Target
% of children developmentally on track in EDI scores in targeted school districts	TBD	TBD	TBD

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY20 Target
1.Engage with community partners in selected cities to develop and implement a plan to improve EDI scores	# of cities with focused collaborative on EDI that hospital is participating in	0	1	2
2.Participate in development of an Early Childhood Policy Framework for Orange County	Policy Framework developed	No policy framework	Policy Framework/Education Equity Forum held	Policy Framework developed and utilized
3.Identify opportunities to link community benefit investments with efforts to improve the EDI domains	Number of Community Benefit programs linked to efforts to improve the EDI domains	0	1	3

The outcome measures will be developed in partnership with work groups in each community who will determine the focus area for their EDI work.

Evidence Based Sources: www.edi.offordcentre.com

Key Community Partners: School Districts, Cities, CBO's, Public Libraries, Children and Families Commission, OCDE

Resource Commitment: Staff time to participate in community collaboratives.

Other Community Benefit Programs and Evaluation Plan

Initiative (community need being addressed):	Program	Description	Target Population (Low Income or Broader community)
1. Engaging community partners to address health disparities	Healthy Communities	Technical assistance to support community collaboratives	Low-income
2. Lack of public transportation	Transportation Program	Provide non-emergency medical transportation	Low-income
3. 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
4. Lack of support services for frail elderly	Senior Services	Information and referrals, support groups, classes, Caring Neighbors volunteer program	Low-income
5. 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
6. 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
7. 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)
8. 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
9. Need for patient/family education	Rehab Community Program Follow-Up	Nurse follow-ups with patients post-discharge	Broader community
10. Lack of resources for homeless population	Community Care Navigation	Identification and intervention to assist the homeless and underserved population	Low-income
11. 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
12. 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
13. 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
14. At-risk youth and their families	ACT Anaheim Big Brothers Big Sisters Network Anaheim Partners	Support for ACT Anaheim and related organizations to address the needs of at-risk youth	Low-income
15. CalOptima population	St. Joseph Heritage Healthcare	Support for care coordination services for CalOptima members	Low-income
16. Low Income communities	St. Joseph Community Partnership Fund	Community Building, Emergency Food and Shelter and Mental Health Upstream grants	Low-income
17. Education Equity	EDI	Partner with community collaboratives to address EDI	Low Income

Governance Approval

This FY18-FY20 Community Benefit Plan/Implementation Strategy Report was approved at the October 11, 2017 meeting of the St. Jude Medical Center Community Benefit Committee a sub-Committee of the Board of Trustees.

Community Benefit Committee Chair's Signature confirming approval of St. Jude Medical Center's FY18-FY20 Community Benefit Plan/Implementation Strategy Report

10/11/2017
Date

Appendix

Definition of Terms

Community Benefit: An initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives:

a. Improves access to health services;
b. Enhances public health;
c. Advances increased general knowledge; and/or
d. Relieves government burden to improve health.

Community benefit includes both services to the poor and broader community.

To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following:

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

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

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

Initiative: An initiative is an umbrella category under which a ministry organizes its key priority efforts.

Program: A program is defined as a program or service provided to benefit the community (in alignment with guidelines).

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

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

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