Whole Person Care Program:
Recuperative housing for homeless patients requiring post-acute hospitalization care
Anaheim, CA

ST. JOSEPH HOSPITAL

FY18 - FY20 Community Benefit Plan/Implementation Strategy Report

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

To provide feedback about this Community Benefit Plan, email:
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EXECUTIVE SUMMARY

St. Joseph Health, St. Joseph Hospital is an acute-care hospital founded in 1929, is located at Orange, California. It became a member of St. Joseph Health in 1982. The facility has 465 licensed beds, 379 of which are currently available, and a campus that is approximately 38 acres in size. St. Joseph Hospital has a staff of more than 3,100 and professional relationships with more than 1,000 local physicians. Major programs and services include cardiac care, critical care, diagnostic imaging, emergency medicine and obstetrics.

In response to identified unmet health-related needs in the community needs assessment, during FY18-20 St. Joseph Hospital will focus on Access to Health Care, Mental Health, and Diabetes/Obesity/Food and Nutrition for the broader and underserved disadvantaged members of the surrounding community.

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

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

- Access to Health Care for the Uninsured and Underinsured
- Mental Health
- Diabetes/Obesity/Food and Nutrition

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

St. Joseph Health, St. Joseph Hospital is an acute-care hospital founded in 1929, is located at Orange, California. It became a member of St. Joseph Health in 1982. The facility has 465 licensed beds, 379 of which are currently available, and a campus that is approximately 38 acres in size. St. Joseph Hospital has a staff of more than 3,100 and professional relationships with more than 1,000 local physicians. Major programs and services include cardiac care, critical care, diagnostic imaging, emergency medicine and obstetrics.

ORGANIZATIONAL COMMITMENT

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

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

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

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

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

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

A charter approved in 2007 establishes the formulation of the St. Joseph Hospital Community Benefit Committee. The role of the Community Benefit Committee is to support the Board of Trustees in overseeing community benefit issues. The Committee acts in accordance with a Board-approved charter. The Community Benefit Committee is charged with developing policies and programs that address identified needs in the service area particularly for

underserved populations, overseeing development and implementation of the Community Health Needs Assessment and Community Benefit Plan/Implementation Strategy Reports, and overseeing and directing the Community Benefit activities.

The Community Benefit Committee has a minimum of eight members including three members of the Board of Trustees. Current membership includes 6 members of the Board of Trustees and 6 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 every other month.

Roles and Responsibilities

Senior Leadership

- CE 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

Patient 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. Joseph Hospital has a **Patient Financial Assistance Program**[1] that provides free or discounted services to eligible patients.

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

For information on our Financial Assistance Program click the link:
https://www.sjo.org/for-patients/billing-insurance-and-payment/patient-financial-assistance/

Medicaid and Other Local Means-Tested Government Programs

St. Joseph Hospital provides access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California and other local-means-tested government programs.

COMMUNITY

Definition of Community Served

St. Joseph Hospital provides Orange County communities with access to advanced care and advanced caring. The hospital's total service area extends from Yorba Linda in the north, Lake Forest in the south, Corona in the east and Huntington Beach in the west. Our Hospital Total Service Area includes the cities of Orange, Santa Ana, Tustin, Anaheim, Garden Grove, Villa Park, Westminster, Yorba Linda, Placentia, Irvine, Corona, Fullerton, Fountain Valley, Costa Mesa, Buena Park, Stanton, Silverado, Lake Forest, Cypress and Foothill Ranch. This includes a

[1] For information on our Financial Assistance Program click here.

population of approximately 2,380,838 people, an increase of approximately 5% from the prior assessment.

Community Profile

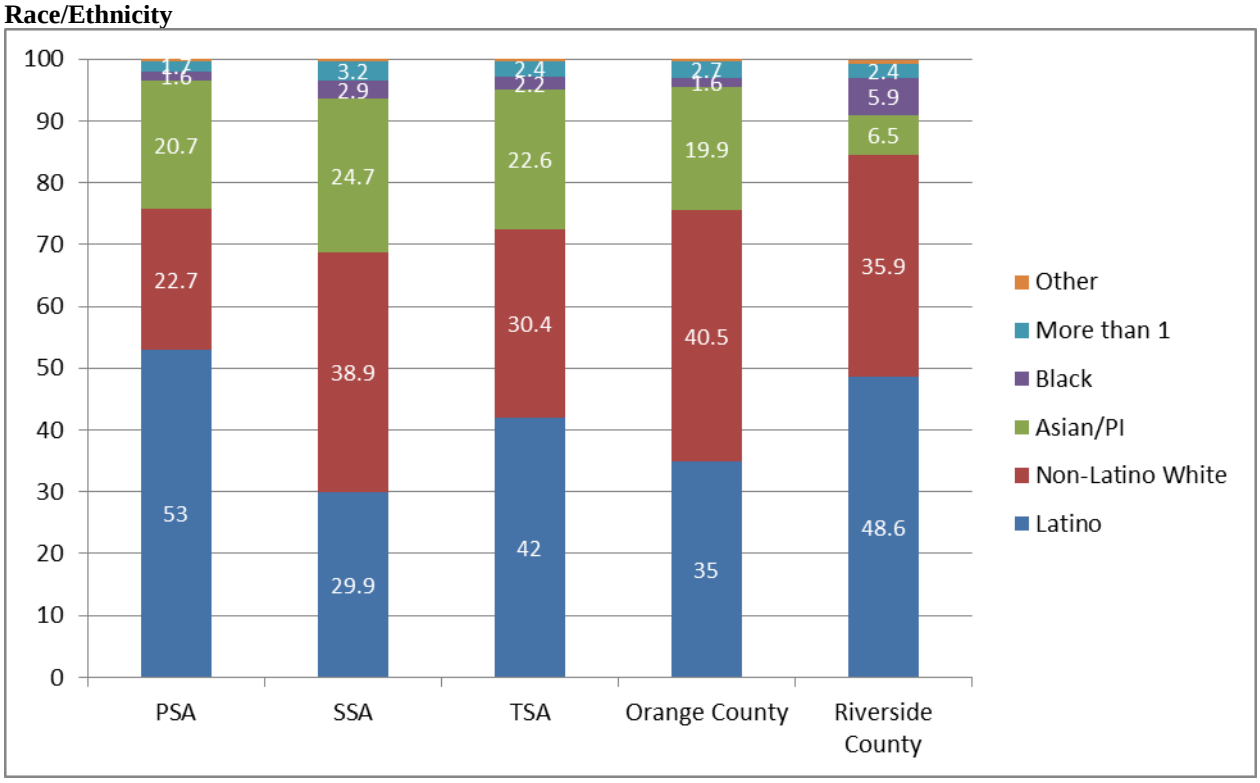
The table and graph below provide basic demographic and socioeconomic information about the St. Joseph Hospital Orange Service Area and how it compares to Orange County, Riverside County, and the state of California. Riverside County data is included because nearly a quarter of the Secondary Service Area (SSA) population is in Riverside County. However, throughout this report, comparisons of the Total Service Area (TSA) are made to Orange County. 14

The TSA of St. Joseph Hospital Orange has nearly 2.4 million people, with a median household income of just under $74,000. There are more children and fewer older adults in the TSA relative to Orange County and California. Compared to Orange County, the Primary Service Area has a much lower median household income and much higher rates of poverty while the SSA is better off on those same measures. The PSA has a higher percentage of Latinos and smaller percentage of non-Latino Whites than Orange County.

Service Area Demographic Overview

Indicator	PSA	SSA	TSA	Orange County	Riverside County	California
Total Population	1,253,825	1,127,013	2,380,838	3,172,848	2,341,521	38,986,171
Under Age 18	25.8%	23.1%	24.5%	22.9%	26.2%	23.6%
Age 65+	11.0%	11.7%	11.3%	13.5%	13.4%	13.2%
Speak only English at home	35.7%	57.2%	45.9%	54.4%	60.1%	56.2%
Do not speak English "very well"	31.9%	16.9%	24.8%	20.6%	15.3%	19.1%
Median Household Income	$62,480	$82,163	$73,636	$78,612	$58,155	$62,554
Households below 100% FPL	13.9%	7.9%	10.9%	9.2%	13.1%	12.3%
Households below 200% FPL	35.5%	20.0%	27.8%	23.5%	32.7%	29.8%
Children living below 100% FPL	25.2%	14.2%	20.2%	17.6%	23.4%	22.7%
Older adults living below 100% FPL	11.6%	7.5%	9.6%	8.7%	9.4%	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 Orange, Santa Ana, Tustin, Anaheim, Garden Grove, Villa Park, and Westminster. The SSA is comprised of another

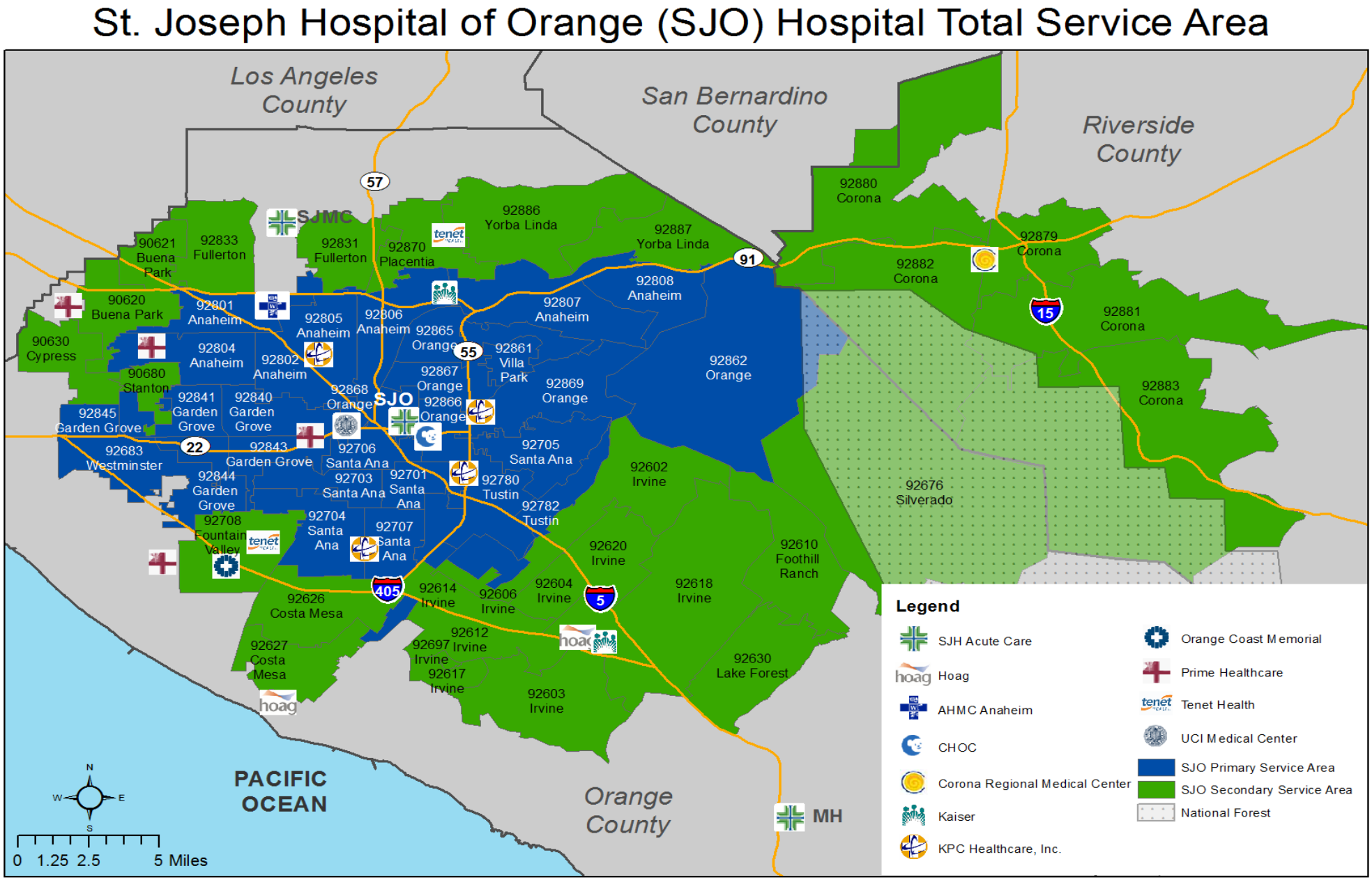
area, Yorba Linda, Placentia, Irvine, Corona, Fullerton, Fountain Valley, Costa Mesa, Buena Park, Stanton, Silverado, Lake Forest, Cypress and Foothill Ranch.

Table 1. Cities and ZIP codes

Cities/ Communities	ZIP Codes	PSA or SSA
Orange	92856, 92857, 92859, 92862, 92863, 92865, 92866, 92867, 92868	PSA
Santa Ana	92701, 92702, 92703, 92704, 92705, 92706, 92707, 92711, 92735, 92799	PSA
Tustin	92780, 92781, 92782,	PSA
Anaheim	92801, 92802, 92803, 92804, 92805, 92806, 92807, 92808, 92809, 92814, 92815, 92816, 92817, 92825	PSA
Garden Grove	92840, 92841, 92842, 92843, 92844, 92845, 92846	PSA
Villa Park	92861	PSA
Westminster	92683, 92864, 92685	PSA
Yorba Linda	92885, 92886, 92887	SSA
Placentia	92870, 92871	SSA
Irvine	92602, 92603, 92604, 92606, 92612, 92614, 92616, 92617, 92618, 92619, 92620, 92623, 92697	SSA
Corona	92877, 92878, 92879, 92880, 92881, 92882, 92883	SSA
Fullerton	92831, 92833, 92834, 92838	SSA
Fountain Valley	92708, 92728	SSA
Costa Mesa	92626, 92627, 92628	SSA
Buena Park	90620, 90621, 90622	SSA
Stanton	90680	SSA
Silverado	92676	SSA
Lake Forest	92630	SSA
Cypress	90630	SSA
Foothill Ranch	92610	SSA

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

Figure 1. St. Joseph Hospital Total Service Area



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. SJMC = St. Jude Medical Center; MH = Mission Hospital.
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):

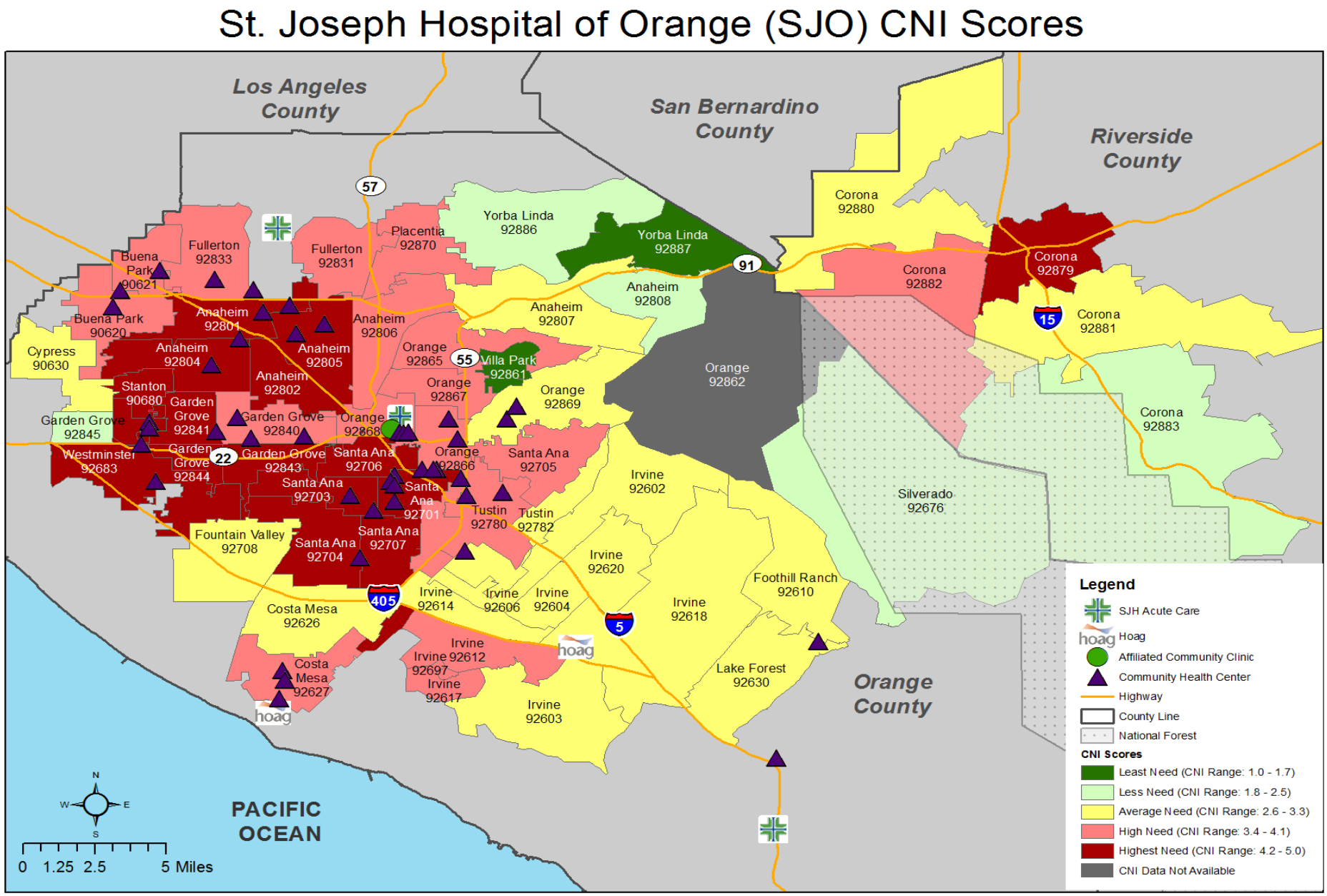
- Income Barriers (Elder poverty, child poverty and single parent poverty)
- Culture Barriers (non-Caucasian limited English);
- Educational Barriers (% population without HS diploma);
- Insurance Barriers (Insurance, unemployed and uninsured);
- Housing Barriers (Housing, renting percentage).

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 92703 (City of Santa Ana) on the CNI map is scored (in red) 4.2 - 5.0, making it a High Need community.

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

Figure 2. St. Joseph Hospital Community Need Index (Zip Code Level)

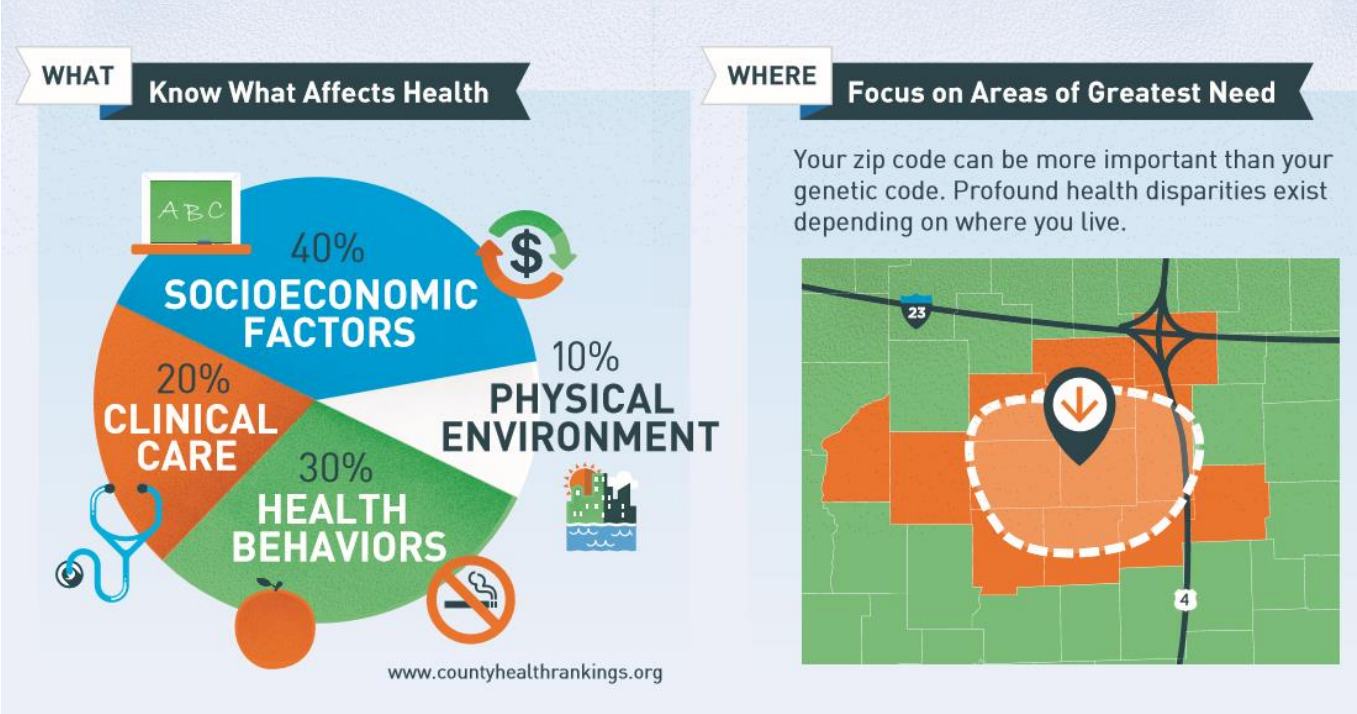


Sources: Dignity Health Community Need Index (cni.chw-interactive.org), 2015 (accessed March 2016); The Coalition of Orange County Community Health Centers (coccc.org) (accessed Sept. 2016). Prepared by the St. Joseph Health Strategic Services Department, April 2016.

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

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

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



Examples of the types of information that was gathered, by health factor, are:
Socioeconomic Factors – income, poverty, education, and food insecurity

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

Health Behaviors – obesity[2], sugary drink consumption, physical exercise, smoking, and substance abuse

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

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

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

Collaborative Partners

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

Community Partners:

St. Joseph Hospital Orange partnered with the following community groups to recruit for and host the Focus Groups and Forums.

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

My Safe Harbor, Anaheim. My Safe Harbor provides mothers an experience of personal and family transformation so they can change their future and the future of their community. They hosted and recruited for a Community Focus Group.

Orange County Congregation Community Organization (OCCCO), Anaheim. OCCCO is a faith-based community organization working to strengthen families and improve neighborhoods, by engaging communities to shape public policy and build a legacy of leadership throughout Orange County. OCCCO hosted and recruited for two community focus groups.

The Orange County Asian and Pacific Islander Community Alliance (OCAPICA), Garden Grove. OCAPICA is dedicated to enhancing the health, and social and economic well-being of Asians and Pacific Islanders in Orange County, California. Established in 1997, OCAPICA works to improve and expand the community's opportunities through service, education, advocacy, organizing and research, and to empower Asians and Pacific Islanders to define and control their lives and the future of their community. OCAPICA played a key role in planning the Community Forum and recruiting its participants.

Southland Integrated Services, Westminster. Southland Integrated Services (formerly Vietnamese Community of Orange County) provides comprehensive health, human, and economic development services to Vietnamese Americans in order to enable them to become actively participating citizens in the mainstream society through empowerment and capacity enhancement of each citizen. They hosted, recruited for, and facilitated a focus group in the Westminster/Garden Grove area.

Secondary Data/Publicly available data

Within the guiding health framework for the CHNA, publicly-available data was sought that would provide information about the communities (at the city and zip code level when available) and people within our service area. In addition, comparison data was gathered to show how the service area communities are faring compared to the county or state. Indicators were chosen if they were widely accepted as valid and appropriate measures[3] and would readily communicate the health needs of the service area. Preference was given to data that was obtained in the last 5 years and was available at the zip code level. The data sources used are highly regarded as reliable sources of data (e.g., ESRI Business Analyst Online, US Census Bureau American FactFinder, and California Health Interview Survey Neighborhood Edition). In total, 81 indicators were selected to describe the health needs in the hospital's service area. Appendix 2 includes a complete list of the indicators chosen, their sources, the year the data was collected, and details about how the information was gathered.

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

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

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

Community Input

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

Resident Focus Groups

For Community Resident Groups, Hospital Community Benefit staff, in collaboration with their Community Benefit Committees and the St. Joseph Health Community Partnerships Department, identified geographic areas where data suggested there were significant health needs, 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 provided 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.

Nonprofit and Government Stakeholder Focus Group

For the Nonprofit and Government Stakeholder Focus Group, Community Benefit staff developed a list of leaders from organizations that serve diverse constituencies within the hospital's service area. Ministry staff sought to invite organizations with which they had existing relationships, but also used the focus group as an opportunity to build new relationships with stakeholders. 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.

Community Resident Forum

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

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

Orange County Public Health officials reviewed the final draft of the 2017 CHNA Report. Their feedback stated that many of the priorities identified were consistent with those in the 2017 OC Health Improvement Plan.

Name	Title	Organization
Jane Chai, MPH	Public Health Projects Manager	Orange County Health Care Agency
Donna Fleming	Chief, Public Health Operations	Orange County Health Care Agency

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

- Access to Care for the Uninsured and Underinsured
- Mental Health

- Diabetes / Obesity / Food and Nutrition

Access to Care for the Uninsured and Underinsured is a concern that emerged in both the data and through community input. Although the data used for the CHNA do not reflect the most recent enrollments due to the Affordable Care Act, they show that rates of uninsured children and adults were slightly higher in the TSA than for Orange County. Rates in parts of Santa Ana and Anaheim were especially high. Community input focused on the challenges people face with using insurance, talking about the cost of premiums and co-pays, the difficulty navigating an unfamiliar health care system, and the need for linguistically and culturally sensitive care. Access to Care tied with Mental Health as the top priority after the first 3 steps of the prioritization process.

Mental Health received the most votes by far at the community forum and was tied with Access to Care as the top priority after the first 3 steps of the prioritization process. Mental health, and specifically stress and depression, was linked to many other issues such as economic challenges, housing, and immigration. Community members also noted the continued stigma associated with mental illness and the difficulties they face navigating the mental health system and finding culturally appropriate mental health services. Emergency Room usage rates for mental health reasons are extremely high in lower-income areas of Santa Ana and Anaheim.

Diabetes / Obesity / Food and Nutrition were originally considered as separate issues but combined by the Community Benefit Committee. The Committee agreed that these three significant health needs had enough correlation and a "cause and effect" implication among them that by addressing one or two, we could essentially address all three. While the overall rate of diabetes in the TSA is similar to Orange County's rate (7.8% in the TSA compared to 7.4% in the County), the rate in the PSA is higher (8.7%). Certain communities have much higher rates of diabetes, ranging from 10.2% to 11.9% in Westminster and Garden Grove. Rates in Santa Ana and Anaheim hover between 9 and 10 percent.

The data on overweight and obesity shows the TSA has slightly higher rates than Orange County (24.2% of teenagers in the TSA are overweight or obese compared to 20.9% across the county), but those rates are below the California rate of 33.1%. The highest rates of overweight and obesity in teenagers in the PSA were found in Santa Ana and Anaheim, where the highest rate was 29.0%. Data on obesity in adults showed a similar pattern, with more than 25% of the adult population considered obese in some zip codes of Santa Ana and Anaheim, compared to 20.3% in the TSA and 18.4% in Orange County.

Concerns about Food and Nutrition, a root cause of diabetes and obesity, were raised both in the data and through community input. The data shows high rates of food insecurity, especially in the PSA (11.3% compared to 6.8% in Orange County) and the PSA communities of Santa Ana and Anaheim (as high as 22.6% in one zip code area of Santa Ana). Concerns about the cost,

availability, and ease of preparing healthy food compared to abundant, cheap, and quick unhealthy options were raised at all of the focus groups and the community forum.
St. Joseph Hospital anticipates that implementation strategies may change and therefore, a flexible approach is best suited for the development of its response to the St. Joseph Hospital CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by St. Joseph Hospital in the enclosed CB Plan/Implementation Strategy.

Identification and Selection of Significant Health Needs
Selection Criteria and Process

Evaluators from The Olin Group performed a rigorous review of the publicly-available data and community input to assist Community Benefit Committee to identify three significant health needs for St. Joseph Hospital Orange.

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.

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**

Rank-ordered significant health needs

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

Significant Health Need	Health Category	Total Rank Score	Community Data	Resident Focus Groups (FG)	N.P./ Govt. Stakeholder FG	Community Forum
Access to Care for the Uninsured and Underinsured	Clinical Care	47.6	✓	✓	✓	✓
Mental Health	Health Outcome	47.6	✓	✓	✓	✓
Diabetes	Health Outcome	43.2	✓		✓	
Housing Concerns	Physical Environment	41.7	✓	✓	✓	
Obesity	Health Behavior	41.5	✓	✓		
Education	Socioeconomic	40.9	✓	✓	✓	✓
Food and Nutrition	Health Behavior	40.3	✓	✓	✓	
Language and Cultural Barriers	Socioeconomic	40.1	✓	✓	✓	✓
Economic Insecurity	Socioeconomic	39.2	✓	✓		
Immigration Status	Socioeconomic	37.7	✓	✓		✓
Access to Resources	Clinical Care	36.9		✓	✓	
Public Safety	Physical Environment	32.9	✓	✓	✓	
Parks	Physical Environment	28.9	✓	✓		✓

For definitions go to the SJO CHNA Report.

Community Health Needs Prioritized

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

- Access to Care for the Uninsured and Underinsured
- Mental Health
- Diabetes / Obesity / Food and Nutrition

Access to Care for the Uninsured and Underinsured is a concern that emerged in both the data and through community input. Although the data used for the CHNA do not reflect the most recent enrollments due to the Affordable Care Act, they show that rates of uninsured children and adults were slightly higher in the TSA than for Orange County. Rates in parts of Santa Ana and Anaheim were especially high. Community input focused on the challenges people face with using insurance, talking about the cost of premiums and co-pays, the difficulty navigating an unfamiliar health care system, and the need for linguistically and culturally sensitive care. Access to Care tied with Mental Health as the top priority after the first 3 steps of the prioritization process.

Mental Health received the most votes by far at the community forum and was tied with Access to Care as the top priority after the first 3 steps of the prioritization process. Mental health, and specifically stress and depression, was linked to many other issues such as economic challenges, housing, and immigration. Community members also noted the continued stigma associated with mental illness and the difficulties they face navigating the mental health system and finding culturally appropriate mental health services. Emergency Room usage rates for mental health reasons are extremely high in lower-income areas of Santa Ana and Anaheim.

Diabetes / Obesity / Food and Nutrition were originally considered as separate issues but combined by the Community Benefit Committee. The Committee agreed that these three significant health needs had enough correlation and a "cause and effect" implication among them that by addressing one or two, we could essentially address all three. While the overall rate of diabetes in the TSA is similar to Orange County's rate (7.8% in the TSA compared to 7.4% in the County), the rate in the PSA is higher (8.7%). Certain communities have much higher rates of diabetes, ranging from 10.2% to 11.9% in Westminster and Garden Grove. Rates in Santa Ana and Anaheim hover between 9 and 10 percent.

The data on overweight and obesity shows the TSA has slightly higher rates than Orange County (24.2% of teenagers in the TSA are overweight or obese compared to 20.9% across the county), but those rates are below the California rate of 33.1%. The highest rates of overweight and obesity in teenagers in the PSA were found in Santa Ana and Anaheim, where the highest rate was 29.0%. Data on obesity in adults showed a similar pattern, with more than 25% of the adult population considered obese in some zip codes of Santa Ana and Anaheim, compared to 20.3% in the TSA and 18.4% in Orange County.

Concerns about Food and Nutrition, a root cause of diabetes and obesity, were raised both in the data and through community input. The data shows high rates of food insecurity, especially in the PSA (11.3% compared to 6.8% in Orange County) and the PSA communities of Santa Ana and Anaheim (as high as 22.6% in one zip code area of Santa Ana). Concerns about the cost, availability, and ease of preparing healthy food compared to abundant, cheap, and quick unhealthy options were raised at all of the focus groups and the community forum.

Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. We are committed to continue our Mission through community benefit programs and by funding other non-profits through the St. Joseph Health Community Partnership Fund.

As previously mentioned, St Joseph Hospital will endorse local non-profit organization partners to apply for funding through the St. Joseph Health Community Partnership fund. Local non-profits that receive funding provide specific services and resources to meet the identified needs of underserved communities throughout St. Joseph Hospital's service areas. The following community health needs identified in the St. Joseph Hospital CHNA will not be addressed and an explanation is provided below:

Housing concerns: The hospital does not directly address housing needs. However, we support and endorse grant applications to the St. Joseph Health Community Partnership Fund-Emergency Food and Shelter Initiative for several local central Orange County community based organizations. In addition, the hospital will be available to support maintenance/custodial services to the new Mercy House project to convert the Sisters of St. Joseph Mother House into affordable housing units for women and children.

Language and Cultural Barriers: The hospital does not directly address language and cultural needs except to patient population. The hospital provides cultural competency training for its employees. However, these trainings are not open to the public.

Economic Insecurity: The hospital does not directly address the effects of poverty and economic concerns. However, the hospital partners with Taller San Jose Hope Builders to support their graduating participants secure employment by providing pre-employment health screenings.

Immigration Status: The hospital does not directly address immigration issues. However, La Amistad Family Health Center (SJNHC) partners with the Public Law Center in referring patients who request immigration services. Furthermore, SJO may disclose Protected Health Information to Law enforcement including the US Immigration and Customs Enforcement (ICE) for the following purposes **only**: a) Injury resulting from a deadly weapon or from other criminal act; b) Rape or other sexual assault.

Access to Resources: The hospital does not directly offer access to resources in general. However, a Patient Advocate is stationed in the Emergency Care Center to assists low income underserved persons seeking care to enroll in appropriate and affordable health insurance programs and social services programs. In addition, we support and endorse grant applications to the St. Joseph Health Community Partnership Fund for several local central Orange County community based organizations seeking funds to address access to health and social services resources.

Public Safety: The hospital does not directly address issues around public safety. However, we support and endorse grant applications to the St. Joseph Community Partnership Fund-Community Building Initiative for local community based organizations who directly address

these social and infrastructure issues. Without this funding, these organizations would not be able to sustain and/or further their work in this area.

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

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

COMMUNITY BENEFIT PLAN

Summary of Community Benefit Planning Process
Prioritization Process and Criteria
To rank order the list of significant health needs and ultimately select the three health needs to be addressed by St. Joseph Hospital Orange, 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 located on the hospital CHNA which is posted on the website.

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. Joseph Hospital Orange convened a working group of internal and external 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.

Information about Ethical and Religious Directives is available http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf

Step 4: The final step of prioritization and selection was conducted by the St. Joseph Hospital Orange 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.

St. Joseph Hospital Orange will address the following priority areas:

- Access to Care for the Uninsured and Underinsured
- Mental Health
- Diabetes / Obesity / Food and Nutrition

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

1. **Initiative/Community Need being Addressed:** According to secondary data gathered, the hospital's Primary Service Area is worse off than the Total Service Area and Orange County on all socioeconomic indicators.

Goal (anticipated impact): Increase Access to Care for the Uninsured and Underinsured in central Orange County who lack appropriate health services.

Outcome Measure	Baseline	FY18 Target	FY20 Target
Number of uninsured persons served by expanded health services.	7,306 patients served in FY17	7,500 patients served	TBD

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY20 Target
1. Implement expansion of Orange/Santa Ana (La Amistad) site of St. Jude Neighborhood Health Centers	# of visits at Orange site of SJNHC	21,644 visits FY17	22,750 visits (medical, dental, vision, behavioral)	TBD
2. Pursue all options available to support the establishment of an new site/location in Anaheim (target zip code 92805)	# of visits at Anaheim site of SJNHC	New site	300 visits (medical, dental, vision)	TBD
3. Build a new assessment tool within the Electronic Health Record to screen for Social Determinants of Health (SDOH).	Report documenting most common SDOH	N/A	Establish baseline	TBD
4. Partner with community groups to understand and address/support	# of partners/groups engaged working to address unmet needs in Asian/Pacific Islander	Participated in funding local grassroots Asian/Pacific	Identify 1-3 key priority areas to support and	TBD

identified needs of underserved Asian/Pacific Islander population in central OC.	population.	Islander stakeholder interviews/needs assessment.	advocate for systemic changes affecting target population.	
5. Partner with OC Healthier Together Social Determinants of Health Work Group.	Develop a county-wide plan to prioritize the most pressing Social Determinants of Health affecting underserved communities.	Work Group started September 2017	Priority plan established.	TBD

Key Community Partners: Coalition of OC Health Centers, Family Resource Centers, Asian Americans Advancing Justice OC, CalOptima and St. Joseph Heritage Foundation.

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

2. **Initiative/Community Need being Addressed:** FY2017 CHNA quantitative data shows that mental health, particularly stress and depression related to undocumented status, among women and especially Latinas, trauma from domestic violence, and PTSD from violence in their home country before immigrating to the US, was a concern across all focus groups.

Goal (anticipated impact): Increase Access to Mental Health Services

Outcome Measure	Baseline	FY18 Target	FY20 Target
Number of underserved persons served by new or expanded mental health prevention and treatment services supported by St. Joseph Hospital.	3,278 visits in FY17	4,190 patients served	TBD

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY20 Target
1. Improve integration of primary care and mental health services.	# of mental health clinicians FTE integrated into Central Orange County clinic practices # of encounters provided	0.5 319 patients served in FY17	1.0 600 patients served	TBD
2. Participate in Regional Psychiatry Collaborative	# of patients receiving initial psychiatric assessment and medication management.	256 patients served in FY17	260 patients served	TBD
3. Increase connection of Emergency Care Center patient population with crisis stabilization, behavioral/ mental health, substance abuse services and recuperative housing.	# of psychiatric patients triaged in the Emergency Care Center. # of homeless patients discharged from the Emergency Care Center transitioned to recuperative 6-bed housing facility.	2,703 patients served in FY17 4 patients served since Feb. 2017	3,324 patients served 6 patients served	TBD
4. Improve the quality of care provided at La	# of patients whose baseline PHQ 9 is greater than 10 who improve by	0	25	TBD

	Amistad Health Center (SJNHC) for patients experiencing depression.	one level			
5.	Engage a strategic and comprehensive local coalition of partners to address the upstream social determinants of 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	TBD

Key Community Partners: La Amistad Family Health Center (SJNHC), Hoag Center for Healthy Living, Camino Health Center, Mission Hospital Family Resource Center, CSU Fullerton, Jamboree Housing Corp., The Prevention Institute.

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

3. **Initiative/Community Need being Addressed:** 2017 CHNA data reports that the hospital's PSA has higher rates of diabetes in adults, higher rates of overweight, obesity and sugary drink consumption and lower rates of regular exercise.

Goal (anticipated impact): Improve management of diabetes, increase percentage of healthy weight persons, and promote healthy behavior and lifestyle.

Outcome Measure	Baseline	FY18 Target	FY20 Target
# of diabetic patients with improved clinical values.	71% of diabetic patients are controlled as defined by HgA1C< 9.0	75% of diabetic patients are controlled as defined by HgA1C< 9.0	TBD

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY20 Target
1. Improve the percentage of patients with well controlled diabetes (A1C below 9).	% of patients with A1C below 9.	71% of patients in FY17	75% of patients	TBD
2. Improve the percentage of patients with (1) BMI charted and (2) follow up plan documented if patient is overweight/ underweight.	% of patients with charted BMI and follow up plan.	34% of patients in FY17	40% of patients	TBD
3. Adapt and implement Heritage Medical Group standard diabetes education protocol.	# of education encounters	2,218 education encounters in FY17	2,616 education encounters	TBD
4. Participate in local collaborative partnerships	# of local collaborative partners engaged in improvement efforts	10	15	TBD

focused on diabetes to advocate for county-wide coordinated resources/ referral and collective impact.				

Key Community Partners: La Amistad Family Health Center (SJNHC), St. Joseph Heritage HealthCare, HCA Diabetes Collaborative.

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

4. **Regional Initiative/Community Need being Addressed:** Regional Education Equity focused on low income populations.

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	N/A	Establish baseline	TBD

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY20 Target
1. Engage with community partners in selected cities to develop a plan to improve EDI scores	# of cities with focused collaborative on EDI that hospital is participating in	0	1	TBD

Key Community Partners: Orange County United Way, Garden Grove and Anaheim Unified School Districts, ROP North Orange County, Central Orange County Career technical Education Partnership

Other Community Benefit Programs and Evaluation Plan

Initiative/Community Need Being Addressed:	Program Name	Description	Target Population (Low Income or Broader Community)
Access to Dental Services	La Amistad & Puente a la Salud Dental Services (SJNHC)	Provide fixed and mobile comprehensive dental services for adults and children.	Low Income
Access to Vision Services	Puente a la Vision Services (SJNHC)	Provide mobile vision services for adults and children.	Low Income
Access to Health Screening	Taller San Jose Hope Builders Pre-employment Screening Program	Provide pre-employment screening and vaccines to teens and young adults.	Low Income
	Imaging and Laboratory Services	Provides various lab tests and imaging to La Amistad and Lestonnac Free Clinic patients.	Low Income
Transportation	Taxi vouchers	Provide transportation support to ED indigent population.	Low Income
Postpartum Services	Postpartum Depression Comprehensive Services	Provide screening and treatment to women referred.	Broader Community
	Mother/Baby Assessment Center	Provide physical and psycho-social assessment of mother and baby.	Broader Community
Food Insecurity	Meals On Wheels Program	Provide meals to seniors and disabled persons.	Broader Community
	Waste Not OC Program	Provide food donations from hospital cafeteria to local food bank for the homeless.	Low Income
Access to Rx	Pharmacy Meds Program	Provided needed Rx to patients upon discharge from the hospital.	Low Income

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) and entered in CBISA Online (Lyon Software). .

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.