St. Joseph Hospital, Orange
Community Benefit Plan
FY 09-11

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Executive Summary

Communities served by St. Joseph Hospital (SJH) are ever-growing, multi-culturally diverse, resilient in the face of ongoing economic change and vibrant in their spirit to thrive. In recent years, the population in the hospital's Primary Service Area (PSA) has decreased slightly since 2004/2005. As a whole, the population is growing older to the aging of baby boomers and to out flux of young adults. Latinos and Vietnamese comprise a larger proportion of the population. About 12% of the population remains below the Federal Poverty Level (FPL), but there has been a drop in the numbers of people at higher income levels. SJH's PSA is home to a large proportion of Orange County's impoverished children.

These are some of the most significant findings in the Orange County Health Needs Assessment Survey 2007 (OCHNA). According to OCHNA, a staggering 4 of the top 5 Orange County school districts with the highest percent of children eligible for free or reduced school meals (at or below 185% of FPL) are located within the SJH PSA, with an average of 75% of the student population meeting eligibility criteria. Orange County has among the highest proportion of overweight low-income youth when compared to surrounding counties and California overall, with approximately 21% of youth age 2 to <5 and 24% ages 5 to <20 considered overweight. Within the PSA, prevalence of childhood overweight/obesity is an astounding 26% (N=280,483) and an estimated 45% of adults are overweight or obese. Latino children are at greater risk of overweight as are those living below the FPL.
An estimated 16% (134,397 individuals) of the PSA is without health insurance. However, an additional 8% who were insured at the time of the OCHNA interview had been without insurance at some point during the previous year. The majority of these individuals reside in Santa Ana, followed by Anaheim, Garden Grove and Westminster. This suggests that there is a certain level of instability in continuous health insurance coverage among a proportion of the residents. Those who are 35-54 years of age comprise the largest age groups in uninsured. Compared to the overall PSA, the uninsured have lower annual incomes, with a greater proportion of those with annual incomes in the $25-49K range being uninsured. A large proportion of the estimated PSA (40%) do not have dental insurance coverage.

The Orange County Smile Survey documented that, "A pandemic of dental disease is compromising the health and quality of life of Orange County's children." More than half of kindergartners and more than 7 out of 10 3rd graders experienced tooth decay, and 34% of these had untreated decay. More than 2,850 children in these age groups had serious dental disease problems including: abscesses, inflammation and pain. Consequently, an estimated 15% of the children in the PSA have never visited the dentist and 10% have not visited the dentist in the past year.

Latinos are disproportionately represented among uninsured adults and children as are Asian/Pacific Islanders. Uninsured PSA residents are far less likely to have had a routine physical in the past year, and they are far more likely to have never received one. Lack of health insurance is inversely related with education and income, and there are vast differences in income within the PSA. Furthermore, lack of health insurance

results in worse health outcomes in the areas of: obtaining routine physicals, reasons for ER usage, perceived experiences of discrimination, access and use of prescriptions, self-rated health status, and rates of obesity. The prevalence of mental health issues among the PSA population is estimated to be just over 6% (54,801 individuals) reporting they had emotional, mental and behavioral health problems.

The needs and disparities among the communities served by SJH appear vast, multi-layered and perhaps even daunting. However, challenges such as these have yet to discourage the commitment and priorities set fourth to address them. Conversely, it is these opportunities that compel us to truly determine the best course of action. In keeping with our long standing tradition of going out into the community, discovering the needs, figuring out solutions and finding others to join in our efforts, SJH is committed to dedicating available resources and expertise necessary to carry out the following priorities and initiatives for the next three years.

FY 09-11 Community Benefit Priorities
Each initiative will incorporate the following commitment- where possible; collaborate/work in partnership with existing community organizations to achieve common healthcare goals (grant projects, healthy lifestyle, media, etc).

Initiative # 1
Increase our capacity to provide preventive and curative healthcare services.
Initiative # 2
Increase the availability of prevention and treatment of chronic disease with a focus on: diabetes, obesity and dental services.
Initiative # 3
MediKids Program: Oversee the effective transition to the Children's Health Initiative of Orange County (CHIOC).
Initiative # 4
Enhance community mental health services with a focus on collaboration in the areas of:

- Prevention
- Early identification
- Education
- Particular focus on depression, spousal abuse and addiction

A. Community Profile

According to the St. Joseph Health System's Annual Market Assessment 2007, the leading psychographic segment for the SJH service area is known as the "International Marketplace" (these neighborhoods represent the cutting edge of immigration one of the major demographic trends shaping the U.S. future) and is the 5th most diverse in the country. SJH's PSA is comprised of 28 Orange County zip codes in the cities of Anaheim, Anaheim Hills Garden Grove, Villa Park, Orange, Santa Ana, Tustin and Westminster. The SJH Secondary Service Area (SSA) includes: Irvine, Costa Mesa, Lake Forest, Huntington Beach, Midway City, Silverado, Fountain Valley, Fullerton, Placentia, Corona and Yorba Linda.

The population is young, with a median age of 30.4 years. Seventy percent of households are occupied by families. These markets have a high proportion of immigrants. Almost 45% of the population is Hispanic and 1 and 9 residents are Asian. Eighty-two percent of these households derive income from wages; some receive Supplemental Security Income or public assistance.

The SJHS Annual Market Assessment 2007 also reports that the average household size is 3.2 living in a 3.2 bedroom household with a median household income of $70,322. However, the average jumped to 4.7 individuals per household in the City of Santa Ana. Close to 70% of the estimated population owned their home, compared to 62% county-wide.

It is important to note that this data does not account for the unreported households where multiple families reside in various arrangements throughout the dwelling (i.e., converted garages, living rooms and dining rooms converted into makeshift bedrooms, etc). The same principle can be applied for reported median household income. Based on anecdotal information collected for the past three years by MediKids Program Care Coordinators, unreported income is generally due to the population having multiple employments where the employer conducts business “in cash” and does not keep legal records of employees and labor specifications.

The following demographic profile focuses on adults living in the SJH PSA. The profile looks at five characteristics of the population including age, ethnicity, income, education and health insurance coverage.

Table 1- Adult Age Distributions within PSA (2004 N=878,000; 2007 N=869,495)

Age	2004	2007
18-24	15%	8%
25-34	21%	18%
35-44	21%	23%
45-54	23%	26%
55-64	9%	8%
65+	11%	17%

Table 2- Adult Population in PSA by Race/Ethnicity (2004 N=878,000; 2007 N=869,495)

Ethnicity	2004	2007
Latino	35%	43%
White	45%	37%
Vietnamese	7%	11%
Other	13%	9%

Table 3- Adult Population in PSA by Income (2004 N=878,000; 2007 N=869,495)

Income	2004	2007
<$25K	16%	17%
$25-$49K	26%	34%
$50-$74K	22%	16%
$$75-$99K	15%	15%
>$100K	21%	18%

Table 4- Adult Population in PSA by Education (2004 N=878,000; 2007 N=869,495)

Education	2004	2007
<HS	14%	12%
HS	26%	29%
<Coll	22%	25%
BA/BS	15%	22%
Post-Grad	21%	12%

Table 5- Health Insurance Coverage (2004 N=878,000; 2007 N=869,495)

	Yes	No
2004	86.3%	13.7%
2007	84%	16%

B. Community Needs & Assets Assessment Process

SJH retained consultant, Laura D'Anna, MPA, DrPH to conduct an analysis of the data related to the current status of residents in the PSA. Seven sources of data were employed to analyze the PSA. The Orange County Health Needs Assessment (OCHNA) and Methodology Report 2007, Community Health Assessment Survey 2007 SJHS and Executive Summary by Dr. Azhar Qureshi, SJH PSA Demographic Indicators, SJHS Community Outreach Department, The 13th Annual Report on the Conditions of Children in Orange County 2007- Children and Families Commission of Orange County, Orange County Community Indicators Report 2007, Orange County Smile Survey- The Dental Health Foundation 2005, and California Department of Public Health County Health Status Profiles 2007. These data sources served as reference for identifying communities in the PSA with Disproportionate Unmet Health Needs (DUHN). The consultant, Dr. Laura D'Anna conducted an analysis of the data related to the current status of residents in the PSA and made a formal presentation of the results to the SJH Community Benefit Committee. In her presentation, Dr. D'Anna provided a foundation for strategic discussions and planning that included:

- Provide an overview of Orange County's demographic characteristics, focusing on SJH's PSA.
- Examine selected health indicators, health outcomes, and related health behaviors within the PSA.
- Describe potential barriers to accessing health care.
- Inform the SJH Community Benefit strategic planning process.

In addition, the Community Benefit Committee held a "planning session" facilitated by the Director of Strategic Planning, to identify, prioritize and rank key initiatives to set fourth the focus for the three-year Community Benefit Plan. The session was structured to cover four major areas- 1) FY 2007 Highlights including Access to Care, 1St Phase of Children's Health Initiative and Advancing the State of the Art of Community Benefit; 2) Recap of Community Planning Data; 3) Tie to SJH Mission, Vision and Values; and FY 09-11 Strategic Plan- Prioritization and Ranking Process.

C. Identification and Selection of DUHN Communities

DUHN Population Group or Community	Key Community Needs	Key Community Assets
Uninsured low-income agricultural workers of Orange County (OC)	Agricultural workers (working at farms, wholesale nurseries, landscaping firms and food processors) have a high degree of diabetes and occupational	A strong and established collaborative relationship with farms, wholesale nurseries, landscaping firms and food processors.

DUHN Population Group or Community	Key Community Needs	Key Community Assets
	health issues. This service is the only mobile medical service caring for agricultural workers in OC.	Puente has a long standing reputation for trust and high quality of service delivery.
Clinic patients referred by providers from La Amistad and Puente clinics for joint clinic health education and support	This activity supports patients of both Clinics to change their health behaviors and manage their chronic disease.	The population has an understanding of their chronic disease and is relatively motivated to manage their disease.
Low-income children without health insurance who live in OC	It is estimated by many studies that the number of uninsured children residing in OC is over 60,000. This program and its partners provided enrollment assistance to over 48,000 children since 2005.	Community partnerships in OC have dramatically strengthened around the area of enrollment and care coordination. Families are very familiar with established enrollment sites throughout the county.
Low income and uninsured living in primary service area	Mental Health needs have been recognized as an underfunded and unavailable health service for the majority of residents of OC. Low income and uninsured residents have a particular difficult time in locating appropriate low cost or free mental health services.	Currently in the process of building strong connection with local groups, organizations and public government programs experienced in providing mental health services.
Low income and agricultural workers with dental disease	According to the most recent (2001) Needs Assessment of Clinic Patients (Coalition of OC Community Clinics) there are high numbers of low income adults needing dental treatment services who reside in OC.	Puente Dental Mobile Clinic is able to reach the agricultural worker population on site and on the weekends.
Low-income diabetic patients referred by community clinics	There are high numbers of very low income diabetic adults living in OC. This service is the only mobile vision clinic caring for those at risk for serious vision loss due to complications of diabetes.	The vision mobile clinic provides services in three locations in north, central and south OC.
Low-income children between the ages of 0 – 13 living in OC	Per California Dental Association Smile Study, Orange County, 2005, uninsured and low income children have a high degree of dental decay. This service is one of the few mobile clinics that care for children at elementary school sites in OC.	An established dental mobile clinic referral system has been in place among local community clinics. There are multiple school sites throughout OC where children can be seen on the dental mobile clinic.

DUHN Population Group or Community	Key Community Needs	Key Community Assets
Overweight students in selected OC schools	OC has among the highest proportion of overweight low-income youth when compared to surrounding counties and California over all, with 20.9% of youth age 2 to <5 and 23% of youth age 5 <20 considered overweight.	Local school districts are supportive and willing collaborative partners. Santa Ana school district has already adopted health and fitness programs in their schools which have demonstrated a positive impact on students and families.
Mothers with Newborns in OC suffering from depression	Local hospitals only provide screening for postpartum depression.	St. Joseph Hospital Caring for Women with Maternal Depression program is unique in that we are not only screening we are providing treatment and education with Licensed Behavioral Health Clinicians.
Adults in OC who suffer from or are at risk of developing mental disorders (outpatient community counseling)	It is estimated that just over 6% of the PSA population (54,801 individuals) have emotional, mental and behavioral health problems. They include: 49% major depressive; 21% chronic mild depression; 15% bipolar; 10% general anxiety; and 5% eating disorder.	Program does not require insurance coverage, prior mental health diagnosis, or referral by health care provider. Program fees are low- cost and available at a sliding scale fee based both on monthly income and ability to pay. Services are provided to people living within and outside the PSA.
Clinic patients ages 6 and above who fall within 200% of the FPG or below, reside in PSA and have no private dental insurance	There is a limited number of low-cost/ no-cost dental clinics in OC providing comprehensive dental services to adults w/o dental insurance.	La Amistad's Dental Clinic is an important part of Orange County's Safety Net system. We serve low income patients who have been unable to secure access to oral health services elsewhere. Children 6 to 17 years of age have access to secondary care.
Low income, uninsured children ages 0-5 who reside within PSA.	Three out of four low income children are affected by dental disease. In OC, more than 50% of kindergartners have experienced dental decay.	Over the past 5 years, OC has experienced a dramatic increased capacity in oral health services targeting low-income uninsured children. Children have access to secondary care.
Clinic patients who fall within 200% of the FPG or below, reside within PSA and have no private health insurance.	The majority of La Amistad patients have one or more risk factors for or actually have been diagnosed with cardiovascular disease or diabetes. Cardiovascular disease is the leading cause of death in Orange County and diabetes is # 7.	Unlike many stand-alone community clinics in the OC who treat patients with cardiovascular disease or diabetes, La Amistad Clinic patients have access to secondary (specialty care referrals) and tertiary care in the hospital when necessary.

D. Initiative and/or Activity/Program (A/P) Prioritization Process

Criteria used for selecting key DUHN initiatives and programs generally follows the outcome from the needs and assets process which was described earlier in the report. Upon determining the direction in which we will focus our efforts and resources, we are able to discern which community benefit programs will be maintained, enhanced, redesigned and/or phased out. The four initiatives to come out of the Community Benefit Committee planning session will have program(s) that address each initiative. The Community Benefit Committee has an opportunity to see how each initiative is addressed on a tactical level, provide feedback and recommend modifications where needed. Ranking and prioritization takes place during the planning session. At this juncture, the goal and task of the Community Benefit Committee is to determine and ensure that the over-arching initiatives are linked to programs that operationalize the intent of each initiative. As stated earlier, the initiatives have been founded based upon data supporting an existing need(s) and gap(s) in the communities served.

The majority of Community Benefit Committee members are key local community stakeholders and therefore are the voice for residents who are direct recipients of the programs and services to address the identified needs. In addition, ongoing coordination and collaboration with partners and community stakeholders (not serving on the Community Benefit Committee) is maintained through participation and membership of local efforts and collaborative groups working towards common goals. Program tactics and strategies are sometimes changed or adapted during the program cycle in response to a new learning or after discovering a more effective method to deliver services. Such changes and adaptations are generally driven by feedback from the program recipients themselves. Shared accountability with community stakeholders who have equal standing with the hospital encourages dialogue and decision-making with regards to program design and direction. As such, they are invested in the success of the program/services.

E. FY 09-11 Community Benefit Plan: Key DUHN Community Benefit Initiatives and/or Activities/Programs (A/P) & Advancing the State of the Art in Community Benefit (ASACB) Alignment

For a full inventory of key programs, refer to attachment A.

Initiative # 1- Increase our capacity to provide preventive and curative healthcare services.

- Puente a La Salud Mobile Medical Clinic Services program- has engaged Community Stakeholders in collaborative governance through grant partnerships and joint outcome measures. ASACB enhancement strategies have been incorporated. Program addresses ASACB principles of primary prevention and continuum of care.
- El Club de Salud Joint Clinic Health Education Program- has engaged Community Stakeholders in collaborative governance through grant partnerships and joint outcome measures. ASACB enhancement strategies have been incorporated. Program addresses ASACB principles of primary prevention and continuum of care.
- La Amistad Medical Clinic- is fully funded by the hospital and therefore would not engage Community Stakeholders in collaborative governance. Several ASACB

Initiative # 2-Increase the availability of prevention and treatment of chronic disease with a focus on: diabetes, obesity and dental services

- Puente a La Salud Adult Mobile Dental Program
- Puente a La Salud Pediatric Dental Clinic services
- Puente a La Salud Mobile Vision Clinic Program

All three Puente programs have engaged Community Stakeholders in collaborative governance through grant partnerships and joint outcome measures. ASACB enhancement strategies have been incorporated. Program addresses ASACB principles of primary prevention and continuum of care.

- La Amistad Dental Clinic- has engaged Community Stakeholders in collaborative governance through grant partnerships and joint outcome measures. Several ASACB enhancement strategies have been incorporated. Clinic addresses ASACB principles of primary prevention and continuum of care.
- La Amistad Pediatric Dental Program- has engaged Community Stakeholders in collaborative governance through grant partnerships and joint outcome measures. Several ASACB enhancement strategies have been incorporated. Clinic addresses ASACB principles of primary prevention and continuum of care.
- Healthy 4 Life- Program- has engaged Community Stakeholders in collaborative governance through grant partnerships and joint outcome measures. This is a new program, no existing enhancement strategies. Program addresses ASACB principle of primary prevention.

Initiative # 3-MediKids Program: Oversee the effective transition to the Children's Health Initiative of Orange County (CHIOC).

- MediKids Program- has engaged Community Stakeholders in collaborative governance through grant partnerships and joint outcome measures. ASACB enhancement strategies have been incorporated. Program addresses ASACB principles of primary prevention, continuum of care and capacity building.

Initiative # 4-Enhance community mental health services with a focus on collaboration in the areas of: prevention, early identification, education, particular focus on depression, spousal abuse and addiction

- Mental Health Services- is still in exploration and gathering of information phase.
- Caring for women with maternal depression has engaged Community Stakeholders in collaborative governance through grant partnerships. Some ASACB enhancement strategies have been incorporated. Program addresses ASACB principles of primary prevention and continuum of care.
- Community Counseling is fully funded by the hospital and therefore would not engage Community Stakeholders in collaborative governance. At this time, ASACB enhancement strategies have not been incorporated due to budget restraints. Program addresses ASACB principles of primary prevention, continuum of care.

F. All Other Community Benefit Initiatives and/or Activities/Programs (A/P)

See attachment B.

G. Ministry's Governance and Management Structure

Governance- The following outlines the Community Benefit Committee's 1) role and responsibilities in planning and monitoring of Community Benefit programs; 2)linkage to the governance structure; and 3) addresses ASACB principle of Collaborative Governance.

The role of the Community Benefit Committee of the hospital's Board of Trustees is to support the Board in overseeing community benefit issues.

The Community Benefit Committee supports the Board in overseeing community benefit in accordance with a Board-approved charter. The Community Benefit Committee of the Board of Trustees consist of at least eight (8) members. The Committee includes at least three (3) members of the Board of Trustees. At least a majority of the Committee consists of members from the community who have knowledge or experience with populations who have Disproportionate Unmet Health Needs.

The Community Benefit Committee is charged with the following:

1. Develop policies and programs to address the identified needs in the Corporation's service area with particular attention to communities (provides a physical context, rather than just focusing on individuals) with disproportionate unmet needs.
2. Oversee the development and implementation of a Community Needs Assessment and Community Benefit Plan every three years as well as an annual update.
3. Oversee and provide general direction to the Corporation's Community Benefit activities including:
   a. Budgeting decisions- Review, approve, and recommend the Care for the Poor budget and all community benefit expenditures annually.
   b. Program content- Review, approve, and recommend new community benefit program content.
   c. Program design- Review, approve, and recommend overall program design that will best meet the need of the community(ies) served.
   d. Geographic/population targeting- Insure that community benefit programs target communities with disproportionate unmet health needs in the service area of the Corporation.
   e. Program continuation/termination- Review and recommend programs for continuation/ discontinuation annually.
   f. Fund Development support- Identify funding sources and partnerships for community benefit programs. Provide letters of support or introduction as appropriate.
   g. Community wide Engagement- Assure effective communication and engagement of diverse stakeholders in community benefit planning and implementation.

Management- Two of the hospital's senior Executive Management Team (EMT) members serve on the Community Benefit Committee, the Chief Executive Officer/

President and the Vice President of Mission Integration. Once the Community Benefit Plan is approved by the Board, each EMT member receives a copy of the report. In addition, the EMT receives regular updates on Community Benefit Programs' progress and outcomes status.

The Community Benefit Plan is directly linked to the hospital's strategic plan. One the four major outcome goals and areas of focus for the hospital's Strategic Plan FY 08-12 is tied to Community Benefit- Healthiest Communities. The goal of Healthiest Communities is to improve the health status of all identified residents in the areas we serve: -Directly: through clinical care, education, screening, prevention and wellness
-Indirectly: through advocacy

Hospital Strategic Plan FY 08-12- strategies spanning the next five years include:

- Identify and study organizations that have been effective in improving the health status of communities with an aim toward applying lessons learned.
- Explore and develop partnerships with outside organizations, physicians and others to provide services that improve the health of our community.
- Sustain current community benefit efforts.
- Assist in the development of the Community Health Status Index and then utilize this index to target populations in which to provide services within our PSA and Orange County.

Hospital Strategic Plan FY 08-12- targeted outcomes over the next five years:

- Identify and study organizations that are linked well with community needs such as childhood obesity.
- Maximize the use of existing community advisory boards relative to community health initiatives.
- Partner with sister ministries and/or community organizations to sustain and consider the enhancement of Behavioral Health Services.
- Develop and implement a senior health strategy.
- Explore partnership with CHOC and/or other organizations to address childhood wellness.
- Increase the number of OC children who have access to appropriate health insurance programs by assisting with enrollment.
- Expand access to primary health services via mobile clinics, La Amistad, etc., for populations with disproportionate unmet needs throughout PSA.
- Achieve fundraising goals.
- Choose a key driver of the Community Health Status Index (CHSI) and develop a plan of "intervention" to impact this key driver, in turn impacting the CHSI.
- Design the most effective intervention strategy possible given the baseline status of CHSI and resource constraints.

Attachment A

ACTIVITY/PROGRAM LEVEL
Template for Key DUHN Community Benefit Activities/Programs

Activity/Program Name: Puente a La Salud Mobile Medical Clinic Services Program

Outcome Measure (if available):

DUHN Target group: uninsured low-income agricultural workers of Orange County

Content category of activity/program: Community Health Services

Sub-content category of activity/program: Community Based Clinic Services

How does this activity/program fit with the identified DUHN needs and assets?

Agricultural workers (working at farms, wholesale nurseries, landscaping firms and food processors) have a high degree of diabetes and occupational health issues. This service is the only mobile medical service caring for agricultural workers in Orange County

How many unduplicated persons do you target to serve in this activity/program in FY 09? 2,520

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
Treatment and prevention of illness within this DUHN population	*1.* Provide health services at convenient locations *2.* Provide community health education assistants for personal guidance and information though El Club Program	*Strategy 1 - Measure:* No shows will be no more than 20% of scheduled visits *Strategy 2 - Measure:* 10% of agricultural workers will be referred to El Club program for personal follow-up

Activity/Program Name: Puente a La Salud Adult Mobile Dental Program

Outcome Measure (if available):

DUHN Target group: Low income and agricultural workers with dental disease

Content category of activity/program: Community Health Services

Sub-content category of activity/program: Community based health services

How does this activity/program fit with the identified DUHN needs and assets?

According to the most recent (2001) Needs Assessment of Clinic Patients (Coalition of OC community Clinics) there are high numbers of low income adults needing dental treatment services who reside in Orange County

How many unduplicated persons do you target to serve in this activity/program in FY 09? 1,250

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
Provide treatment to patients with dental disease and provide dental education	*1.* locate services in convenient locations for patients *2.* partner with 1 HQFC to provide dental treatment	*Strategy 1 - Measure:* complete dental treatment plan for at least 10% of patients *Strategy 2 - Measure:* provide chair side prevention education by dentist to all patients with dental disease

Activity/Program Name: Puente a La Salud Pediatric Dental Clinic services

Outcome Measure (if available):

DUHN Target group: low-income children between the ages of 0 – 13 living in Orange County

Content category of activity/program: Community Health Services

Sub-content category of activity/program: Community based dental services

How does this activity/program fit with the identified DUHN needs and assets?

Per California Dental Association Smile Study, Orange County, 2005, uninsured and low income children have a high degree of dental decay. This service is one of the few mobile clinics that care for children at elementary school sites in Orange county

How many unduplicated persons do you target to serve in this activity/program in FY 09? 1,400

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
Dental treatment for children ages 0 - 13	*1.* Receive referrals through membership in Orange County Pediatric Dental Collaborative 2.Select sites based upon needs of referred children and their families	*Strategy 1 - Measure:* Provide dental treatment to eliminate caries in referred children *Strategy 2 - Measure:* Each referred child will receive patient care coordination

Activity/Program Name: Puente a La Salud Mobile Vision Clinic Program

Outcome Measure (if available):

DUHN Target group: low-income diabetic patients referred by community clinics

Content category of activity/program: Community Health Services

Sub-content category of activity/program: Community based clinic services

How does this activity/program fit with the identified DUHN needs and assets?

There are high numbers of very low income diabetic adults living in Orange County. This service is the only mobile vision clinic caring for those at risk for serious vision loss due to complications of diabetes

How many unduplicated persons do you target to serve in this activity/program in FY 09? 2,200

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
Prevention and treatment of eye disease	1. locate clinic at convenient locations for referred patients 2. maintain continuity by continuing contract to train residents of the Southern California College of Optometry, Fullerton	*Strategy 1 - Measure:* Treat all patients referred by La Amistad and Puente clinics *Strategy 2 - Measure:* Provide referral for those patients needing advanced care

Activity/Program Name: El Club de Salud Joint Clinic Health Education Program
Outcome Measure (if available):

DUHN Target group: clinic patients referred by providers from La Amistad and Puente clinics

Content category of activity/program: Community Health Services

Sub-content category of activity/program: Community based health services

How does this activity/program fit with the identified DUHN needs and assets?

This activity supports patients of both Clinics to change their health behaviors and manage their chronic disease.

How many unduplicated persons do you target to serve in this activity/program in FY 09? 400

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
Improve health status of El Club "member/patients"	*1.* provide various classes and activities to encourage healthy behaviors *2.* Provide one on one coaching by community health education assistants 3. Member/patients will be given health surveys every four months to assess their health behaviors	*Strategy 1 - Measure:* Diabetic patients will reduce their HgA1C by a statistical significant measurement based on independent evaluator's reports *Strategy 2 - Measure:* 300 members/patients will have more than one health survey

Activity/Program Name: La Amistad Medical Clinic

Outcome Measure (if available):

DUHN Target group: Patients who fall within 200% of the Federal Poverty Guidelines or below, reside within St. Joseph Hospital's Primary Service Area and have no private health insurance.

Content category of activity/program: Community Health Services

Sub-content category of activity/program: Community Based Clinic Services

How does this activity/program fit with the identified DUHN needs and assets?

The majority of La Amistad patients has one or more risk factors for or actually have been diagnosed with cardiovascular disease or diabetes. Cardiovascular disease is the leading cause of death in Orange County and diabetes is #7.

How many unduplicated persons do you target to serve in this activity/program in FY 09? 2,000

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
To restore and maintain to a healthy state, for those with little or no other access to medical care.	1. Provide medical services for patients with acute and chronic healthcare needs.	Strategy 1 - Measure: Provide 9,000 medical treatment visits.

Activity/Program Name: La Amistad Dental Clinic

Outcome Measure (if available):

DUHN Target group: Patients ages 6 and above who fall within 200% of the Federal Poverty Guidelines or below, reside in St. Joseph Hospital's primary service area and have no private dental insurance.

Content category of activity/program: Community Health Services

Sub-content category of activity/program: Community Based Clinic Services

How does this activity/program fit with the identified DUHN needs and assets?

La Amistad's Dental Clinic is an important part of Orange County's Safety Net system. We serve low income patients who have been unable to secure access to oral health services elsewhere.

How many unduplicated persons do you target to serve in this activity/program in FY 09? 1,500

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
To restore and maintain, to a healthy, pain-free state, those who have little or no access to dental services.	1. Provide dental prophylaxis and treatment. 2. Provide oral health education.	*Strategy 1 - Measure:* Provide 3,500 dental prophylaxis and treatment visits. *Strategy 2 - Measure:* Offer oral health education to 1,500 patients.

Activity/Program Name: La Amistad Pediatric Dental Program (Grant Funded)

Outcome Measure (if available):

DUHN Target group: Low income, uninsured children ages 0-5 who reside within St. Joseph Hospital's primary service area.

Content category of activity/program: Community Health Services

Sub-content category of activity/program: Community Based Clinic Services

How does this activity/program fit with the identified DUHN needs and assets?

Three out of four low income children are affected by dental disease. In Orange County, more than 50% of kindergartners have experienced dental decay.

How many unduplicated persons do you target to serve in this activity/program in FY 09? 250

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
To restore and maintain, to a healthy, pain-free state, dental health issues of children 0-5 years of age.	1. Provide dental prophylaxis, sealants and treatment. 2. Provide oral health education.	*Strategy 1 - Measure:* Provide 416 dental prophylaxis and treatment visits. *Strategy 2 - Measure:* Offer oral health education to 250 patients and/or parents.

Activity/Program Name: From the Heart Screening Program

Outcome Measure (if available): St. Joseph Hospital **From the Heart screening program** is designed to increase awareness of cardiovascular disease, and its prevention and treatment, along with improving access to care for underserved and low-income members of our communities.

DUHN Target group: Underserved and low-income women and men in our community.

Content category of activity/program: Community Health Services

Sub-content category of activity/program:

How does this activity/program fit with the identified DUHN needs and assets?

St. Joseph Hospital's long-standing **Vision** is to bring people together to provide compassionate care, promote health improvement and create healthy communities and our **Mission** is to continually improve the health and quality of life of people in the communities we serve. The **From the Heart** screening program encourages our community members to take that first step toward enhancing their health by focusing on protecting their most precious asset, their hearts!

How many unduplicated persons do you target to serve in this activity/program in FY 09? At least 250 people

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
Educate 250 low-income and underserved patients on cardiovascular disease and its prevention and treatment.	1. Locate the screenings at appropriate resource centers. 2. Provide qualified clinical staff at screening locations.	*Strategy 1 - Measure:* Provide clinical outcomes to at least 250 low-income and underserved patients. *Strategy 2 - Measure:* Provide referrals to those patients requiring follow up due to their screening results.

Activity/Program Name: Healthy 4 Life

Outcome Measure (if available):

DUHN Target group: overweight students in selected Orange County schools

Content category of activity/program: Community Health

Sub-content category of activity/program:

How does this activity/program fit with the identified DUHN needs and assets?

OC has among the highest proportion of overweight low-income youth when compared to surrounding counties and California over all, with 20.9% of youth age 2 to <5 and 23% of youth age 5 <20 considered overweight.

How many unduplicated persons do you target to serve in this activity/program in FY 09? Students at 8 schools within the SJO PSA , 8 schools in South Orange County and 8 schools in North Orange County.

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
Recruit schools to participate in Healthy 4 Life	1. Provide technical assistance to Lead Organization (St. Jude Medical Center 2. Participate on Healthy 4 Life Steering Committee	*Strategy 1 - Measure:* 8 schools in PSA will agree to participate *Strategy 2 - Measure:* 8 schools will activate the program

Activity/Program Name: MediKids Program

Outcome Measure (if available):

DUHN Target group: low-income children without health insurance who live in Orange County

Content category of activity/program: Community Building

Sub-content category of activity/program: Community based health coverage enrollment

How does this activity/program fit with the identified DUHN needs and assets?

It is estimated by many studies that the number of uninsured children residing in Orange County is over 60,000. This program and its partners provided enrollment assistance to over 48,000 children since 2005. This program is a one year extension of the MediKids three year grant project which ended its original phase June 30, 2008

How many unduplicated persons do you target to serve in this activity/program in FY 09? SJH staff: 2,550 and 16,000 with community partners.

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
enrollment assistance, care coordination and retention services to uninsured children; help guide the Children's Health Initiative of Orange County to serve as central location for uninsured child enrollment services	1. locate enrollment staff at convenient locations 2. provide care coordination to confirm enrollment 3. provide retention information to parents 4. serve on CHIOC governing committee and provide guidance to their staff	*Strategy 1 - Measure:* SJH staff: enrollment assistance to 2,550 children; community partners: 16,000 *Strategy 2 - Measure: make at least 15* retention presentations to community groups and parents *Strategy 3 CHIOC will stabilize under guidance by targeted group of stakeholders*

Activity/Program Name: Mental Health Services

Outcome Measure (if available):

DUHN Target group: low income and uninsured living in primary service area

Content category of activity/program: Community Building

Sub-content category of activity/program: Community based collaborations

How does this activity/program fit with the identified DUHN needs and assets?

Mental Health needs have been recognized as an underfunded and unavailable health service for the majority of residents of Orange County. Low income and uninsured residents have a particular difficult time in locating appropriate low cost or free mental health services.

How many unduplicated persons do you target to serve in this activity/program in FY 09? __-0-_

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
Prevention, early identification, education with emphasis on depression, spousal abuse and addiction	*1.*identify current programs available *2.*participate in community planning collaboratives	*Strategy 1 - Measure: explore at least two current programs offered in the community* *Strategy 2 - Measure:* participate in at least one mental health community planning effort

Activity/Program Name: Caring for women with maternal depression

Outcome Measure (if available): Screening 100% of mothers giving birth at St. Joseph Hospital for postpartum depression.

DUHN Target group: Mothers with Newborns in Orange County suffering from depression.

Content category of activity/program: Community Health Services/Health Professionals Education.

Sub-content category of activity/program: Hospital Based Clinic.

How does this activity/program fit with the identified DUHN needs and assets?

There are other hospitals screening for postpartum depression. St. Joseph Hospital Caring for Women with Maternal Depression program is unique in that we are not only screening we are providing treatment and education with Licensed Behavioral Health Clinicians.

How many unduplicated persons do you target to serve in this activity/program in FY 09? 300

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
Provide treatment for mothers suffering with Maternal Depression in Orange County	1.Increase screening/ identification and treatment 2. Increase availability of education about Postpartum Depression in Orange County.	*Strategy 1 - Measure:* # of screenings and treatment scores. *Strategy 2 - Measure:* # of monthly educational trainings.

Activity/Program Name: Community Counseling

Outcome Measure (if available): Use of self-report pre- and post-tests for clients in PACE and individual counseling programs

DUHN Target group: Adults in Orange County who suffer from *or* are at risk of developing mental disorders

Content category of activity/program: Counseling and education

Sub-content category of activity/program: Decrease levels of depression, anxiety and mood cycles. Improve communication and family understanding of client issues. Improve ability to function independently and problem-solve effectively. Reduce need for emergency mental health services through education and prevention of all types of mental illness.

How does this activity/program fit with the identified DUHN needs and assets?

There is no requirement for insurance coverage, prior mental health diagnosis, or referral by health care provider. Program fees are low- cost and available at a sliding scale fee based both on monthly income and ability to pay.

How many unduplicated persons do you target to serve in this activity/program in FY 09? 1,500

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
To improve prevention, early identification, education, and treatment for mental health needs	1. Increase access of mental health services for homebound seniors *2.* Increase access to education of mental health issues for preventive care 3. Improve understanding of healthy relationships within families to reduce incidences of child and spousal abuse.	Strategy 1 – Measure the # of seniors referred to the PACE Program. Strategy 2 – Measure the # of individuals served in support groups and psycho-educational workshops. Strategy 3 – Measure the # of individuals attending Family and Relationship Center Workshops.

Attachment B

Template for All Other Community Benefit Initiatives and/or Activities/Programs
DUHN and Broader Community

#	All Other Community Benefit Initiatives and/or Activities/Programs
1	**Initiative** *Not Applicable (N/A)* **Activity/Program Name**: *Kids On The Block, Inc. Educational Puppet Programs- "BULLIES AND SCHOOL SAFETY"* ***(DUHN Population)*** **Activity/Program Description:** *This is a new program that deals with bullying in elementary schools. The curriculum is an educational tool that was developed to educate children about this world-wide issue, plus promotes sensitivity toward peers. The program provides specific strategies to make schools a safer place and to help children avoid or cope with bad situations.* **Target Group**: *Low income, Catholic Elementary School Children*
2	**Initiative** (If applicable): Not Applicable (N/A) **Activity/Program Name:** Peripheral Arterial Disease (PAD) Screening **(Broader Community)** **Activity/Program Description**: A low-cost screening program to increase awareness and assess risk of PAD in the community. **Target Group**: Men and women 55 years and older living in the PSA
3	**Initiative** (If applicable): Not Applicable (N/A) **Activity/Program Name**: Heart Risk Assessment **(Broader Community)** **Activity/Program Description**: A program aimed to Improve access to superior cardiovascular education, screening and treatment services. The assessment includes a low-cost screening. **Target Group**: Men and women 35 years and older living in the PSA
4	**Initiative** (If applicable): Not Applicable (N/A) **Activity/Program Name**: Bridges For Newborn Program **(DUHN population)** **Activity/Program Description**: Serving newborns and their families who deliver at SJH and live in OC by providing resources to meet their psycho-social and medical needs. **Target Group**: Children 0-5

#	All Other Community Benefit Initiatives and/or Activities/Programs
5	**Initiative** (If applicable): Not Applicable (N/A) **Activity/Program Name**: Mother Baby Assessment Center **(DUHN & Broader Community)** **Activity/Program Description**: Providing physical and psycho-social follow up from discharge of Mother Baby unit to ensure healthy transition of mother and baby and successful breastfeeding. **Target Group**: mothers and newborns
6	**Initiative** (If applicable): Not Applicable (N/A) **Activity/Program Name**: Perinatal Education **(Broader Community)** **Activity/Program Description**: Designed to support new parents as they prepare for parenthood by providing education on childbirth, breastfeeding, and parenting. Classes are held pre and post delivery for ongoing support in the first 2 years of a child's life. **Target Group**: expectant and new mothers and fathers
7	**Initiative** (If applicable): Not Applicable (N/A) **Activity/Program Name**: Infant / Child CPR **(Broader Community)** **Activity/Program Description**: Provide CPR classes and certification. **Target Group**: Adults, parents, day care providers and anyone involved in caring for children
8	**Initiative** (If applicable): Not Applicable (N/A) **Activity/Program Name**: Community Education CPR **(Broader Community)** **Activity/Program Description**: Provide CPR classes and certification. **Target Group**: health care workers, nurses and doctors

#	All Other Community Benefit Initiatives and/or Activities/Programs
9	**Initiative** (If applicable): Not Applicable (N/A) **Activity/Program Name**: Community Education Lectures **(Broader Community)** **Activity/Program Description**: Provide free health-related lectures at senior centers and churches in the following topics: sinus, heart, colon, prostate, colorectal breast cancer and orthopedics. In addition, provide employer outreach activities: health and wellness programs, lunch and lecture and screenings. **Target Group**: seniors and local employers and the community in PSA