St. Joseph Hospital, Orange

Fiscal Year 2009 COMMUNITY BENEFIT REPORT

EXECUTIVE SUMMARY

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

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

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

Who We Are and What We Do

For 80 years, St. Joseph Hospital (SJH) has been dedicated to continually improving the health and quality of life of the people in the communities it serves. Located in the heart of Orange County, SJH is a 525-bed not-for-profit, acute care facility with approximately 3,700 employees and 940 physicians on Staff. SJH has the second busiest Emergency Room in the state of California and the busiest in Orange County. It is the first in Orange County and fourth in the state for surgical volume (25,902 procedures), first in Orange County for the number of deliveries (5,197 live births), and has the largest volume of cardiovascular bypass procedures in Orange County (374).

SJH offers a broad range of services on its modern campus, allowing for the treatment of more complex medical conditions in a variety of specialties. SJH provides a comprehensive range of services, centers and programs: Anesthesia Services, Bariatric Care Center, Behavioral Health/Psychological Services, Blood Donor Center, Comprehensive Breast Center, Cancer Genetics, Cardiology Services, Colorectal Services, Dialysis Center, Head and Neck Cancer, Kidney Transplant, Melanoma Services, Minimally Invasive Surgery, Nasal Sinus Services, Neurosurgical Services, Obstetrics, Orthopedics, Prostate Cancer, Radiology and Imaging Services, Rehab Services, Sleep Disorder Center, Thoracic Oncology Center and Vascular Institute. The Center for Cancer Prevention and Treatment at SJH opened in August 2008. It is the first center of its kind in Orange County and one of a few such centers in the nation offering convenient access to the latest in diagnosis, treatment and clinical trials.

SJH has a solid reputation for top-notch care. This outstanding reputation is substantiated by these and other recent honors:

- Named America's Best Hospital for Orthopedic Care by *U.S. News & World Report* for 2007, 2008 and 2009
- Achieved Magnet designation for nursing excellence, the highest recognition in the nursing profession

- Selected by the National Cancer Institute to participate in its Community Cancer Center Program- the only hospital on the West Coast named to participate in this prestigious program
- Achieved "Superior" rating in overall patient experience again in 2008 by CalHospitalCompare.org, which offers comparisons of hospitals to help consumers choose a hospital based on its performance in key areas
- Achieved "Top Ten Healing Hospital in America for 2007 and 2008" designation by the Baptist Healing Trust
- Named in top 50 of Leapfrog Group's "Top Hospital's 2006" for hospital quality and safety
- Awarded 2007 and 2008 Gallup "Great Workplace" Award for employee engagement- only 20 companies worldwide selected
- Again in 2008, more than 40 physicians on the SJH Medical Staff were named by the Orange County Medical Association and recognized in Orange Coast magazine as Physicians of Excellence for their achievement
- SJH received the highest ranking for Adult Cardiac Surgery from the Society of Thoracic Surgeons. In an analysis of U.S. hospitals from 7/1/06 to 6/30/07, the STS found that just 12% of hospitals were deserving of the top-tier, 3-star rating, based on complication and mortality rates and adherence to evidence-based care.

In FY 2009, SJH provided **$51,266,902 for community benefit programs/activities.** This includes services for the poor, vulnerable and at-risk populations as well as for the broader community (this total excludes unpaid costs to Medicare of **$38,855,432)**. *(13.8% change from previous fiscal year).*

Organizational Structure and Community Involvement

Two of the hospital's senior Executive Management Team (EMT) members serve on the Community Benefit Committee, the Chief Executive Officer/ President who is a member of the Board of Trustees and the Vice President of Mission Integration. Once the Community Benefit Report 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.

Financial Assistance Policy

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 Health System has a **Patient Financial Assistance Program** that provides free or discounted services to eligible patients. *In FY 09, a total of $5,795,689 was provided in Charity Care. (16.4 % increase in change from previous fiscal year).*

Community Plan Priorities

The Community Benefit Plan FY 09-11 was structured around four key initiatives. These initiatives were developed based on input from the Community Benefit Committee of the Board of Trustees, findings from the Orange County Health Needs Assessment, and in

support of SJH's Strategic and Operating Plan. Each priority addresses the gaps and unmet health care needs that impact the quality of life of underserved populations living in the hospital's primary service area.

Each initiative incorporates 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 (developed to enroll uninsured children in available programs): 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

INTRODUCTION

Who We Are and What We Do

The following information provides a brief summary of accomplishments associated with each of the four initiatives for FY 09:

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

- La Amistad and Puente a la Salud Community Clinics provided a combined total of **23,123 medical, dental, vision encounters** to the Disproportionate Unmet Health Needs (DUHN) population.
- **100%** of 1,458 Puente Clinic adult dental patient visits received chair side education by dental provider.
- **51% of children** served by the Puente Pediatric Dental Clinic received patient care coordination.
- Puente Vision Mobile Clinic **treated and/or referred 100%** of referred La Amistad patients, Puente patients and clinic partner patients.
- From the Heart Screening Program provided **304 heart risk assessments** at 16 sites to DUHN population in the primary service area.

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

- El Club de Salud Program Evaluator reported that the analysis shows El Club diabetic patients reduced their HgA1C by a **statistically significant measurement** (-.51 ($t=5.36$, $p<.001$).
- Puente a la Salud Vision Mobile Clinic provided **2,280 unduplicated diabetic vision screenings and exams** to diabetic patients in DUHN population. In addition, the vision mobile clinic provided 3,145 diabetic patient visit.

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

- MediKids Program provided enrollment assistance to **4,269 children.** Community Partners provided enrollment assistance to a combined total of **19,614 children**.

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

- Caring for Women with Maternal Depression Program provided **4,075 screenings.**
- **675 women** were identified at risk and treated.
- **109 Postpartum** groups sessions were provided.
- Joint Disease Management Program launched depression support group

In FY 09, SJH provided **$51,266,902 for community benefit programs/activities**. This includes services for the poor, vulnerable and at-risk populations as well as for the broader community (this total excludes unpaid costs to Medicare of **$38,855,432** *(13.8% change from previous fiscal year).*

Overview of Community Needs and Assets Assessment

In 2008, SJH retained consultant, Laura D'Anna, MPA, DrPH to conduct an analysis of the data related to the current status of residents in the Primary Service Area (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:

- Providing an overview of Orange County's demographic characteristics, focusing on SJH's PSA.
- Examining selected health indicators, health outcomes, and related health behaviors within the PSA.
- Describing potential barriers to accessing health care.
- Informing 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.

According to the St. Joseph Health System's Annual Market Assessment 2008, 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 in 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 2008 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.

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 three characteristics of the population including age, ethnicity and average household size in current year 2008 and future year 2013.

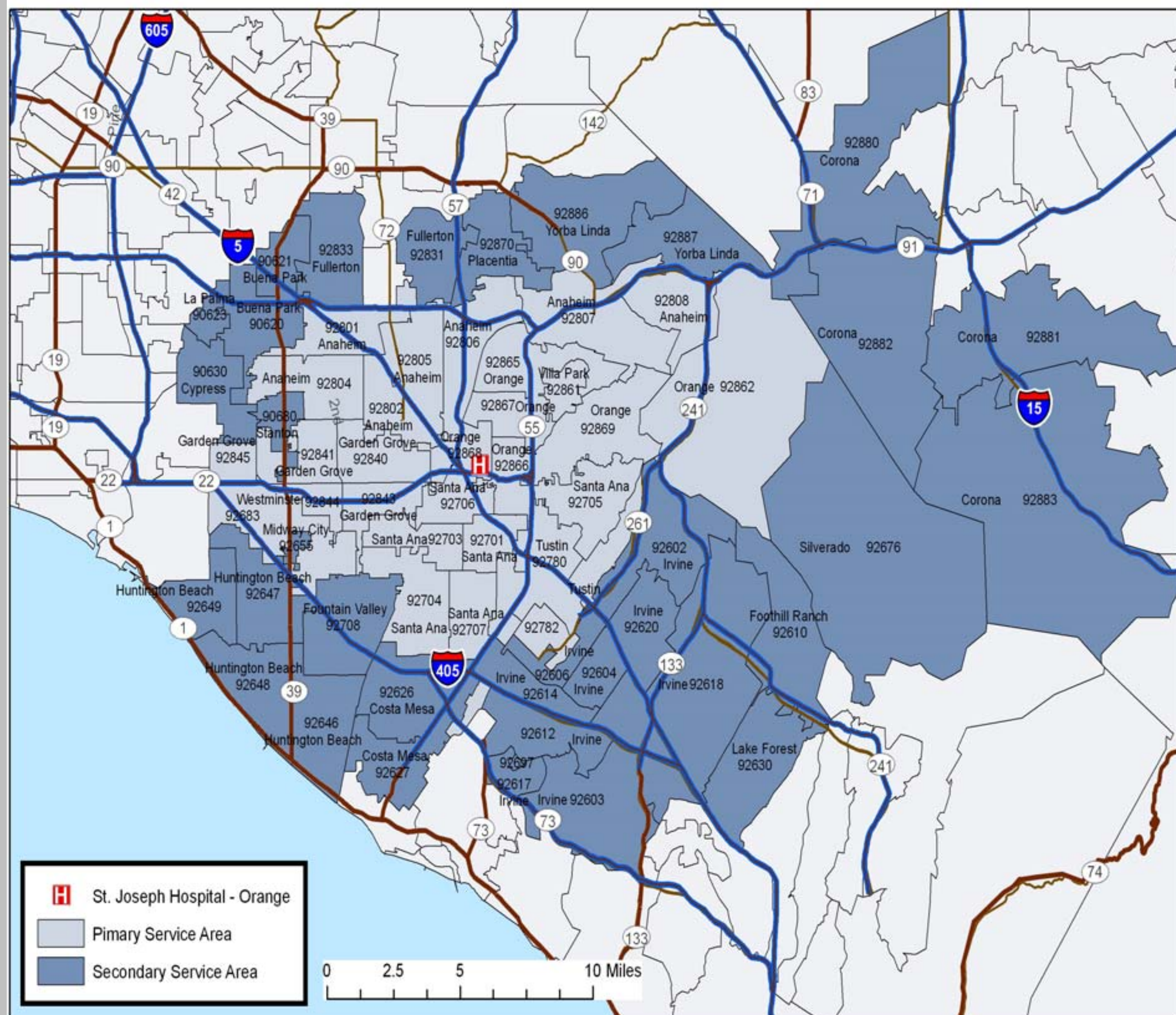
Current Year – 2008		Future Year - 2013
Population	1,219,002	1,262,116
Households	334,402	344,948
Average Household Size	3.66	3.69
Median Age	31.1	31.4
Median Male Age	30.3	30.5
Median Female Age	31.8	32.4

	Total Population by Age Current Year – 2008		Total Population by Age Future Year – 2013	
	Number	% of Total	Number	% of Total
0-17	357,600	29.34	365,286	28.94
18-44	493,544	40.49	479,444	37.99
45-64	257,815	21.15	294,477	23.33
65+	110,043	9.03	122,909	9.74

	Race and Ethnicity Current Year – 2008		Race and Ethnicity Future Year – 2013		Race and Ethnicity Change 2008- 2013	
	Number	% of Total	Number	% of Total	Number	% Change
White Alone	319,441	26.21	283,993	22.50	(35,448)	(3.71)
Black Alone	19,414	1.59	19.929	1.58	515	(0.01)
Asian Alone	212,849	17.46	236,193	18.71	23,344	1.25
Other	29,207	2.40	29,022	2.30	(185)	(0.10)
Hispanic or Latino Alone	638,091	52.35	692,979	54.91	54,888	2.56

Source: St. Joseph Health System Annual Market Assessment Fall 2008

St. Joseph Hospital PSA & SSA (Source: Annual Market Assessment 2008)



Organizational Structure and Community Involvement

The Community Benefit Committee meets six times a year. 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. The Community Benefit Committee consists 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 and experience with populations who have Disproportionate Unmet Health Needs. The Trustees and EMT receive regular updates on Community Benefit Programs' progress and outcomes status. Per the new Community Benefit Committee Charter, this fiscal year, the Committee's involvement with Community Benefit programs

included overseeing and providing general direction to the Hospital'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.

Financial Assistance Policy

We believe that as a Catholic health service organization, SJHS has a social responsibility and moral obligation to make quality health services accessible to the medically poor. We further believe all persons have a right to an adequate level of health care and that the provision of health care for those who require it is an obligation of justice as well as charity or mercy (A Vision of Value, 1986, Rev. 1991).

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 Health System has a **Patient Financial Assistance Program** that provides free or discounted services to eligible patients.

In FY 09, St. Joseph Hospital of Orange provided $5,795,689 charity care to 6,272 persons. (*16.4 % increase in expense and 5% in persons served from previous fiscal year).*

FY 09 – FY 11 Community Benefit Plan:
FY 09 Progress

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, fields, nurseries, and processing/packing canneries) have a high degree of diabetes and occupational health issues. This service is the only mobile medical service caring for agricultural workers and their families 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
ACCOMPLISHMENTS (report by Strategy Measure)		
Strategy 1-Measure: Puente provided services to 2,476 unduplicated patients out of 3,112 patient visits. We did not meet our target goal of 2,520 unduplicated patients due to the reduction of County TSR and state EAPC funding. Due to state budget cuts our DHS grant was terminated. Our medical program was reduced by ½, loosing the program's part time Family Nurse Practitioner (FNP). Our greatest accomplishment was being able to provide 3,112 visits by having one part-time FNP towards the mid year. We did not experience an increase in our no-show rate. Strategy 2-Measure: Puente exceeded goal. 58% of 212 Agricultural workers were referred to El Club 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
ACCOMPLISHMENTS (report by Strategy Measure)		
Strategy 1-Measure: Puente provided services to 1,362 unduplicated patients out of 1,458 patient visits. We exceeded our goal even though we had maintenance repair situations (the dental mobile clinic was canceled 4 times during the fiscal year) and reduction of county TSR and state EAPC funding. Due to state budget cut our DHS grant was terminated. Puente lost a per-diem dentist for Saturday clinic and .05 FTE Dental Hygienist. We exceeded our goal of dental treatment plans completed at 12% or 163 unduplicated patients completed dental treatment. Strategy 2-Measure: 100% of 1,458 patient visits received chair side education by dental provider.		

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 vacities in referred children *Strategy 2 - Measure:* Each referred child will receive patient care coordination
ACCOMPLISHMENTS (report by Strategy Measure)		
Strategy 1-Measure: Provided services to 830 unduplicated patients out of 1,220 patient visits. We did not exceed our goal due to a reduction of grant funding and EAPC state funding. In addition, the dental mobile clinic had maintenance repair issues. As a result, the pediatric dental clinic was canceled 6 times during the fiscal year. Puente met the goal of providing dental treatment to all referred children. Strategy 2-Measure: 51% or 423 unduplicated children received 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
ACCOMPLISHMENTS (report by Strategy Measure)		
Strategy 1-Measure: Puente provided services to 2,280 unduplicated patients out of 3,145 patient visits. Our greatest accomplishment was being able to treat and/or refer 100% of referred La Amistad patients, Puente patients and clinic partner patients. Strategy 2-Measure: Patients not qualifying for our vision program were referred to the Southern California College of Optometry, Access OC Surgery Program and Lestonnac Free Clinic Ophthalmology Study Program.		

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
ACCOMPLISHMENTS (report by Strategy Measure)		
Strategy 1-Measure: Independent evaluator, Dr. Laura D'Anna reported that the analysis shows El Club diabetic patients reduced their HgA1C by a statistically significant measurement (-.51(t=5.36, p<.001) Strategy 2-Measure: 543 (67%) of the 812 participants had completed a second El Club 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.
ACCOMPLISHMENTS (report by Strategy Measure)		
Strategy 1-Measure: La Amistad provided 9,928 medical treatment visits for 3,689 unduplicated patients.		

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.
ACCOMPLISHMENTS (report by Strategy Measure)		
Strategy 1-Measure: La Amistad provided 3,859 dental clinic treatment visits for 1,630 unduplicated patients. Strategy 2-Measure: We offered oral health education to 1,630 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.
ACCOMPLISHMENTS (report by Strategy Measure)		
Strategy 1-Measure: We provided 401 dental treatment visits for children ages 0-5. (We were a little under our goal, because we are no longer the lead agency for this grant. We now rely on Healthy Smiles For Kids of Orange County to send us appropriate referrals). Strategy 2-Measure: We offered oral health education to 246 unduplicated 0-5 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.
ACCOMPLISHMENTS (report by Strategy Measure)		
Strategy 1-Measure: The program continues to raise awareness and lowering incidence by educating women and men about the risk factors and symptoms associated with heart disease. Our multidisciplinary team empowers women and men with life-preserving information, tools and tactics to address their cardiovascular health. During FY 09, we provided 304 heart risk assessments at 16 sites serving low-income and underserved persons in our primary service area. Exceeded goal by 122%. Strategy 2-Measure: We had 47 referrals to La Amistad and 93 referrals to the patients' primary care physician and/or clinic. In FY 08, we only had 25 referrals to La Amistad and 64 referrals to the patients' primary care physicians and/or clinic. By comparison from previous years, the program is clearly achieving its goals of making a difference in the communities served.		

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
ACCOMPLISHMENTS (report by Strategy Measure)		
Strategy 1 & 2 Measure: 21 schools in the PSA have agreed to participate and have activated 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.

<table>
<tr><th>GOAL</th><th>STRATEGY(IES)</th><th>STRATEGY(IES) MEASURE</th></tr>
<tr><td>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</td><td>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</td><td>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</td></tr>
<tr><td colspan="3">ACCOMPLISHMENTS (report by Strategy Measure)</td></tr>
<tr><td colspan="3">Strategy 1-Measure:
Staff provided enrollment assistance to 4,269 children. Community Partners provided enrollment assistance to a combined total of 19,614 children.

Strategy 2-Measure:
Staff made 21 retention presentations to community groups and parents.

Strategy 3-Measure:
Due to the problems with the State budget and with fund development in this down economy, the CHIOC is challenged to complete their stabilization plans. Infrastructure support continues to come from the Children & Families Commission, Health Funders Partnership and other small foundations. Premium subsidy for Healthy Kids continues to be supported by The California Endowment, the Sisters of St. Joseph Health Care Foundation and others.</td></tr>
</table>

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 particularly 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
ACCOMPLISHMENTS (report by Strategy Measure)		
Strategy 1-Measure: Joint Disease Management Program launched depression support group. Meets 5 times per month. Strategy 2-Measure: Participation on local planning committee for Mental Health Program regarding Prop 65.		

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.
ACCOMPLISHMENTS (report by Strategy Measure)		
Strategy 1-Measure: Provided 4,075 initial screenings 675 women were identified at risk and treated Provided 109 Postpartum group sessions 538 participants attended group sessions Strategy 2-Measure: Provided 12 monthly educational trainings. This strategy will not be part of the scope of work for next fiscal year.		

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.
ACCOMPLISHMENTS (report by Strategy Measure)		
Strategy 1-Measure: Community Counseling department eliminated support groups and programs due to budgetary reductions.		

Other Community Benefit Initiatives and Programs

#	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* **Accomplishments**: No presentations were scheduled in '08, because the puppeteers were new to the program and had not perfected their role prior to the end of the school year. However, in July and August of '09, "Bullies and School Safety" was performed at 5 local libraries. A total 326 children and their parents have viewed the program to date.
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 **Accomplishments:** During FY 09, we had 652 vascular pad screenings. We have streamlined our processing time to mail out patient results within 24-48 hours after their vascular pad screening. We had the privilege of doing 6 employer site visits for our vascular pad screening program. The employees were very appreciative that we were able to serve them at the work site. Our vascular nurse provided 7 community lectures at various sites focusing on vascular disease and prevention. These events promoted our screening program which increased our screening outcomes.
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 **Accomplishments:** During FY 09, we had 181 heart risk assessments which also included 180 C-Reactive Protein (CRP) blood draws and over 200 EBCT heart scans. The cardiac nurse provided 18 community lectures focusing on cardiovascular disease, prevention and treatment at various lecture sites in our primary service area. These events promoted our screening program which increased our screening outcomes. On a monthly basis the cardiac nurse has a "Blood Pressure" clinic at the Tustin Senior Center. This

#	All Other Community Benefit Initiatives and/or Activities/Programs
	event promotes awareness of heart disease and our screening program. In January 2009, we introduced a new screening program called "Risk for Sudden Cardiac Arrest." This screening includes an EKG and an Echocardiogram along with a 20 minute intake session with the cardiac nurse.
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 **Accomplishments:** 1. 72% of new mothers delivering at SJH were screened for risk factors. 2. 3,884 First Five Kits given to families with instructions; 3,241 English and 643 Spanish kits. 3. 22.3% of screened families were referred to Family Resource Centers, Service Providers and resources within SJH and the community.
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 **Accomplishments:** 1. 84% of deliveries at SJH were seen within 3-7 days (4,232 couplet visits). 2. 64.9% of MBAC Assessments were provided to low income families. Of this total, 86% were provided to low income Latino women with DUHN. 3. 80% exclusive breastfeeding rates at the time of hospitalization, 90% DUHN. 4. 60% exclusive breastfeeding rates at the time of MBAC appointment 95% were "any" breastfeeding (any includes breast milk fed through a bottle or a syringe). 5. 70% exclusive breastfeeding rates at 8 weeks. 20% were "any" breastfeeding.
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

#	All Other Community Benefit Initiatives and/or Activities/Programs
	Accomplishments: Total number of classes provided: 698 (an increase from last year). Total number of registrations: 3816 (a decrease from last year). Total number of attendance: 8,303 (an increase from last year).
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 **Accomplishments:** Program is being re-evaluated. Currently there is no instructor for Community Education.
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 **Accomplishments:** Program is being re-evaluated. Currently there is no instructor for Community Education.
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 **Accomplishments:** In conjunction with American Heart Association offered Heart of Your Community event in February 2009 to the community. Free screenings and Health Education by our cardiologist. Over 200 in attendance. A Day of Ophthalmology for the community offered in May 2009. Free eye screenings provided by Allergen. Approx. 220 in attendance. Disney Pound for Pound Program assisted in weighing in 2,000 cast members. St. Joseph nurses offered health education materials and motivation on healthy eating.

Community Benefit Investment 2008 and 2009

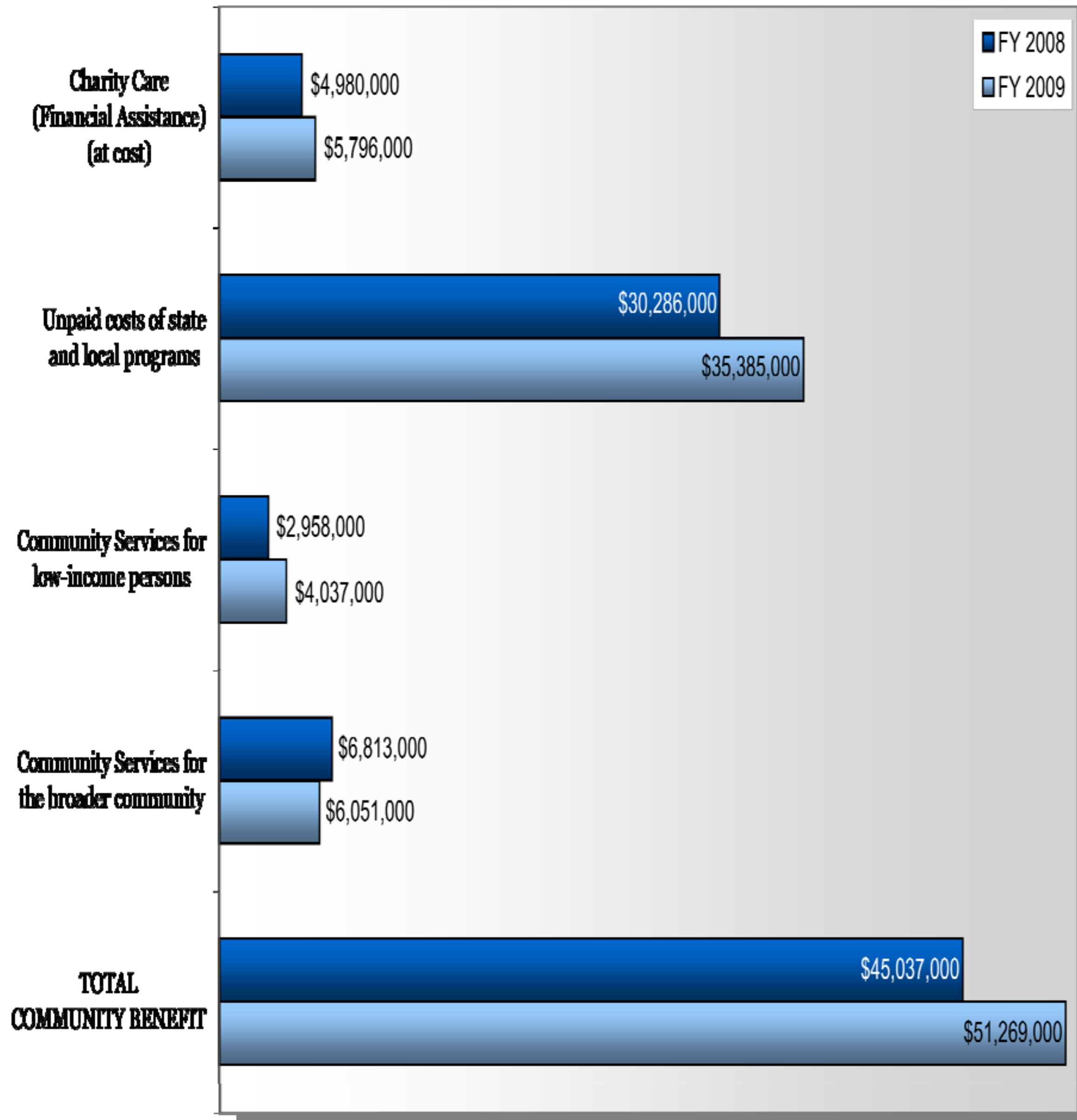
	FY 2008	FY 2009
BENEFIT FOR LOW- INCOME PERSONS		
Charity Care [1] (Financial Assistance) **(at cost)**	$4,980,174	$5,795,689
Community Services for low-income persons [2]	$2,957,529	$4,036,259
Unpaid costs of state and local programs	$30,285,755	$35,384,800
A. TOTAL BENEFIT FOR LOW- INCOME PERSONS	$38,223,458	$45,216,748

BENEFITS FOR THE BROADER COMMUNITY		
Community Services for the broader community	$6,813,171	$6,050,154
B. TOTAL BENEFIT FOR THE BROADER COMMUNITY	$6,813,171	$6,050,154

	FY 2008	FY 2009
TOTAL COMMUNITY BENEFIT (A +B)	$45,036,629	$51,266,902
Percentage of total net patient revenue	8.1%	8.7%
Percentage of total operating expenses	8.5%	8.9%

	FY 2008	FY 2009
BENEFIT FOR THE BROADER COMMUNITY		
Unpaid cost of Medicare	$28,441,716	$38,855,432

[1] Charity care provided for households at or below 500% of Federal Poverty Levels.
[2] SJHS Foundation (Care for the Poor) Funds included in Community Services for Low-Income Persons
– FY 08 $ 2,548,307.64
SJHS Foundation (Care for the Poor) Funds included in Community Services for Low-Income Persons
– FY 09 $ 3,469,676.80


Fiscal Year 2008 - 2009
Community Benefit Investment
St. Joseph Hospital Orange
FY 2008
FY 2009
Charity Care (Financial Assistance) (at cost)
$4,980,000
$5,796,000
Unpaid costs of state and local programs
$30,286,000
$35,385,000
Community Services for low-income persons
$2,958,000
$4,037,000
Community Services for the broader community
$6,813,000
$6,051,000
TOTAL COMMUNITY BENEFIT
$45,037,000
$51,269,000

St. Joseph Health System
500 S. Main St., Ste. 1000
Orange, CA
stjhs.org

St. Joseph Health System (SJHS) is an integrated healthcare delivery system providing a broad range of medical services. The system is organized into three regions--Northern California, Southern California, and West Texas/Eastern New Mexico - and consists of 14 acute care hospitals, as well as home health agencies, hospice care, outpatient services, skilled nursing facilities, community clinics, and physician organizations. The ministries that comprise SJHS offer a wide variety of services within each of the three regions. From well-established acute care hospitals to clinics in non-traditional settings like school rooms and shopping malls, SJHS is establishing a "continuum of care," that is, a system that links and coordinates an entire spectrum of health services.