



**Puente a la Salud Mobile Clinic and El Club de Salud Health Education Program**

*St. Joseph Hospital, Orange*

**Fiscal Year 2010 COMMUNITY BENEFIT REPORT**

**St. Joseph Hospital**   
ST. JOSEPH  
HEALTH SYSTEM

## 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**

St. Joseph Hospital (SJH) is a values-based Catholic healthcare provider with a tradition of and commitment to excellence, based on the vision of the Sisters of St. Joseph of Orange. The hospital's strong belief in the intrinsic dignity of each person commits it to be a just employer to its 3,800 employees; to provide healthcare for the whole person, body, mind and spirit; and to collaborate with the 1,000-member medical staff and other healthcare providers to increase access to quality health care. As a nonprofit community hospital, SJH is committed to offering care to those in need without regard to their financial status or level of insurance. This is especially important since Orange County does not have a county hospital to provide services to low-income families. Our hospital provides comprehensive care to some of the poorest communities in Southern California - including some in Santa Ana – a city determined by the Nelson A. Rockefeller Institute of Government in their most recent Update on Urban Hardship as being the most difficult urban area in the United States in which to live<sup>1</sup>.

SJH provides a comprehensive range of services, centers and programs: Anesthesia Services, Bariatric Care Center, In-patient 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.

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<sup>1</sup> Montiel LM, Nathan RP, Wright DJ. “An Update on Urban Hardship”, Nelson A. Rockefeller Institute of Government, 2004.

**FY 2010 Community Benefit Report**

In **FY 10**, SJH Community Clinics (La Amistad Family Health Center and Puente a la Salud Mobile Clinics) provided a **total of 20,482 patient encounters**. Three hundred individuals in El Club de Salud- Joint Clinic Health Education Program experienced a drop in A1C levels from enrollment to second measurement. In total with community partners, the Children's Access Program assisted in the enrollment of **1,563 children** into appropriate health insurance programs. The childhood obesity program, Healthy 4 Life had **1,575 students** participate in the program (a total of 15 schools in the hospital's primary service area). The Postpartum Depression program (PPD), the only screening and treatment hospital-based program in Orange County, identified 1,895 women as at greater risk for depression. Of those women, 1,449 mothers received follow up. Fifty-six percent of women identified as at risk for maternal depression were enrolled in the program and **received treatment**. A total of 272 individual sessions were provided.

**Community Benefit Investment 2009 and 2010**

In FY 2010, SJH provided **\$55,207,248 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 **\$35,359,195**).

**Patient Financial Assistance Program**

Our mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why St. Joseph Health System has a **Patient Financial Assistance Program** that provides free or discounted services to eligible patients. *In FY 10, a total of \$5,025,392 was provided in Charity Care.*

**Community Plan Priorities**

The following information provides a brief summary of accomplishments associated with each of the four Community Benefit Initiatives for FY 10:

**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 **20,482 medical, dental, and vision encounters** to the Disproportionate Unmet health needs (DUHN) population.
- Puente Case Management and Education visits were captured with the implementation of the new patient management system, CCPro.net.
- Provided **189** off-site mobile clinic cardiovascular screenings. Of those, **14%** resulted in a referral to the hospital's community clinics for follow up.
- Puente provided health services at four different community locations.
- 79% of Puente patients scheduled for the medical clinic received personal guidance and information on health, nutrition and wellness through El Club de Salud program.

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

- **300 individuals experienced a drop in A1C levels** from enrollment to the second measurement. For the patients evaluated, there was statistically significant improvement in their A1C scores.
- La Amistad Dental Clinic provided **oral health education to 1,191 adult patients and 200 children.**
- **61%** of Puente's adult dental patients **completed treatment.**
- Of the 1,575 participating in the childhood obesity program, Healthy 4 Life, the percentage of obese students **decreased from 25.5% at baseline to 23.8%** of students at the end of the year.

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

- **1,563 children** were assisted in the enrollment process for accessing appropriate health insurance programs. Together with our Community Partners, a total of **11,423 children were enrolled county wide.**
- MediKids Program **provided in-kind our most experienced** Health Care Access Coordinator (1 FTE) to the CHIOC as part of the transitional plan. As funding for MediKids ended this fiscal year, the CHIOC secured additional funding sources to hire that Health Care Access Coordinator to maintain continuity of care coordination.

**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.

- **37 EI Club members and 35 non members** participated in the depression support group.
- Secured grant funding to collaborate with MOMS of Orange County to provide an onsite Licensed Clinical Therapist once a week.
- PPD program Identified 1,895 women at greater risk for maternal depression. Further screening determined that 213 mothers were at risk, **121 received treatment.**

## **INTRODUCTION**

### **Who We Are and What We Do**

For 81 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 3,800 employees and 971 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 second in the State of California for surgical volume (28,027 surgeries), first in Orange County (and second in the State of California) for the

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number of deliveries (5,149 live births), and has the second largest volume of cardiovascular bypass procedures in Orange County (341).

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 (NCI) to participate in its Community Cancer Centers Pilot Program (NCCCP). St. Joseph Hospital is the only hospital on the West Coast named to participate in this prestigious program
- ✦ In 2009 St. Joseph Hospital underwent a rigorous survey to become Orange County's first hospital and one of just 80 nationwide designated "Baby Friendly"
- ✦ 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
- ✦ More than 70 physicians on the St. Joseph Hospital Medical Staff were named by the Orange County Medical Association and recognized in *Orange Coast* magazine as 2010 Physicians of Excellence for their achievements.

In FY 10, our community benefit programs provided direct medical services, offered preventative care and education, and joined with various collaborative partners to deliver a greater impact on the communities we serve. One example of this success is our Joint Clinic Health Education Program- El Club de Salud. In its fourth year, El Club has been successful in demonstrating impact and has been the catalyst for bringing together internal systems to benefit patients served by our hospital clinics. El Club uses an evidence-based model for identifying the specific behaviors which contribute to serious chronic disease in each individual patient and helps patients to replace these behaviors with healthier habits that will reduce clinically measurable risk factors and disease indicators.

#### **From a Shocking A1C to Renewed Health and Happiness**

Pablo joined El Club with a shocking A1C score of 16%- this score is higher than many doctors have ever seen. Our community health educator met with him and enrolled him in our El Club diabetes management classes. He learned how to use a glucometer and to self-inject insulin. He attended many El Club activities and worked very hard to make changes in his lifestyle. He was able to lower his A1C level to a healthy and safe 5.7% Pablo is very thankful for the El Club program. He says he "is a new man". He feels more productive at work and has renewed energy. He is not only happy to be healthy, but also very happy about how happy his improved health has made his wife and daughter.

### ***Community Benefit Investment 2009 and 2010***

In FY 2010, SJH provided **\$55,207,248 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 **\$35,359,195**).

### ***Community Benefit Governance Structure***

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.

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- 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.

**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 13<sup>th</sup> 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, 1<sup>st</sup> 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 5<sup>th</sup> most diverse in the country.

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*SJH's Community Benefit Service Area (CBSA)* is comprised of 31 Orange County zip codes in the cities of Anaheim, Garden Grove, Orange, Santa Ana, Tustin and Westminster, Costa Mesa, Huntington Beach, Fullerton, and Stanton. Secondary Community Benefit Service Areas include: Placentia, La Habra, Brea, and Buena Park. Different from the hospital's Primary and Secondary Service Areas which focus on market share and business development, the CBSA encompasses geographic regions (zip code specific) that identify residency of the populations served by our Community Benefit Programs. These populations/communities are all considered Disproportionate Unmet Health Needs (DUHN) populations evidenced by the demographic information we collect prior to rendering services.

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 four 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.

	<b>Current Year – 2008</b>	<b>Future Year - 2013</b>
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

	<b>Total Population by Age Current Year – 2008</b>		<b>Total Population by Age Future Year – 2013</b>	
	<b>Number</b>	<b>% of Total</b>	<b>Number</b>	<b>% of Total</b>
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

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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

### **Patient Financial Assistance Program**

Our mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why St. Joseph Health System has a **Patient Financial Assistance Program** that provides free or discounted services to eligible patients. In FY 10, St. Joseph Hospital provided \$5,025,392 in charity care to 10,036 persons.

### **FY 09 – FY 11 Community Benefit Plan: FY 10 Progress on CB Priority Initiatives or Programs**

**Initiative or Program Name:** La Amistad Medical Clinic

**Key Community Partner(s):** Coalition of Orange County Community Clinics



**Target Population:** Patients who fall within 200% of the Federal Poverty Guidelines or below, reside within the St. Joseph Hospital Primary Service Area and who are uninsured.

**Goal:** To restore and maintain to a healthy state, for those with little or no other access to medical care.

**How will we measure success?:**

TBD

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**Strategy 1:** Provide medical services for patients with acute and chronic healthcare needs.

**Strategy Measure 1:** Provide 9,000 medical treatment visits.

**FY 10 Accomplishments:**

La Amistad Medical Clinic provided 10,888 medical treatment visits. We exceeded our goal by 21%.

**Initiative or Program Name:** La Amistad Dental Clinic

**Key Community Partner(s):** Coalition of Orange County Community Clinics



**Target Population:** Patients ages 6 and above who fall within 200% of the Federal Poverty Guidelines or below, reside in St. Joseph Hospital’s Primary Services Area and who are uninsured.

**Goal:** To restore and maintain, to a healthy, pain-free state, those who have little or no access to dental services.

**How will we measure success?:**

TBD

**Strategy 1:** Provide dental prophylaxis and treatment.

**Strategy Measure 1:** Provide 3,500 dental prophylaxis and treatment visits.

**Strategy 2:** Provide oral health education.

**Strategy Measure 2:** Offer oral health education to 1,500 patients.

**FY 10 Accomplishments:**

La Amistad Dental Clinic provided 3,176 dental prophylaxis and/or treatment visits. La Amistad Dental Clinic provided oral health education to 1,192 patients. We exceeded our revised goal by approximately 3%.

**Initiative or Program Name:** La Amistad Pediatric Dental Program

**Key Community Partner(s):**



**Target Population:** Low income uninsured children ages 0-5 who reside within St. Joseph Hospital's Primary Service Area.

**Goal:** To restore and maintain, to a healthy, pain-free state, dental health issues of children 0-5 years of age.

**How will we measure success?:**

TBD

**Strategy 1:** Provide dental prophylaxis, sealants and treatment.

**Strategy Measure 1:** Provide 416 dental prophylaxis and treatment visits.

**Strategy 2:** Provide oral health education.

**Strategy Measure 2:** Offer oral health education to 250 patients and/or parents.

**FY 10 Accomplishments:**

La Amistad Dental Clinic provided 332 dental prophylaxis and/or treatment visits for children 0.5. We fell short of our goal by 20% due to a lack of referrals. La Amistad Dental Clinic provided oral health education for 200 children and /or parents. Healthy Smiles of Orange County is the lead agency for this collaborative and is responsible for referring children to our clinic.

**Initiative or Program Name:** Puente a la Salud Mobile Medical Clinic Services Program

**Key Community Partner(s):** Corbin Family Resource Center in Santa Ana, Delhi Family Resource Center in Santa Ana, St. Anne's Church in Santa Ana, Friendly Center in Orange and Coalition of Orange County Community Clinics.



**Target Population:** Uninsured patients who fall within 200% of the Federal Poverty Guidelines or below and reside within the St. Joseph Hospital's PSA.

**Goal:** Treatment and prevention of illness within the target population.

**How will we measure success?:**

TBD

**Strategy 1:** Provide health services at convenient locations.

**Strategy Measure 1:** No-show rate will be no more than 20% of scheduled visits.

**Strategy 2:** Provide community health education assistants for personal guidance and information through El Club Program.

**Strategy Measure 2:** 10% of agricultural workers will be referred to El Club program for personal follow-up.

**FY 10 Accomplishments:**

Puente provided health services at four different community locations: two family resource centers in Santa Ana; one family resource center in Orange; and once Catholic Church in Santa Ana.

Puente's No-Show rate was 14% (216 no-shows) out of 1,554 scheduled medical appointments.

El Club de Salud Health Educators provided 1,228 one-on-one patient visits out of 1,554 medical visits. 79% of our patients scheduled for the medical clinic received personal guidance and information on health, nutrition and wellness through El Club de Salud Program.

Of the 394 agricultural patients, 70 patients (18%) received one-on-one personal health and wellness education by a Health Educator from El Club de Salud Program.

Puente provided an additional 134 medical wellness screenings.

Case Management and Education visits were captured with the implementation of our new patient management system, CCPro.net.

**Initiative or Program Name:** Puente a la Salud Adult Mobile Dental Program

**Key Community Partner(s):** Corbin Family Resource Center in Santa Ana, Delhi Family Resource Center in Santa Ana, Central City Health Center in Anaheim and La Amistad de Jose Health Center in Orange.



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**Target Population:** Uninsured patients who fall within 200% of the Federal Poverty Guidelines or below and reside within the St. Joseph Hospital's PSA.

**Goal:** Provide treatment to patients with dental disease and provide dental education.

**How will we measure success?:**

TBD

**Strategy 1:** Locate services in convenient locations for patients.

**Strategy Measure 1:** Complete dental treatment plan for at least 10% of patients.

**Strategy 2:** Educate target population on dental and oral health practices.

**Strategy Measure 2:** Provide chair side prevention education by dentist to all patients with dental disease.

**FY 10 Accomplishments:**

Provided dental services at four different community locations: two family resources centers in Santa Ana; one HQHC community clinic in Anaheim; and La Amistad Family Health Center in Orange. 61% of adult dental patients completed treatment before transferring out. Out of 494 unduplicated adult dental patients, 300 patients completed dental treatment.

182 (37%) unduplicated patients out of 494 total unduplicated patients received additional dental hygiene and nutrition education from patient care coordinator.

494 unduplicated adult dental patients (100%) received chair side dental hygiene education at every dental visit. Puente provided 894 adult dental visits.

Case Management and Education visits were captured with the implementation of our new patient management system, CCPro.net.

Puente Adult Dental services have ceased due to state budget cuts from Denti-Cal, DHS and EAPC contracts. These funds previously funded Puente Adult Dental services. Puente's Dental Provider and Manager successfully transferred 300 adult dental patients to a new dental home in the community.

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**Initiative or Program Name:** Puente a la Salud Pediatric Dental Clinic Services

**Key Community Partner(s):** Central City Community Health Center, Corbin Family Resource Center, Diamond Elementary School, Gonzalez-Northgate Super Market, La Amistad Family Health Center, Oak View Elementary and Family Resource Center, Trinity Cristo Rey Church, Orange County School Districts- Orange, Garden Grove, Anaheim, Santa Ana and Buena Park, Healthy Smiles of Orange County and the Coalition of Orange County Community Clinics.



**Target Population:** Uninsured children 0-18 years of age who fall within 200% of the Federal Poverty Guidelines or below, and reside within St. Joseph Hospital's primary service area. Uninsured children 0-18 years of age of agricultural workers living and or working in Orange County. Denti-Cal Insured children 0-18 years of age.

**Goal:** Dental treatment for children ages 0-13.

**How will we measure success?:**

TBD

**Strategy 1:** Receive referrals through membership in Orange County Pediatric Dental Collaborative.

**Strategy Measure 1:** Provide dental treatment to eliminate cavities in referred children.

**Strategy 2:** Select sites for the Dental Mobile Clinic based upon needs of referred children and their families.

**Strategy Measure 2:** Each referred child will receive patient care coordination.

**FY 10 Accomplishments:**

Puente received 300 referrals from community school nurses in Santa Ana, Anaheim and Garden Grove as well as referrals from our Healthy Smiles Dental Collaborative Partner. These referrals resulted in patient care coordination by phone and /or in person regarding dental treatment, appointments, further referrals and insurance verification and information. Provided dental treatment to 800 unduplicated pediatric patients within the 0-13 age category.

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Provided 972 unduplicated patients received fluoride varnish treatment at every dental visit, totaling in 1,317 visits. Puente provided services at seven different community locations. In total, Puente provided 1,464 pediatric dental visits to 1,081 patients. In addition, Puente patient Care Coordinator provided 241 dental education encounters at elementary school presentations and health fair screenings. Puente added a Registered Dental Assistant to the dental team to oversee the Prophy Schedule for the recommended three-four month patient dental cleanings. Case Management and Patient Care Coordinator visits were captured with the implementation of the new patient management system, CCPro.net.

**Initiative or Program Name:** Puente a la Salud Mobile Vision Clinic Program

**Key Community Partner(s):** Corbin Family Resource Center, Delhi Family Resource Center, La Amistad de Jose Health Center, Lestonnac Free Clinic, St. Jude Neighborhood Clinic, Southern California College of Optometry and the Coalition of Orange County Community Clinics.



**Target Population:** Uninsured community patients who fall within 200% of the Federal Poverty Guidelines or below and reside within St. Joseph Hospital's primary services area. Special focus on diabetic patients referred by community clinic partners.

**Goal:** Prevention and treatment of eye disease.

**How will we measure success?:**

TBD

**Strategy 1:** Locate clinic at convenient locations for referred patients.

**Strategy Measure 1:** Treat all patients referred by La Amistad and Puente clinics, and other community clinics.

**Strategy 2:** Maintain continuity by continuing to contract to train residents of the Southern California College of Optometry, Fullerton.

**Strategy Measure 2:** Provide referrals to those patients needing advanced care.

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Puente goal was not met due to State budget cuts. The Department of Health Services funding was temporarily eliminated until additional funding becomes available. The County TSR funding was divided between medical and vision clinics therefore reducing the amount of funds allocated to our vision program. The Vision Mobile clinic was not operational for a period of four weeks throughout the year due to maintenance and repair issues. The Puente Vision Mobile Clinic provided services at five locations in Orange County. A total of 2,174 patient visits were provided to 1,756 patients. Puente processed 1,289 frame prescription orders for patients in need of Rx glasses. In addition, we provided 53 frame adjustment appointments to walk in patients. Case Management visits were captured with the implementation of our new patient management system, CCPro.net. Case Management oversees specialty referrals. We provided an estimated 520 specialty referrals to Ophthalmologists and the Southern California College of Optometry. Puente's Clinical Training Affiliation Agreement continues as of July 2008. Vision Director provides clinical training to 3<sup>rd</sup> and 4<sup>th</sup> year optometry students, two days a week. Student rotations are every six weeks.

**Initiative or Program Name:** El Club de Salud Joint Clinic Health Education Program

**Key Community Partner(s):** La Amistad and Puente Clinics



**Target Population:** low income diabetic patients referred by La Amistad and Puente Clinics.

**Goal:** Improve health status of El Club member/patients.

**How will we measure success?:**

TBD

**Strategy 1:** Provide various classes and activities to encourage healthy behaviors.

**Strategy Measure 1:** Diabetic patients will reduce their A1C values by a statistically significant measurement based on independent evaluator's report.

**Strategy 2:** Provide one on one coaching by community health education assistants.

**Strategy Measure 2:** 300 members/patients will have more than one health survey.

**FY 10 Accomplishments:**

- 300 individuals experienced a drop in A1C levels from enrollment to the second measurement. For 46 of these individuals, this drop represented moving from “moderate” or “high” risk into the category of “low or no risk”. For the patients evaluated, there was statistically significant improvement of their A1C scores.
- 413 patients have had three health surveys. After analysis, we have adjusted the time frame for using the instrument to baseline plus every six months.

**Initiative or Program Name:** Children’s Access Program (formerly MediKids Program)

**Key Community Partner(s):** CHIOC, CHOC, OC Healthcare Agency



**Target Population:** low income children without health insurance who live in Orange County.

**Goal:** Provide enrollment assistance, care coordination and retention services to uninsured children.

**How will we measure success?:**

TBD

**Strategy 1:** Locate clinic at convenient locations for referred patients.

**Strategy Measure 1:** Treat all patients referred by La Amistad and Puente clinics, and other community clinics.

**Strategy 2:** Provide retention information to parents.

**Strategy Measure 2:** # of renewals provided.

**Strategy 3:** Serve on CHIOC governing committee and provide guidance to their staff.

**Strategy Measure 3:** CHIOC will stabilize under guidance by targeted group of stakeholders.

**FY 10 Accomplishments:**

- Number of families/children assisted: **1,563 with Community Partners: 11,423**
- Participated in a pilot care coordination program with the Children’s Health Initiative of Orange County (CHIOC) to transfer our cases to them for ongoing care coordination after

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approval of coverage. This enabled our limited staff to concentrate on enrollment assistance.

- Provided leadership on the CHIOC Governing Committee and lead the care coordination pilot program as well as the OC Care pilot program to refer uninsured children not qualifying for public programs to participating community clinics for care.
- MediKids Program **provided In-kind our most experienced** Health Care Access Coordinator (1 FTE) to the CHIOC as part of the transitional plan. As funding for MediKids ended this fiscal year, the CHIOC secured additional funding sources to hire that Health Care Access Coordinator to maintain continuity of care coordination.

**Initiative or Program Name:** Mental Health Services

**Key Community Partner(s):** El Club Program

**Target Population:** Low income and uninsured living in primary service area

**Goal:** Prevention, early identification, education with emphasis on depression, spousal abuse and addiction.

**How will we measure success?:**

TBD

**Strategy 1:** Identify current programs available.

**Strategy Measure 1:** Explore at least two current programs offered in the community.

**Strategy 2:** Participate in community planning collaboratives.

**Strategy Measure 2:** Participate in at least one mental health community planning effort.

**FY 10 Accomplishments:**

- 37 El Club members and 35 non members participated in the depression support group. The facilitator held 117 sessions, both on the St. Joseph Hospital campus and out in the community at locations serviced by Puente mobile clinics.
- 10 women completed one repeat PH-9 and 4 completed two repeat PHQ-9s. The mean scores in depression-related symptoms dropped from time 1 to time 2 but this was not a statistically significant change due to the small sample size.
- Secured grant funding to collaborate with MOMS of Orange County to provide an onsite Licensed Clinical Therapist once a week.

**FY 2010 Community Benefit Report**

**Initiative or Program Name:** Healthy 4 Life

**Key Community Partner(s):** St. Jude Medical Center, Mission Hospital, SJHS.



**Target Population:** overweight students in selected Orange County schools.

**Goal:** Recruit schools to participate in Healthy 4 Life

**How will we measure success?:**

TBD

**Strategy 1:** Provide technical assistance to Lead Organization (St. Jude Medical Center).

**Strategy Measure 1:** 8 schools in PSA will agree to participate.

**Strategy 2:** Participate on Healthy 4 Life Steering Committee

**Strategy Measure 2:** Designated staff person attends monthly meetings.

**FY 10 Accomplishments:**

There were 1,575 students participating in the program from the 51 Title 1 schools at baseline assessment and 1,484 students participating at the year end assessment. A total of 15 schools in the St. Joseph Hospital PSA participated in the program this past school year. In all Title 1 schools the percentage of obese students decreased from 25.5% at baseline to 23.8% of students at year end. The data indicates a shift from students in the obese BMI category to the overweight category. Children and adolescents with a waist circumference >90 percentile for age and gender are at significant risk for obesity related co-morbidities. The percentage of Title 1 school students with waist circumferences >90 decreased from 20.6% of students assessed at baseline to 17.8% of students assessed at year end.

**Initiative or Program Name:** From the Heart Screening Program

**Key Community Partner(s):** Women's Heart Center and El Club de Salud Program



**Target Population:** Underserved and low income women 35 years or older and men age 55 and older in our community.

**Goal:** Educate 250 low income and underserved patients on cardiovascular disease and its prevention and treatment.

**How will we measure success?:**

Will provide underserved, low-income women 35 years or older and men age 55 and older with improved access to superior cardiovascular education, screening and treatment services delivered in culturally sensitive manner respectful of each individuals inherent dignity.

**Strategy 1:** Locate the screenings at appropriate resource centers.

**Strategy Measure 1:** Provide clinical outcomes to at least 250 low income and underserved patients.

**Strategy 2:** Provide qualified clinical staff at screening locations.

**Strategy Measure 2:** Provide referrals to those patients requiring follow up due to their screening results.

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**Strategy 3:** Provide one on one education to all patients regarding heart health.

**Strategy Measure 3:** To increase awareness of cardiovascular disease, and its prevention and treatment, along with improving access to care for underserved members of our communities.

**FY 10 Accomplishments:** Each team member is committed to provide a *"teachable moment"* to help the patient identify and evaluate his or her potential health risks in a personal and caring environment. Most of our patients are Latino, and as such, are most comfortable speaking Spanish. Our bilingual staff were actively recruited for the project and the St. Joseph Hospital Interpreter Services have been instrumental in helping translate program materials into Spanish.

One of the most important avenues for us this past year was to be able to provide a meaningful education that was easily understood and that gave the patient the greatest opportunity for being integrated into the daily routine.

***"From the Heart" 7/1/2009 – 6/30/2010 Program Results***

Off-site Mobile Screenings	SJH On-site Screenings	Percent Male	Percent Female	Average Age	Referrals to La Amistad	Referrals to La Puente	Referrals to patients Primary Care Physician
189	18	21%	79%	M- 57 F- 56	25	1	43

Note: Due to scheduling issues during the months of February and March we did not have as many site visits for the FY 2010. We had two sites cancel their site visits. One on 7/1/2009 @ Access CA and one @ St. Anne's Catholic Church on 6/3/2010. This contributed to the lower amount of screenings provided on the Medical Mobile Unit.

**Initiative or Program Name:** Postpartum Depression Program

**Key Community Partner(s):** MOMS Orange County, St. Jude Hospital and Mission Hospital



**FY 2010 Community Benefit Report**

**Target Population:** All mothers who are at risk for Postpartum Depression (PPD) Or experiencing signs and symptoms. This is inclusive of all demographic population

Goal: Treatment and prevention of PPD within the target population.

**How will we measure success?:**

How many mothers are treated for PPD

**Strategy 1:** Increase the number of session per client in treatment

**Strategy Measure 1:** The number of therapy sessions will increase to 3.

**Strategy 2:** Determine the appropriate intervention for women in the program.

**Strategy Measure 2:** Average change scores for clients utilizing the Edinburgh Postnatal Depression Scale pre and post therapy.

**Strategy 3:** Reduce the financial burden to clients

**Strategy Measure 3:** Provide services at a sliding scale for underinsured families. Continue utilizing the Financial Aid Program for low income families.

**FY 10 Accomplishments:**

During the 12 month fiscal year for 2010, 1,895 women appeared at greater risk for depression and therefore received a further screening utilizing the Edinburgh Postnatal Depression Tool. 1,449 mothers were then followed up with either a re-screening via letter, or phone call. 213 of these women were identified at risk for depression. All of those identified at risk during their preliminary screening received a second screening by phone 4-6 weeks post-delivery. 56% of women identified as at risk for maternal depression were enrolled in the program and received treatment appropriate to their need. Of the 213 mothers identified as at-risk, 121 received treatment. 272 individual sessions were conducted as part of the treatment. Referrals to psychiatrist were made as deemed necessary for medication management. Referrals for treatment continue to be made as a result of our preliminary screenings, follow up calls, and letters sent to patients and their obstetricians.

**Other Community Benefit Initiatives and Programs**

**Initiative or Program Name:** Kids on the Block Inc. Educational Puppet Program- "Bullies and School Safety"

**Key Community Partner(s):** Catholic Elementary Schools, local elementary schools and libraries and the Bower's Children's Museum in Santa Ana.

**FY 2010 Community Benefit Report**



**Target Population:** Low-income

**Goal:** Educate children about this world-wide issue of bullying and promote sensitivity toward peers.

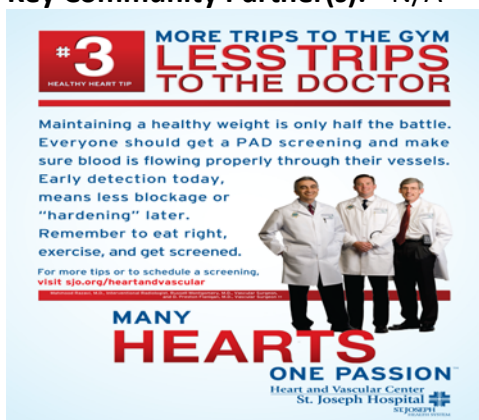
**How will we measure success?:** Provide Kids on the Block presentations to school age children in Catholic Schools in Orange and Santa Ana.

**FY 10 Accomplishments:**

The Bullies and School Safety” program was presented at two Catholic elementary schools, the children at West Orange Elementary School, the children’s after school summer program at three local libraries, and to the children and parents at the Bower’s Children’s Museum. Through this very worthwhile and educational puppet program, more than 800 children, teachers and parents learned about the dangers of bullying and how to get help.

**Initiative or Program Name:** *Peripheral Arterial Disease (PAD) Screening*

**Key Community Partner(s):** N/A



**Target Population:** *Broader Community*

**Goal:** Increase awareness and assess risk of PAD in the community.

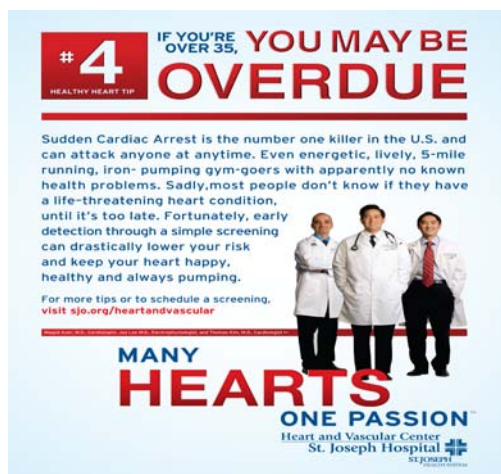
**How will we measure success?:** Provide screening to men and women 55 years and older.

**FY 10 Accomplishments:**

Our multidisciplinary team is dedicated to increase awareness and assess risk of PAD and the prevention of stroke. Working together we can continue to improve the health of all people in our community which is a goal we remain steadfastly dedicated to reaching everyday. During the FY 2010 we screened 402 patients and referred 351 patients for follow up care due to their results. On a monthly basis we mail out reminder cards to the prior year patients, which has increased awareness to our established patients to inspire them to achieve optimal well-being..

**Initiative or Program Name:** Heart Risk Assessment, Sudden Cardiac Arrest Screenings

**Key Community Partner(s):** N/A



**Target Population:** Broader Community

**Goal:** Improve access to superior cardiovascular education, screening and treatment services.

**How will we measure success?:** Provide screenings to men & women in our community.

**FY 10 Accomplishments:**

Our mission is to educate the community help prevent disability and mortality from cardiovascular disease through early detection, education and lifestyle modification. Due the FY 2010 provided 200 screenings to our patients. Each month we send out Birthday letters as a reminder to out patients about following up from their past screenings and also to let them know about additional services available to help them live a heart healthy life.

**Initiative or Program Name:** Community Education Lectures

**Key Community Partner(s):** Senior Centers and local churches



**Target Population:** Broader Community

**Goal:** Educate the senior population on various health-related topics.

**How will we measure success?:** Provide lectures on: sinus, heart, colon, prostate, colorectal and breast cancer and orthopedics. In addition, provide employer outreach activities that include health and wellness programs, lunch & lecture and screenings.

**FY 10 Accomplishments:**

Promoted Community Health Education lectures and special events in the community to increase awareness of the services offered by SJH such as: Many Hearts, One Passion, day of Ophthalmology, and day of Orthopedics with over 200 attendees. Provided cancer related lectures such as Prostate, Liver, Colorectal, Breast, Radiation, Genetics and other community education lectures offered. Provided screenings and health education lectures to local church organizations such as Mariners Church and Temple Beth Emet. Participated in 48 Employer Health Fairs and offered 38 “lunch and learn” with various topics conducted by physician and service line speakers. For example: heart and vascular, sleep and snore, stress related, diabetes and orthopedics talks.

**Initiative or Program Name:** Perinatal Education

**Key Community Partner(s):** MOMS Orange County

**Target Population:** St. Joseph Hospital patients and Broader Community

**Goal:** Support new parents as they prepare for parenthood by providing education on childbirth, breastfeeding, and parenting.

**FY 2010 Community Benefit Report**

**How will we measure success?:** Provide classes pre and post delivery for ongoing support in the first 2 years of a child's life.

**FY 10 Accomplishments:**

With the decline in the economy, we have been able to continue to offer classes to our expectant parents and new parents. There was a decrease from previous years in the number of classes held, registrations and attendees. Number of classes held: 601; number of registrations: 3,786; number of attendees: 7,403.

**Initiative or Program Name:** Mother Baby Assessment Center

**Key Community Partner(s):** Pediatricians and family MD's

**Target Population:** All mothers delivering at SJH

**Goal:** To improve on the outcomes for families delivering at SJH.

**How will we measure success?:**

Total number of families served through the Mother Baby Assessment Center

**Strategy 1:** Provide an assessment to all mothers delivering at St. Joseph Hospital.

**Strategy Measure 1:** Provide 4,000 visits to mothers and newborns delivering at SJH.

**Strategy 2:** Provide referrals to physician for all mothers or newborns with abnormal findings.

**Strategy Measure 2:** Referrals will be made by RN/IBCLC for any abnormal findings found during the assessment.

**Strategy 3:** Provide ongoing support for families to support, sustain and protect breastfeeding.

**Strategy Measure 3:** All families will have the opportunity to return for further assistance for breastfeeding.

**FY 10 Accomplishments:**

For the fiscal year 2010, out of 4,984 deliveries at SJH there were 4,275 mothers and their newborn who were seen. 679 referrals were made to physicians due to abnormal findings. 113 mothers returned for more assistance for a private lactation consult and 559 mothers returned for postnatal breastfeeding workshop for assistance. 1,338 phone calls were made to families requiring further assistance. **SJH continues to be the leader in the community for the highest breastfeeding rates of 19 birthing hospitals in OC at 82%.**

**Initiative or Program Name:** Bridges for Newborn Program

**FY 2010 Community Benefit Report**

**Key Community Partner(s):** Children and Family Commission, HASC, Family Resource Centers and Service Providers

**Target Population:** Low Income Mothers delivering at St. Joseph Hospital residing in Orange County

**Goal:** : Screening mother's of newborns for needs and referring them to appropriate service providers as needed; and collecting demographic and other information on families of newborns for the Commission evaluation. St. Joseph Hospital will work collaboratively with other Bridge's Hospitals and service providers to ensure a coordinated and integrated system of care for children and their families. Will also provide the Kit for New Parents to all new mothers of newborns.

**How will we measure success?:**

The number of Mothers delivering at SJH screened. The number of kits given out to mother's with newborn delivering at SJH

**Strategy 1:** Provide an initial screening to mothers who qualify for Bridges Program and who accept the program.

**Strategy Measure 1:** Provide a screening to all mothers delivering at SJH who reside in OC, who go home with newborn.

**Strategy 2:** Provide kits to all new families delivering at SJH.

**Strategy Measure 2:** All families accept the Kit for New Parents.

**Strategy 3:** All mothers qualifying for referrals service providers are accepted by families.

**Strategy Measure 3:** Provide the information to mothers about the services.

**FY 10 Accomplishments:**

During the 12-month period, out of the 4,984 mothers delivering at SJH, 3,252 women received screening from a case worker through Bridges for Newborn Program. Mothers whose baby was transferred to CHOC or mothers who did not reside in Orange County were not part of the program. Funding only included Orange County families. Families could decline screening if they did not feel that they needed assistance. A secondary screening was done after discharge at 6 weeks. This was a phone call to offer our services once again. Families had a three month period to join the program.

Mothers were also screened for Postpartum Depression using the Edinburgh Tool. Resources were made available to any mother who appeared to be at risk or self referred. All mothers were able to access a therapist through Bridges for Newborn Program.

Program services that families were linked to for services included Family Resource Center (FRC) in the regions in which they resided. These included Anaheim Fullerton FRC, Corbin FRC, Delhi Community Center, La Habra FRC, Magnolia Park (FRC), Oak View FRC, South Orange County FRC (Raise Foundation), Children's Bureau (WEST). Other program services that families were referred to included Service Providers such as Children's Bureau, Hoag Hospital,

**FY 2010 Community Benefit Report**

Prevention Center, St. Jude Hospital and PHN through the Orange County Healthcare Agency. WIC and Healthy families were offered to all families who qualified. Staff also provided information on obtaining for Medi-cal applications. Families were offered services within SJH which included Lactation services, Mother Baby Assessment Center, PPD Program and Mother and Father Support groups.

The Kit for New Parents was offered to all families during their visit to the Hospital either prenatally or postnatally. 3,811 Kits for New Parents were given out to mothers of newborns. Some families declined due to receiving the kit with previous children.

## FY 2010 Community Benefit Report

## Community Benefit Investment FY 2009 and FY 2010

	FY 2009	FY 2010
<b>BENEFIT FOR LOW- INCOME PERSONS</b>		
Charity Care <sup>2</sup> (Financial Assistance) (at cost)	\$5,795,689	\$5,025,392
Community Services for low-income persons <sup>3</sup>	\$4,036,259	\$7,630,382
Unpaid costs of state and local programs	\$35,384,800	\$38,202,567
<b>A. TOTAL BENEFIT FOR LOW- INCOME PERSONS</b>	<b>\$45,216,748</b>	<b>\$50,858,341</b>

<b>BENEFITS FOR THE BROADER COMMUNITY</b>		
Community Services for the broader community	\$6,050,154	\$4,348,907
<b>B. TOTAL BENEFIT FOR THE BROADER COMMUNITY</b>	<b>\$6,050,154</b>	<b>\$4,348,907</b>

	FY 2009	FY 2010
<b>TOTAL COMMUNITY BENEFIT (A +B)</b>	<b>\$51,266,902</b>	<b>\$55,207,248</b>
Percentage of total net patient revenue	8.7%	8.8%
Percentage of total operating expenses	8.9%	9.2%

	FY 2009	FY 2010
<b>BENEFIT FOR THE BROADER COMMUNITY</b>		
Unpaid cost of Medicare	\$38,855,432	\$35,359,195

Care for the Poor Funds (CFTP) for FY 10 totaled \$3,927,804 and were used to support the following programs: La Amistad Medical and Dental Clinics, Puente a la Salud Medical and Vision Clinics, The Joint Clinic Health Education Program- El Club, Healthy 4 Life Program, Community Services Programs, California Kids and Emergency Dept. physician coverage for the indigent. CFTP Funds for FY 09 totaled \$3,469,676.

<sup>2</sup> Charity care provided for households at or below 500% of Federal Poverty Levels.

**FY 2010 Community Benefit Report**

**St. Joseph Health System**  
**500 S. Main St., Ste. 1000**  
**Orange, CA**  
**[stjhs.org](http://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 classrooms, SJHS is establishing a "continuum of care," that is, a system that links and coordinates an entire spectrum of health services.