



*Children participating in physical activities provided by
Healthy For Life Program*

**ST. JOSEPH HOSPITAL, ORANGE
FISCAL YEAR 2011 COMMUNITY BENEFIT REPORT**

St. Joseph Hospital 
ST. JOSEPH
HEALTH SYSTEM

MISSION, VISION AND VALUES

Our Mission

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

Our Vision

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

Our Values

The four core values of St. Joseph Health 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.

EXECUTIVE SUMMARY

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.¹

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.

In FY 11, SJH Community Clinics (La Amistad Family Health Center and Puente a la Salud Mobile Clinics) provided **a total of 20,773 patient encounters**. El Club de Salud- Joint Clinic Health Education Program provided a total of **5,420 health education encounters**. In total with community partners, the Children's

¹ Wright, D. J. & Montiel, L. M. (2007). Divided they fall: Hardship in America's cities and suburbs. The Nelson A. Rockefeller Institute of Government.

Access Program assisted in the enrollment of **11,006 children** into appropriate health insurance programs. **14.8% of students** in the SJH service area participating in the childhood obesity program, Healthy For Life decreased their weight status to a healthier category. The Postpartum Depression program (PPD), the only screening and treatment hospital-based program in Orange County, **screened 3,483 women for PPD**. Of those women who were screened, **366 were identified at risk for PPD** and began treatment. The average number of sessions for each woman's treatment was 3.5 sessions.

In FY 2011, SJH provided **\$60,491,584 for community benefit programs/activities**. This includes services for the poor, vulnerable and at-risk populations as well as for the broader community (a 10% increase from previous fiscal year). Unreimbursed costs to **Medicare totaled \$31,443,413** (an 11% decrease from previous fiscal year). In addition, SJH provided **\$8,798,147 in charity care** to 17,341 persons (a 75% increase from previous fiscal year).

Community Plan Priorities

The following information provides a brief summary of accomplishments associated with each of the four Community Benefit Initiatives for FY 11:

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 **20,773 medical, dental and vision patient encounters** to the Disproportionate Unmet Health Needs (DUHN) population in the hospital's service area.
- Puente's Case Management provided **416 one-on-one specialty referral** follow-up visits for 265 unduplicated medical patients.
- **501 patients** received free Rx frames.
- Puente's Case Management provided **33 one-on-one specialty referrals** for patients needing eye surgery or specialty care to a Community Ophthalmologist.

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

- Puente's Care Coordinator provided **464 one-on-one parent and child dental hygiene education**.
- In addition, **189 children received deep cleanings** due to severe dental decay, tracked by Puente's Registered Dental Assistant.
- La Amistad Dental provided 2,632 dental prophylaxis and treatment visits for children ages 6 and above.
- In addition, La Amistad Dental provided oral health education to **779 patients**.
- In Healthy For Life, there were 2,396 consented students participating in the program from the 67 Title 1 schools (117 classes) at the baseline assessment and 1,398 consented students participating at the yearend assessment.
- 14.8% of SJH students decreased their weight status to healthier category (68 of 458).
- El Club, Joint Clinic Health Education Program provided **5,420 education encounters** (one-on-one coaching, diabetes 4-class series, cooking demonstrations, cholesterol classes, glucose meter orientation, and exercise classes) and activities to 3,437 diabetic clinic patients.

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

- One full time Health Care Access Coordinator enrolled 800 children in appropriate health insurance programs. Together with Community Partners, 11,423 were enrolled.

- SJH staff continues to provide leadership on the CHIOC Governing Committee and support on the care coordination program.

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.

- **58 La Amistad/Puente patients** participated in the depression support group. A total of 368 sessions were provided.
- The St. Joseph Hospital Orange Post-Partum Depression (PPD) Program **screened 3,483 women** for postpartum depression. Of those women, 366 entered the program and began treatment.

INTRODUCTION

Who We Are and What We Do

For over 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 3,800 employees and 1,000 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 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 11, 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 the Childhood Obesity Prevention and Intervention Program, Healthy For Life. In its fourth year, Healthy For Life’s purpose is to reduce the rate of childhood obesity in low income youth in Orange County by assisting schools to support student efforts to establish lifelong healthy lifestyle habits. The following was provided to us by a Physical Education teacher from Anaheim High School.

“Roxanna Ortiz, age 15, told me that her mother asked her how her new Healthy For Life P.E. class was going and Roxanna showed her all the tips of the week that we go over and discuss. Her mother started reading them every week. Roxanna said that at first all of the soda left the house (no more soda for anyone in the family!!). Second, she said that her mom buys and cooks with more fruits, vegetables, chicken and fish and less red meat. Third, Roxanna said the whole family exercises together. They have all lost weight and are feeling healthier with more energy. This makes me feel so good. Not only are we educating our students, but their families as well!! This is truly a success story!”

In FY 2011, SJH provided **\$60,491,584 for community benefit programs/activities**. This includes services for the poor, vulnerable and at-risk populations as well as for the broader community (a 10% increase from previous fiscal year). **Unreimbursed costs of Medicare totaled \$31,443,413** (an 11% decrease from previous fiscal year).

Community Benefit Governance Structure

The Community Benefit Committee met six times over the past 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 communities 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.

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 forth 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 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)

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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 2008 and 2013.

	2008	Projected-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

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

Age Group	Total Population-2008	% of Total	Total Population Projected – 2013	% 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

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

Race and Ethnicity	2008-Number	% of Total	2013-Number	% of Total	Race and Ethnicity Change 2008-2013	% 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 11, SJH provided **\$8,798,147 in charity care** to 17,341 persons (a 75% increase from previous fiscal year).

The Health System enhanced its process for determining charity care by adding an assessment for presumptive charity care. This assessment used predictive modeling and public records to identify and qualify patients for charity care, without a traditional charity care application.

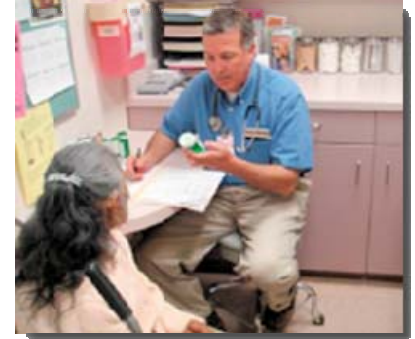
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FY 09 – FY 11 Community Benefit Plan:
FY 11 CB Priorities

La Amistad Medical Clinic

Key Community Partners: 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.



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

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

FY 11 Accomplishments

La Amistad Medical Clinic provided medical services for patients with acute and chronic health care needs. We provided 11,901 medical encounters and exceeded our goal by 32%.

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FY 09 – FY 11 Community Benefit Plan:
FY 11 CB Priorities

La Amistad Dental Clinic

Key Community Partners: 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.



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 11 Accomplishments

La Amistad Dental Clinic provided dental prophylaxis and treatment to patients ages 6 and above. We provided 2,632 dental encounters. In addition, the dental clinic provided oral health education to 779 patients.

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FY 09 – FY 11 Community Benefit Plan:
FY 11 CB Priorities**

La Amistad Pediatric Dental Program

Key Community Partners: Not applicable

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.



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 11 Accomplishments:

La Amistad Dental Clinic provided 344 dental prophylaxis, sealants and treatment for children 0-5. The dental clinic offered oral health education to 158 children ages 0-5 and/or their parents.

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 at or below 200% of the Federal Poverty Guidelines and reside within the St. Joseph Hospital's PSA.

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

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 11 Accomplishments

Our goal of providing 1,300 medical visits was exceeded. Puente provided 1,722 medical encounters out of 852 unduplicated patients. Puente provided an additional 592 Wellness screenings out in the community to 545 unduplicated patients. Case Management at Puente provided 416 one-on-one

specialty referral follow up visits for 265 unduplicated patients. Our goal to maintain our No-Show rate at or below 20% was exceeded again. Our no-show rate was 16% for total visits.

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Puente a la Salud Adult Mobile Dental Program

Key Community Partners: 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.

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.

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.

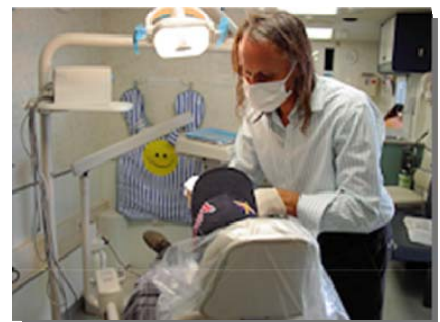
FY 11 Accomplishments

N/A- Puente no longer provides Adult Dental Care due to reduction in funding.

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Puente a la Salud Pediatric Dental Clinic Services

Key Community Partners: 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.

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 11 Accomplishments

Our goal of providing 1,400 dental visits was exceeded. Puente provided 1,994 pediatric and adolescent dental encounters out of 724 unduplicated dental patients. Puente's Patient Care Coordinator provided an additional 464 one-on-one parent and child dental hygiene education. 189 children received additional deep cleanings due to severe dental decay, tracked by Puente's Registered Dental Assistant. Case Management at Puente provided 12 one-on-one specialty referral follow up visits to children needing dental surgery or specialty care outside of Puente scope of services.

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FY 09 – FY 11 Community Benefit Plan:
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Puente a la Salud Mobile Vision Clinic Program

Key Community Partners: 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.

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.

FY 11 Accomplishments

Puente provided 2,011 vision encounters out of 1,519 unduplicated patients. Our goal of providing 2,100 was not met due to vision mobile clinic maintenance problems. Vision mobile clinic services had to be canceled on several occasions. 501 patients received free Rx frames. Puente provided 69 additional patients with vision screenings at various community sites. Puente also provided an additional 80 frame adjustment appointments to walk-in patients. Case Management at Puente provided 33 one-on-one specialty referrals to a community Ophthalmologist for patients needing eye surgery or specialty care.

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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.

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 11 Accomplishments

El Club provided 5,420 education encounters (one-on-one coaching, diabetes 4-class series, cooking demonstrations, cholesterol classes, glucose meter orientation, and exercise classes) and activities to 3,437 diabetic clinic patients. During FY 11, El Club lost outside funding and was not able to retain the services of the Evaluation Consultant. Even though the program continued to collect clinical lab values, we were not able to have the significance of those results analyzed. We have secured outside funding for FY 12 and will be able to resume data analysis.

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Children's Access Program (formerly MediKids Program)

Key Community Partner(s): Children's Health Initiative of Orange County (CHIOC), Children's Hospital of Orange County (CHOC), Orange County 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.

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 11 Accomplishments

One full time Health Care Access Coordinator enrolled 800 children in appropriate health insurance programs. Together with Community Partners, 11,423 were enrolled. SJH enrollment staff 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 approval of coverage. This enabled our limited staff to concentrate on enrollment assistance. SJH staff continues to provide leadership on the CHIOC Governing Committee and support on the care coordination program as well as the OC Care pilot program to refer uninsured children not qualifying for public programs to participating community clinics for care. CHIOC was successful in securing additional funding sources to hire SJH's Health Care Access Coordinator to maintain continuity of care coordination.

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FY 09 – FY 11 Community Benefit Plan:

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Mental Health Services

Key Community Partners: 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.

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 11 Accomplishments:

58 female clinic patients participated in the depression support group. The facilitator held sessions both on the St. Joseph Hospital campus and out in the community at locations serviced by Puente mobile clinics. A total of 368 encounters were provided. On average the women had 6.3 visits.

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FY 09 – FY 11 Community Benefit Plan:
FY 11 CB Priorities



Healthy For Life

Key Community Partners: St. Jude Medical Center, Mission Hospital, and St. Joseph Health System (SJHS)

Target Population: Overweight students in selected Orange County schools.

Goal: Recruit schools to participate in Healthy For Life

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 For Life Steering Committee

Strategy Measure 2: Designated staff person attends monthly meetings.

FY 11 Accomplishments: A total of 2,396 students participated in the program from the 67 Title 1 schools (117 classes) at the baseline assessment and 1,398 students participated at the year end assessment. The SJHS Foundation goal of implementing the Healthy for Life program in 45 new classes in the third year was accomplished. The program served 57 preschool classes, 28 elementary school classes, 21 middle school classes and 22 high school classes. One hundred and twenty one of the 126 schools plan to continue the program into the 2011-2012 school year. A total of 38 schools in the SJH service area participated in the program this past year. Overall, 14.8% of SJH service area students decreased their weight status to a healthier category (68 of 458). SJH staff participated in all Healthy For Life collaborative meetings.

Body Mass Index (BMI) was determined using the Centers for Disease Control and Prevention (CDC) 2000 growth charts for ages 2-20 years and by gender. Height and weight were obtained from each participating student and BMI was determined.

All Orange County Classes

	# of students at baseline assessment	% of students at baseline assessment	# of students at end of year assessment	% of students at end of year assessment
Overweight	364	21.7%	291	17.4%
Obese	438	26.1%	380	22.7%
Total Students	802	47.8%	671	40.1%

The data indicates a shift from students in the obese BMI category to the overweight category which is a move in the healthier direction. This data also suggests a strong correlation with increased overweight/obesity prevalence in low socioeconomic children 3 – 18 years of age. Of those who were obese at baseline (26.1%, n=438), 58 (13.2%) students decreased their status to overweight. Of those students that were overweight at baseline (21.7%, n=364) 73 (20.1%) decreased their status to a healthy weight. The student initial BMI data compares to the PedNSS data 2008 obtained from the 2010 Report on the Conditions of Children in Orange County. This data indicates obesity prevalence among Orange County's low-income children was similar to that of the previous year among the 5 to 11

(22.2%) and 12 to 19 (20.0%) age groups, with a slight increase found among 0- to 4- year olds (14.1%).

From the Heart Screening Program

Key Community Partners: 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.

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 11 Accomplishments:

Of the 336 patients screened (51%) were referred for follow up testing and treatment. Of these 70 (43%) to La Amistad and 93 (57%) were referred to a community clinic closer to their home or to their primary care provider if they already had one. The primary reasons for an individual being referred for additional medical care were high cholesterol, high blood pressure, high glucose and abnormal EKGs. This year, we made a few updates to our patient information packets. We added information about Walmart’s and Target’s \$4.00 prescription program and also included the most current calendar of events brochure about the hospital. The patients are very thankful when receiving information after their screenings to help them make heart healthy choices. We continue to implement appropriate improvements to our process.

“From the Heart” 7/1/2010 – 6/30/2011 Program Results

Off-site Mobile Screenings	SJH On-site Screenings	Percent Male	Percent Female	Average Age	Referrals to La Amistad Clinic	Referrals to Puento a la Salud Mobile Clinic	Referrals to patients Primary Care Physician
336	16	13.5%	86.5%	Male- 62 Female- 61	70	0	93



Postpartum Depression Program

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

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.

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 Assistance Policy (FAP) for low income families.

FY 11 Accomplishments:

3,483 mothers were screened for Postpartum Depression utilizing the Edinburgh Postpartum Depression Screening Tool (EPDS) on day 3-7 days postpartum at the Mother Baby Assessment Center. The average number of sessions for each mother's treatment was 3.5 sessions. The average change score for clients utilizing the EPDS pre and post therapy showed 83% improvement. The pre and post EDPS score also showed a recovery of 85%. PPD continues to use the FAP for low-income families. The FAP was utilized for all clients requesting financial assistance. A set rate of \$25.00 was established to reduce financial burden for clients. Many changes were implemented to improve on the quality outcomes for PPD. A continued assessment is monitored to identify improvement with the changes made to support quality evidenced based practice. A data was developed to identify monthly statistics.

Other Community Benefit Initiatives and Programs

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 Bowers Kidseum in Santa Ana.

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 11 Accomplishments

Starting in October 2010 through April 2011, The Kids on the Block, Inc. Educational Puppet Program visited three local elementary schools and the Bowers Kids Museum after school program. Approximately 1,200 students were educated about the world-wide issue of bullying. The students also learned how to cope with bad situations among peers and how to make their school a safer place. The teachers and some parents also attended each program.

Peripheral Arterial Disease (PAD) Screening

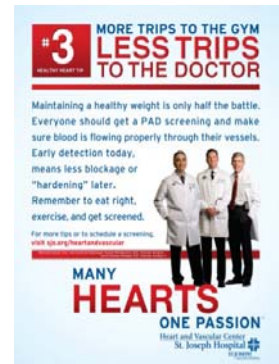
Target Population: Broader Community

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 11 Accomplishments

“If you could prevent a stroke or heart attack would you?” Our dedicated team members promote our screening programs each and every day. Our vascular PAD screening is a simple, painless, low-cost program that can detect PAD by checking for blockages in the arteries and aneurysms, which can lead to stroke or heart attacks. During FY 11, we provided 662 PAD screenings to the community. We had 6 off site screenings which included employees at Mazda (2 visits), Econolite and Kingston Technology (3 visits). The employees of these facilities were very impressed with our program and the “compassionate way” our staff delivered care.



Heart Risk Assessment, Sudden Cardiac Arrest Screenings

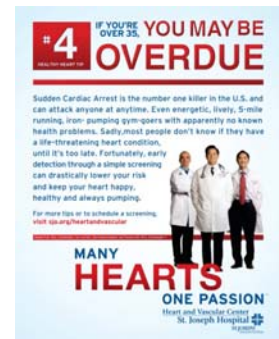
Target Population: Broader Community

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 11 Accomplishments

We provided 158 Heart Risk Assessments, 50 Sudden Cardiac Arrest Screenings, 316 EBCT Heart Screens and 12 A-Fibs to our community members. Also, during this fiscal year our staff members provided lectures and events to promote a heart healthy lifestyle at the following locations: City of Irvine, City of Villa Park, First Christian Church, Aluminum Precision, Freeman Company, California State Employees, Women’s Club of Orange, WomanSage and Orange Coast College.



Other Community Benefit Initiatives and Programs

Perinatal Education

Key Community Partners: 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.

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 11 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.

Other Community Benefit Initiatives and Programs

Mother Baby Assessment Center

Key Community Partners: 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 their families to support, sustain and protect breastfeeding.

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

FY 11 Accomplishments

Provided 4,295 visits to mothers and newborns delivering at SJH for follow assessment. 695 referrals were made to physicians for abnormal findings during the assessment visit. 156 Breastfeeding

Workshop classes were provided with the attendance of 634 mothers for breastfeeding assistance. 109 mother attended private lactation consults for breastfeeding assistance.

Other Community Benefit Initiatives and Programs

Bridges for Newborn Program

Key Community Partners: 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 11 Accomplishments:

2,313 mothers delivering at SJH who qualified for Bridges were screened and enrolled into Bridges Program. 3,688 First 5 Kits in English and Spanish were given out to families delivering at SJH along with education. 523 referrals were completed for families qualifying for Bridges Program. 68 referrals were made specifically for Healthy Families public insurance program.

Other Community Benefit Initiatives and Programs

Perinatal Education

Key Community Partners: 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.

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 11 Accomplishments

626 classes were held pre and postnatal to support education to parents on childbirth, parenting, baby care and breastfeeding. A total of 7,152 attended the classes.

Other Community Benefit Initiatives and Programs

Community Education Lectures

Key Community Partners: 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 11 Accomplishments

Provided Community Education lectures and special events throughout the community in the following areas:

- Many Hearts, One Passion Special Event, over 200 attendees. Included SJH Physician speakers spoke on various topics such as heart and vascular disease, diabetes, ophthalmology, nutrition and healthy food cooking demonstration.
- Women's Center Event "It's Time to Celebrate a Healthier You" with over 200 participants attending. Topics included Breast Cancer Prevention, ovarian and skin cancer education.
- Disney Half Marathon, SJH medical sponsor included over 200 volunteers from SJH both clinical and non-clinical provided care to over 12,000 runners.
- Offered free osteoporosis screenings to the community screened over 100 people.
- Dinosaur Dash Run City of Tustin over 5,000 people in attendance provided safe hand washing techniques, blood pressure screenings and health education materials. Participated in the March of Dimes event. Provided blood pressure and safe hand washing techniques. The da Vinci Robotics Surgical System displayed at the Westminster Mall. This community event and lecture helped educate the community on heart health awareness. Participated in 40 employer health fairs, 25 baseline screenings, 30 employer lunch & learns, 19 senior and community lectures with various topics given by physician and service line speakers on topic related to heart & vascular, diabetes, orthopedics, cancer, ophthalmology, sleep and snoring, prevention, nutrition and exercise and stress. Assisted with 4 community flu clinics.

Community Benefit Investment for FY 2011

Community Benefit Expenses totaled \$60,491,585 in FY 11 as compared to \$55,207,248 in FY 10 (a 9.6% increase from previous fiscal year).

FY11 COMMUNITY BENEFIT INVESTMENT
ST. JOSEPH HOSPITAL ORANGE
(ending June 30, 2011)

CA Senate Bill (SB) 697 Categories	Community Benefit Program & Services ²	FY11 Financials
Medical Care Services for Vulnerable³ Populations	St. Joseph Hospital Orange Financial Assistance Program (FAP) (Charity Care-at cost)	\$8,798,147
	Unreimbursed cost of MediCal ⁴	\$30,899,556
	Unreimbursed costs- other means tested government programs	\$6,270,357
Other benefits for Vulnerable Populations	Subsidized Health Services	\$2,423,743
	Community Health Improvements Services	\$5,371,082
	Cash and in-kind Donations	\$33,461
Other benefits for the Broader Community	Community Health Improvements Services	\$4,382,293
	Cash and in-kind contributions	\$45,070
	Community Benefit Operations	\$370,210
Health research, education, and training	Health Professions Education, Training and Research	\$1,897,666
TOTAL COMMUNITY BENEFIT (excluding Medicare)		\$60,491,585
Medical Care Services for the Broader Community	Unreimbursed cost of Medicare <i>(not included in CB total)</i>	\$31,443,413
TOTAL COMMUNITY BENEFIT (including Medicare⁵)		\$91,934,998

Care for the Poor Funds (CFTP) for FY 11 totaled \$2,986,636 and were used to support the following programs: La Amistad Medical and Dental Clinics, Puente a la Salud Medical and Vision Mobile Clinics, the Childhood Obesity Prevention and Intervention Program, Healthy For Life, Children's Health Access Program and Community Services Programs. CFTP Funds for FY 10 totaled \$3,469,676.

² Catholic Health Association-USA Community Benefit Content Categories that incurred expenses.

³ CA SB697: "Vulnerable Populations" means any population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for MediCal, Medicare, California Children's Services Program, or county indigent programs. For SJHS, we exclude unreimbursed costs of Medicare as part of Community Benefit total and only include it below the line for SB697 reporting purposes.

⁴ Accounts for Hospital Fee.

⁵ Reported below the line per requirement of SB 697.

Telling Our Community Benefit Story: Non-Financial⁶ Summary of Accomplishments

SJH's Executive and Management Team members lend their expertise, time and talent to outside organizations committed to delivering healthcare excellence and healthy communities.

The following lists all Board membership participation and volunteer work.

- Taller San Jose Board Member
- Children's Health Initiative of Orange County Board Member
- Chair, Hospital Association of Southern California Joint Behavioral Health Task Force
- California Hospital Association Center for Behavioral Health Board Member
- Secretary, Orange County Breast Coalition
- Secretary, MOMS of Orange County Board
- Orange County Perinatal Council/OC Health Care Agency Member
- Association for Fundraising Professionals Orange County Chapter Board Member
- President, The American College of Cardiovascular Administrators
- Chair, American Heart Association's "Go Red" for Women Luncheon
- Project Hope School Board Member
- Co-Chair, Access Orange County Surgery Day
- CNI College Advisory Board Member
- Treasurer, Orange County Chapter of Clinical Laboratory Management Association Board of Directors
- American Kidney Fund Board Member
- Secretary, National Renal Administrator Association
- Committee Member, National Kidney Foundation
- Presenter, National Association of Nephrology Technologists
- Committee Member, Association for the Advancement of Medical Instrumentation-Renal Disease and Detoxification and Medical Devices in Home Care Application
- Chair, National Kidney Foundation Council of Nephrology Nurses and Technician
- Certified Clinical Hemodialysis Technician-Nephrology Nursing Certification Commission Board Member
- Educational Advisory Council American Kidney Fund
- Clinical Associate for Cultural Competency, California State University
- Participant, Workforce Improvement Project- Compassionate Care to a Diverse Community
- Health Workforce Improvement Advisory Board Member
- Participant, IOM/RWJ Future of Nursing- Saddleback College
- Concordia University Nursing Advisory Board
- Santa Ana College Nursing Advisory Board
- Judge at National Conference , Health Occupations Students of America
- Western University- Advisory Board Member of Nursing Program and New Graduate Transition Program
- Chair, OC/LB Consortium for Nursing
- Participant, Regional Focus Group Meeting on Health Workforce Planning
- Invited Lecturer, UCLA Master's Program- Nursing Administration and Long Beach City College- RN Nursing Program
- Mock Interviewer, Taller San Jose Medical Careers Track Program

⁶ Non-financial summary of accomplishments are referred to in SB 697 as non-quantifiable benefits.