

— 2021 - 2023 —

COMMUNITY HEALTH IMPROVEMENT PLAN

Providence St. Jude Medical Center

Fullerton, California



To provide feedback on this CHIP or
obtain a printed copy free of charge,
please email Barry Ross at
barry.ross@stjoe.org



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EXECUTIVE SUMMARY

Providence St. Joseph Health (PSJH) continues its Mission of service in Orange County through Providence St. Jude Medical Center (SJMC). SJMC is an acute-care hospital with 320 licensed beds, founded in 1957 and located in Fullerton, CA. The hospital's service area is North Orange County and adjacent parts of Los Angeles, Riverside and San Bernardino counties, including 1,733,665 people.

Providence St. Jude Medical Center dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During the most recent calendar year, the hospital provided \$67,539,253 in Community Benefit in response to unmet needs.

The Community Health Needs Assessment (CHNA) is an opportunity for Providence St. Jude Medical Center to engage the community every three years with the goal of better understanding community strengths and needs. The results of the CHNA are used to guide and inform efforts to better address the needs of the community. Through a mixed-methods approach, using quantitative and qualitative data, the CHNA process relied on several sources of information: state and national public health data, qualitative data from Kaiser and UCI CHNA's which included interviews with community stakeholders and listening sessions with community members, and hospital utilization data.

Collaborating Organizations

Orange County Health Improvement Partnership (HIP), Kaiser Permanente, and CalOptima, and University of California, Irvine (UCI) conducted various community and stakeholder engagement sessions in 2019. While PSJH – Orange County had planned several for Spring 2020, these sessions had to be cancelled due to the COVID-19 pandemic. In lieu of those sessions, we are leveraging the previously collected information from local partners and will update with additional community feedback and input as appropriate in response to the pandemic.

ORANGE COUNTY HEALTH IMPROVEMENT PARTNERSHIP (HIP)

Overall, the HIP identified homelessness and housing; environmental health; safety; mental health and substance use; access to care; nutrition; early childhood development; and support for aging populations as the key themes from the sessions. They conducted six diverse focus groups with under-represented communities, including Vietnamese older adults, Spanish-speaking adults and mothers, adolescents, and service providers.

KAISER PERMANENTE CHNA 2019 (ANAHEIM AND IRVINE)

Kaiser Permanente's 2019 CHNA included focus groups based upon high-level findings from secondary data analysis. Additionally, 18 stakeholder interviews were conducted representing the non-profit sector, education, and county agencies. These stakeholders identified housing insecurity, food insecurity, asthma and stroke disparities, oral health, mental health/suicide, and older adult health as key needs. Kaiser Permanente's identified priorities for the service area were access to health care; economic, housing, and food insecurities; mental health and substance use; stroke; and suicide.

CALOPTIMA MEMBER SURVEY

CalOptima is a county organized health system that administers health insurance programs for children, adults, seniors with low incomes and people with disabilities. They administered a member survey as part of a comprehensive assessment. The survey reached a wide variety of demographics and included insights into needs beyond members' immediate health care needs, including social determinants of health. The report notes access barriers, lack of awareness of benefits and resources, and negative social and environmental impacts as the key themes identified.

UNIVERSITY OF CALIFORNIA, IRVINE CHNA 2019

The UCI CHNA included input from stakeholders gathered in Fall 2018, including Orange County Health Care Agency. Stakeholders were asked to rank order identified health needs. The percentage of responses were presented for those needs with severe or significant impact on the community, had worsened over time, and had a shortage or absence of resources available in the community, and level of importance in the community. Substance use and misuse; mental health; and housing and homelessness were the top ranked priorities.

Providence St. Jude Medical Center Community Health Improvement Plan Priorities

As a result of the findings of our [2021 CHNA](#) and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, Providence St. Jude Medical Center will focus on the following areas for its 2021-2023 Community Benefit efforts:

PRIORITY 1: MENTAL HEALTH

Creating awareness and services addressing mental health along with substance use.

PRIORITY 2: ACCESS TO CARE

Increasing health care access as well as other resources for areas that have the biggest challenges.

PRIORITY 3: HOMELESSNESS AND HOUSING

Social determinants of health, like housing, have a substantial impact on health behaviors and health outcomes. Addressing housing instability, housing affordability, and preventing homelessness will improve health in the communities we serve.

PRIORITY 4: HEALTH EQUITY AND RACIAL DISPARITIES

The need for increased health equity and the presence of racial disparities are key priorities to address.

As we develop the Community Health Improvement Plan (CHIP), we will integrate prevention and addressing racial disparities as a cornerstone of each of these priority areas.

INTRODUCTION

Who We Are

Our Mission As expressions of God’s healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Vision Health for a Better World.

Our Values Compassion — Dignity — Justice — Excellence — Integrity

Providence St. Jude Medical Center is an acute hospital founded in 1957 and located in Fullerton, California. The hospital has 320 licensed beds, a staff of 2,496, and professional relationships with 649 local physicians and 99 allied health professionals. Major programs and services offered to the community include the following: Cardiac, Orthopedics, Neurosurgery, Cancer, Perinatal, Rehabilitation and Digestive Services.

Our Commitment to Community

Providence St. Jude Medical Center dedicates resources to improve the health and quality of life for the communities we serve. During Calendar Year 2020 Providence St. Jude Medical Center provided \$67,539,253 in Community Benefit¹ in response to unmet needs and to improve the health and well-being of those we serve in North Orange County and parts of Los Angeles, Riverside and San Bernardino counties.

Health Equity

At Providence St. Joseph Health, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is “Health for a Better World,” and to achieve that we believe we must address not only the clinical care factors that determine a person’s length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes.

To ensure that equity is foundational to our CHIP, we have developed an equity framework that outlines the best practices that each of our hospital will implement when completing a CHIP. These practices include, but are not limited to the following:

¹ Per federal reporting and guidelines from the Catholic Health Association.

Figure 1. Best Practices for Centering Equity in the CHIP



Community Benefit Governance

Providence St. Jude Medical Center demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation, and collaboration with community partners. The Regional Director, Community Health Investment is responsible for coordinating implementation of State and Federal 501r requirements.

A charter approved in 2007 and revised in 2020 established the formation of the Providence St. Jude Medical Center Community Health Committee. The role of the Community Health Committee is to support the Board of Trustees in overseeing community benefit issues. The Committee acts in accordance with a Board-approved charter. The Community Health Committee is charged with developing policies and programs that address identified needs in the service area particularly for underserved populations, overseeing development and implementation of the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP), and overseeing and directing the Community Benefit (CB) activities.

The Community Health Committee has a minimum of twelve members, chaired by a member of the Medical Center Ministry Board. Current membership includes 23 community members. A majority of members have knowledge and experience with the populations most likely to have disproportionate unmet health needs. The Community Health Committee generally meets quarterly.

ROLES AND RESPONSIBILITIES

Senior Leadership

- Chief Executive and senior leaders including the hospital’s Chief Mission Integration Officer, are directly accountable for CB performance.

Community Health Committee (CHC)

- CHC serves as an extension of trustees to provide direct oversight for all charitable program activities and ensure program alignment with “Advancing the State of the Art of Community Benefit” (ASACB) Five Core Principles. It includes diverse community stakeholders. Trustee members on CHC serve as ‘board level champions.’
- The Committee provides recommendations to the Board of Trustees regarding budget, program targeting and program continuation or revision.

Community Health (CH) Department

- Manages CB efforts and coordination between CH and Finance departments on reporting and planning.
- Manage data collection, program tracking tools and evaluation.
- Develops specific outreach strategies to access identified Disproportionate Unmet Health Needs (DUHN) populations.
- Coordinates with clinical departments to reduce inappropriate ER utilization.
- Advocates for CB to senior leadership and invests in programs to reduce health disparities.

Local Community

- Partnership to implement and sustain collaborative activities.
- Formal links with community partners.
- Provide community input to identify community health issues.
- Engagement of local government officials in strategic planning and advocacy on health-related issues on a city, county or regional level.

Planning for the Uninsured and Underinsured

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 Providence St. Jude Medical Center has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

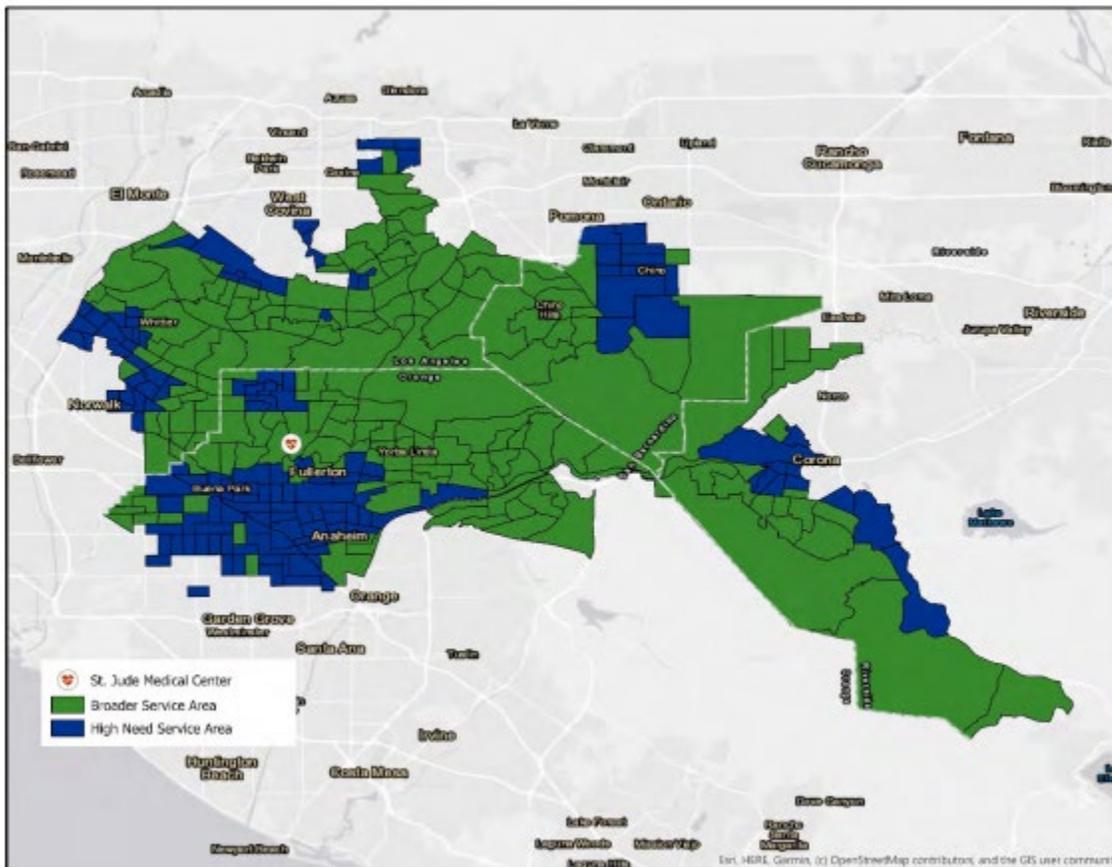
One way Providence St. Jude Medical Center informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital’s service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance Application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible. For information on our Financial Assistance Program click <https://www.providence.org/obp/ca>.

OUR COMMUNITY

Description of Community Served

Providence St. Jude Medical Center’s service area is North Orange County and adjacent parts of Los Angeles, Riverside and San Bernardino counties and includes a population of approximately 1.7 million people.

Figure 2. Providence St. Jude Medical Center’s Total Service Area



Of the over 1.7 million permanent residents of North Orange County and adjacent parts of Los Angeles, Riverside and San Bernardino counties, roughly 45% live in the “high need” area, defined by lower life expectancy at birth, lower high school graduation rates, and more households at or below 200% FPL compared to census tracts across the county. For reference, in 2020, 200% FPL represents an annual household income of \$52,400 or less for a family of four. These households are more likely to regularly make spending tradeoffs regarding utilities, rent, groceries, medicine, and other basic expenses.

Community Demographics

POPULATION AND AGE DEMOGRAPHICS

Of the over 1.7 million permanent residents in the total service area, the male-to-female distribution is roughly equal across geographies.

The high need service area has a higher percentage of people under 34 years of age, 60.2%, compared to 48.8% in the broader community.

POPULATION BY RACE AND ETHNICITY

Individuals identifying as Hispanic had twice the percentage living in high need service areas, 63.5% versus the broader service area, 31.8%. The same was noted for individuals identifying as “other” race, 28.5% versus 11.2%.

People identifying as Asian, 13.2% lived in high need service areas and 29.7% in the broader service area.

SOCIOECONOMIC INDICATORS

Table 1. Income Indicators for Providence St. Jude Medical Center Service Area

Indicator	Broader Service Area	High Need Service Area	Orange County
Median Income Data Source: American Community Survey Year: 2019	\$103,210	\$63,059	\$88,453
Percent of Renter Households with Severe Housing Cost Burden Data Source: American Community Survey Year: Estimates based on 2013 – 2017 data	24.0%	30.8%	28.0%

The high need service area’s median household income is approximately \$40,000 **less than** that of the broader service area, and \$25,000 **less than** the Orange County overall.

Severe housing cost burden is defined as households that spend 50% or more of their income on housing costs. A greater proportion of renter households are severely housing burdened in the high need service area (three out of every ten households, 30.8%) in comparison to the broader service area (two out of every ten households, 24.0%).

Full demographic and socioeconomic information for the service area can be found in the [2021 CHNA for Providence St. Jude Medical Center](#).

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

Improving the health of our communities is foundational to our Mission and deeply rooted in our heritage and purpose. Our Mission calls us to be steadfast in serving all, with a special focus on our most economically poor and vulnerable neighbors. This core belief drives the programs we build, investments we make, and strategies we implement.

Knowing where to focus our resources starts with our Community Health Needs Assessment (CHNA), an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets, and opportunities. The 2021 CHNA was approved by the SJMC Community Health Committee on April 8, 2021.

The Community Health Needs Assessment (CHNA) process is based on the understanding that health and wellness are influenced by factors within our communities, not only within medical facilities. In gathering information on the communities served by the hospitals, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors.

In addition, we recognize that there are often geographic areas where the conditions for supporting health are substantially poorer than nearby areas. Whenever possible and reliable, data are reported at the ZIP Code or census block group level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address disparities within and across communities.

We reviewed data from the American Community Survey and local public health authorities. In addition, we include hospital utilization data to identify disparities in utilization by income and insurance, geography, and race/ethnicity when reliably collected.

Significant Community Health Needs Prioritized

Through a collaborative process engaging Community Health Committee members and the Director of Community Health Investment, the hospital worked from a list of the seventeen (17) health and social needs identified by data from the Orange County Health Improvement Partnership, 2019 Kaiser Permanente CHNA, 2019 University California, Irvine Medical Center CHNA, CalOptima Member Survey, morbidity and mortality data; and hospital-level data. Staff developed a point system to assign each of the seventeen (17) identified needs to gain perspective and develop a hierarchy of which top needs have the potential to offer the highest impact in the High Desert. Each need was listed, and assessed based on the following:

- Trend over time (Getting “Worse” or “Better”)
- Impact on low-income or communities of color (“Very High” to “Very Low”)

- Are “High Need Areas” worse off than state averages? (“Yes” or “No”)
- Opportunity for Impact (“Low” to “Very High”)
- Alignment with System Priorities (“Yes” or “No”)
- Community Vital Signs Priority (“Yes” or “No”)
- Attorney General Requirement (“Yes” or “No”)

Based upon the scoring system and discussion, SJMC’s Community Health Committee identified the following priorities:

PRIORITY 1: MENTAL HEALTH

Creating awareness and services addressing mental health along with substance use.

PRIORITY 2: ACCESS TO CARE

Increasing health care access as well as other resources for areas that have the biggest challenges.

PRIORITY 3: HOMELESSNESS AND HOUSING

Social determinants of health, like housing, have a substantial impact on health behaviors and health outcomes. Addressing housing instability, housing affordability, and preventing homelessness will improve health in the communities we serve.

PRIORITY 4: HEALTH EQUITY AND RACIAL DISPARITIES

The need for increased health equity and the presence of racial disparities are key priorities to address.

Needs Beyond the Hospital’s Service Program

No hospital facility can address all of the health needs present in its community. We are committed to continuing our Mission partnering with like-minded partners that count with the capacity and expertise to address the needs of Los Angeles and Orange County Residents by funding other non-profits through our Care for the Poor program managed by Providence St. Jude Medical Center.

Furthermore, Providence St. Jude Medical Center will endorse local non-profit organization partners to apply for funding through the [St. Joseph Community Partnership Fund](#). Organizations that receive funding provide specific services and resources to meet the identified needs of underserved communities throughout SJMC’s service areas.

The following community health needs identified in the ministry CHNA will not be addressed and an explanation is provided below:

1. **Obesity** – While this was a low priority in the assessment, the Medical Center will continue its support of its Move More Eat Health initiative focused on obesity prevention.
2. **Prevention** – While this was a low priority in the assessment, the Community Health Committee requested that prevention be integrated into all the approved priorities.
3. **Diabetes** – While this was a low priority in the assessment, it was recognized that the Orange County Health Improvement Partnership is addressing this issue.

4. **Food Insecurity** - While this was a low priority, the Medical Center will continue to address food insecurity through partners such as Second Harvest Food Bank.
5. **Sexually Transmitted Diseases** – While this was a low priority in the assessment, this need is being addressed by the Orange County Health Improvement Partnership.
6. **Economic Stability** – While this was a low priority in the assessment, it will be addressed by other partner organizations, such as Hopebuilders and CAPOC.
7. **Environment/Climate** – While this was a low priority in the assessment, [Providence St. Joseph Health has committed to being carbon negative by 2030](#). This effort will involve all hospital staff. The Regional Director, CHI for OC/HD is a member of the Providence Environmental Justice Committee.
8. **Safety** – While this was a low priority in the assessment, safety is a priority for some of our partners such as the Center for Healthy Neighborhoods.
9. **Stroke** – While this was a low priority, Providence St. Jude Medical Center is an accredited comprehensive stroke center.
10. **Cancer** - While this was a low priority in the assessment, Providence St. Jude Medical Center has a comprehensive Cancer Center to serve the community.
11. **Teen Birth Rate**- This was a low priority based on the declining teen birth rate in the hospital service area.
12. **Alzheimer Disease** – While this was a low priority in the assessment, the Medical Center does have programs supporting caregivers of persons with Alzheimer’s Disease.
13. **Early Childhood** - While this was a low priority in the assessment, the Medical Center supports with time and grant funding Early Childhood OC.

In addition, the hospital will collaborate with local non-profit, like-minded organizations that address the aforementioned community needs to coordinate care and referrals to address these unmet needs.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

Providence St. Jude Medical Center developed a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners, considering resources, community capacity, and core competencies. The CHIP process integrated the community input received from over 50 stakeholders at a regional housing/homeless forum, input from the Board of St. Jude Neighborhood Health Centers related to their plans and builds on our mental health partnerships. The 2021-2023 CHIP was approved on October 12, 2021 and made publicly available no later than December 28, 2021.

The 2021-2023 Community Health Improvement Plan (CHIP) process was impacted by the SARS-CoV-2 virus and COVID-19, which has impacted all of our communities. While we have focused on crisis response, it has required a significant re-direction of resources and reduced community engagement in the CHIP process. The Medical Center's Community Health Committee, composed of diverse representatives of the communities served and the target population, have had deep dialogues to determine the key strategies, outcomes, resources and partners for the CHIP.

This CHIP is currently designed to address the needs identified and prioritized through the 2021 CHNA, though COVID-19 will have substantial impacts on our community needs. These impacts are likely to exacerbate some of the needs identified, and cause others to rise in level of priority. While this is a dynamic situation, we recognize the greatest needs of our community will change in the coming months, and it is important that we adapt our efforts to respond accordingly. We are committed to supporting, strengthening, and serving our community in ways that align with our Mission, engage our expertise, and leverage our Community Benefit dollars in the most impactful ways.

Providence St. Jude Medical Center anticipates that implementation strategies may change and therefore, a flexible approach is best suited for the development of its response to the CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by Providence St. Jude Medical Center in the enclosed CHIP.

Addressing the Needs of the Community: 2021- 2023 Key Community Benefit Initiatives and Evaluation Plan

PRIORITY #1: HOMELESSNESS AND AFFORDABLE HOUSING

Community Need Addressed

Increase in homelessness and the lack of affordable housing

Goal (Anticipated Impact)

Reduce chronic homelessness, increase the number of affordable housing units and strengthen affordable housing policies.

Outcome measure:

Reduce chronic homelessness as measured by the rate of individuals experiencing chronic homelessness in the Annual Point in Time Count.

Increase affordable housing units by at least 200 in North Orange County.

Strengthen affordable housing policies in the 2021-2028 housing elements in at least 3 target North Orange County cities.

Table 2. Strategies and Strategy Measures for Addressing Homelessness and Affordable Housing

Strategy	Target Population	Strategy Measure	Baseline	2023 Target
1. Train a minimum of 100 additional housing champions in North Orange County cities.	Residents with low to moderate incomes	# of housing champions trained in North Orange County	151	251
2. Engage with housing champions in local city housing element public process to promote stronger policies in the 2021-2028 housing elements that will result in more affordable housing.	Resident engagement with Planning and City Council	# of cities with inclusionary housing ordinances and other strong policies promoting affordable housing in North OC	0	3
3. Support the approval of affordable housing projects in the pipeline so that at	Residents, Planning Commissions, City Councils	# of affordable housing units added by 2023 in North Orange County	0	200

least 200 new units are built by 2023 in North Orange County.				
4. Continue homeless care navigation program and implement best practices identified in the region.	People experiencing chronic homelessness	Decrease in administrative days in homeless population	Average of 8 days per month in first six months of 2021	Average of no more than 5 days per month
5. Partner with the OC Superior Court, Public Law Center and other partners to implement a collaborative court for eviction diversion in Orange County.	Low-income persons at risk of eviction	% of evictions diverted	0	50%
6. Influence Cal Optima to add additional in lieu services to support the needs of persons experiencing homelessness that are being discharged from the hospital.	Cal Optima members who are experiencing homelessness	# of in lieu services provided by Cal Optima for CalAim clients	0	5
7. Advocate for data sharing to allow hospitals to access HMIS database and to improve referral system to shelters and navigation centers.	Persons experiencing homelessness	Access to HMIS by hospitals Ability of hospital staff to refer directly to shelters/navigation centers	No access by hospitals to HMIS and no ability to directly refer to shelters/navigation centers	Data sharing and access agreements in place to allow direct referral to shelters and navigation centers.

Evidence Base

Center for Evidenced Based Solutions on Homelessness: Chronic Homelessness
www.evidenceonhomelessness.com

Evidence Based Interventions to Address Homelessness; Utah State Legislature Issue Brief 2018

Planned Collaboration

Collaborative partners include: the Kennedy Commission; United Way OC; YIMBY, Habitat for Humanity, Fullerton Tri-Parish Council.

Resource Commitment

Financial commitment to support partners organizations. FTE including homeless community care navigators and grants to partner organizations.

PRIORITY #2: MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Community Need Addressed

Mental Health and Substance Use Disorders

Goal (Anticipated Impact)

Improved system to access mental health and substance use services to ensure that patients receive care at the appropriate level of care, reduced mental health stigma in the community and increase in resources for youth.

Outcome measure:

Reduce # of avoidable Emergency Department visits for mental health and substance use disorders

Increase # of schools and students participating in Work 2 Be Well program

Increase # of residents who are active on Each Mind Matters social media

Table 3. Strategies and Strategy Measures for Addressing Mental Health and Substance Use Disorders

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
1.Participate in the Be Well Clinical Campus Steering Committee and ensure strong referral protocols are in place to reduce avoidable ED visits for mental health and substance use and to decrease ED length of stay.	Patients with mental health and substance use disorders	% reduction in ED visits for mental health and substance use	TBD	50% reduction from 2020 baseline
2.Implement MAT program in Emergency Department	Patients with Opioid Use Disorders	# of patients receiving MAT services in ED	0	60 per year

3. Adapt the Each Mind Matters Campaign/Promise to Talk in response to COVID 19	Latinas and their households with low incomes	# residents active on the EMM/PTT social media site.	12,898 in FY 20	20,000
4. Implement prevention programs for youth including Work 2 Be Well and Strength in Numbers programs	Middle and high school students	# of schools engaged in Work 2 Be Well and Strength in Numbers in North Orange County	0	4 schools
5. Reduce the % of 11th graders in target high school districts who report using alcohol and other drugs within the last 30 days by implementing Strength in Numbers program.	11 th graders	% of 11 th graders in targeted high school districts who report using alcohol and other drugs in the last 30 days	17% (2017-2018)	16%
6. Divert substance use patients requiring sobering and withdrawal management to the Be Well campus instead of to the Emergency Department by partnering with Be Well to advocate for a waiver for ambulances to not be required to bring these patients to the hospital.	Patients with substance use disorders	Waiver achieved	No waiver in place Ambulances must bring patients needing sobering to the Emergency Department	Waiver approved and patients with substance use disorders brought by ambulance directly to Be Well campus
7. Advocate to pass in California current proposals to expand mental health services for students.	Pre-K – 12 Students	Number of bills passed	Student mental health bills have been proposed but not yet passed.	At least 2 bills currently being proposed to support student mental health services passed by legislature and signed by Governor

Evidence Based Sources

Preventing Drug Use among Children and Adolescents (In Brief) Prevention Principles

<https://www.drugabuse.gov/publications/preventing-drug-use-among-children-adolescents/prevention-principles>

<https://theathenaforum.org/CSAPprinciples>

Planned Collaboration

Be Well OC; NAMI, St. Jude Emergency Medical Group; St. Joseph Hospital; Mission Hospital; PSJH Work 2 Be Well; Westbound Communications, Orange County Mental Health, St. Jude Neighborhood Health Centers, Fullerton Joint Union High School District, Placentia Yorba Linda School District.

Resource Commitment

Financial and staffing to resource a Chemical Dependency Counselor and to support Each Mind Matters, Work 2 Be Well, Strength in Numbers and other mental health strategies.

PRIORITY #3: ACCESS TO CARE AND CARE NAVIGATION

Community Need Addressed

Lack of access to primary care, dental care, mental health care and difficulties in navigating services

Goal (Anticipated Impact)

Increase the number of primary care, dental care and mental health visits provided for the uninsured and underinsured in Orange County

Outcome measure:

Number of primary care, dental and mental health visits provided by St. Jude Neighborhood Health Centers in North Orange County.

Table 4. Strategies and Strategy Measures for Addressing Access to Care

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
1.Open the Ponderosa Park site in 2021	Uninsured and underinsured persons with low income	Clinic opened # of visits	Clinic not open	Clinic opened and providing medical, dental and mental health services 10,000 visits
2.Open the Manchester site in 2023	Uninsured and underinsured	Clinic opened # of visits	Clinic not open	Clinic opened and providing medical visits.

	persons with low income			10,000 visits
3. Assess the integration of virtual visits into clinic operations as a way to reduce barriers to care.	Uninsured and underinsured persons with low income	% of virtual visits at St. Jude Neighborhood Health Center	0 before COVID-19	40% of visits
4. Support the enrollment and connection to primary care of newly eligible MediCal members who are undocumented age 50 and over	Residents age 50 and over who are low income and undocumented	# of newly eligible MediCal members 50 and over who are low income and undocumented # newly enrolled members connected to a medical home	0 0	10,000 10,000
5. Advocate for continuation of MediCal expansion	Residents with low income who are undocumented	Passage of expansion of MediCal eligibility for persons who are undocumented	0	1 expansion policy passed by State legislature
6. Ensure the availability of Specialty Care services for uninsured persons in North Orange County	Uninsured persons with low incomes	# of specialty care consults	159	200

Evidence Base

County Health Rankings and Roadmap: Access to Care- Policies and Programs that Work

Planned Collaboration

St. Jude Neighborhood Health Centers; Jamboree Housing; City of Anaheim, OCHAI, Lestonnac Free Clinic

Resource Commitment

Financial resources including capital and operating support to SJNHC as well as supporting on-going access initiatives.

PRIORITY #4: HEALTH EQUITY/RACE DISPARITIES

Community Need Addressed

Disparities in health outcomes by race/ethnicity and lack of health equity

Goal (Anticipated Impact)

Reduce one health disparity selected by the regional Health Equity initiative from a community perspective

Outcome measure:

Reduction in the rate of the selected health disparity by 2022.

Table 5. Strategies and Strategy Measures for Addressing Health Equity and Race Disparities

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
1. Develop a plan to address one issue that interferes with the API population	Uninsured and underinsured persons with low incomes	TBD	TBD	TBD
2. Increase the % of target schools whose Latino/a 5th graders have demonstrated improvement in the Healthy Fitness Zone for Body Composition	Latino 5 th graders in a low-income household	% of schools whose Latino/a 5 th graders have demonstrated improvement in the Healthy Fitness Zone for body composition	36%	50%
3. Align health equity work to address at least one community adopted equity initiative, such as HASC or HCA	People with low-incomes experiencing health disparities	TBD	TBD	TBD

Evidence Base

NCBI: A Roadmap and Best Practices for Organizations to Reduce Racial and Ethnic Disparities in Healthcare

Commonwealth Fund: An Evolving Roadmap to Address Social Determinants of Health

Planned Collaboration

PSJH Health Equity Work Group; Orange County Equity Coalition

Resource Commitment

Funding to partner organizations for grants to support the strategies.

Other Community Benefit Programs and Evaluation Plan

Table 6. Other Community Benefit Programs in Response to Community Needs

Initiative (Community Need Addressed)	Program Name	Description	Population Served
1. Obesity Prevention	Move More Eat Healthy	Policy, system, and environmental change to reduce obesity	Neighborhoods with low incomes in North Orange County
2. COVID 19	Disaster Response	Emergency, mid-term, and long-term response to consequences of COVID -19	Low-income communities in North Orange County
3. Depression and needs of frail elderly	Senior Services	Late life depression, in-home volunteer support and chronic disease management for low-income elderly	North Orange County elderly persons with low income
4. Medication, DME, Transportation and Recuperative Care	Discharge Needs	Provide support to assist patients with low income and patients experiencing homelessness with medication, transportation, recuperative care and other needs.	Uninsured patients of St. Jude Medical Center
5. Navigation	Care Connect	Care coordination for MediCal patients	ED and hospital MediCal patients at St. Jude Medical Center and affiliated physicians and clinics.

2021- 2023 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Providence St. Jude Medical Center Community Health Committee on October 12, 2021. The final report was made widely available by December 28, 2021.



Sr. Mary Rogers
Chair, Community Health Committee
Providence St. Jude Medical Center

10-14-21

Date



Laura Ramos
Chief Executive
Providence St. Jude Medical Center

11/22/21

Date



Justin Crowe
Senior Vice President, Community Partnerships
Providence

12-17-2021

Date

CHNA/CHIP Contact:

Barry Ross
Regional Director, Community Health Investment
Providence St. Jude Medical Center
101 E. Valencia Mesa Dr.
Fullerton, CA 92835
Barry.ross@stjoe.org

To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Improvement Plans please email CHI@providence.org.