



Diabetic patients and their families participating in a Cooking Demonstration Class provided by the Joint Clinic Health Education Program: El Club de Salud

St. Joseph Hospital, Orange

**Fiscal Year 2012 COMMUNITY BENEFIT REPORT
PROGRESS ON FY 12-FY 14 CB PLAN/IMPLEMENTATION STRATEGY**

St. Joseph Health 
St. Joseph Hospital

EXECUTIVE SUMMARY

Our Mission

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

Our Vision

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

Our Values

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

Who We Are and What We Do

St. Joseph Health, St. Joseph Hospital of Orange (referred to in this document at St. Joseph Hospital Orange (SJO)) 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 971-member medical staff and other healthcare providers to increase access to quality health care. As a nonprofit community hospital, SJO 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 residents of Santa Ana – a city determined by the Nelson A. Rockefeller Institute of Government in their most recent *An Update on Urban Hardship* as being the most difficult urban area in the United States in which to live¹.

SJO provides a comprehensive range of services, centers and programs: Anesthesia Services, Bariatric Surgery Program, In-patient Behavioral Health Services, Blood Donor Center, The Center for Breast Imaging and Diagnosis, The Center for Cancer Prevention and Treatment, Clinical Education, Colorectal Program, Emergency, Endoscopy, Heart and Vascular Center, Home Health, Kidney Dialysis Center, Kidney Transplant Center, Maternity, Minimally Invasive Urology & Stone Center, Nasal & Sinus Center, Neurosurgical Services, Nursing Excellence, Ophthalmology, Orthopedics, Pathology Services, Radiology & Imaging Services, Rehabilitation Services, Research, Respiratory Services, Robotics and Minimally Invasive Treatment, Sleep

¹ Montiel LM, Nathan RP, Wright DJ. "An Update on Urban Hardship", Nelson A. Rockefeller Institute of Government, 2004.

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Disorders Center, Stroke Program, Surgical Services, Technology, Women's Services, and Wound Care Center.

In FY 12, SJO Community Clinics provided medical, dental and vision services to **17,123 individual patients** and **19,873 patient encounters**. The Joint Clinic Health Education Program, El Club de Salud provided a total of **4,877 health education encounters**. **Five hundred seventy one (571) new patients** enrolled in El Club de Salud Program. This was the result of multiple efforts by Health Education and clinic staff in identifying patients that would benefit from El Club chronic disease management and health education activities. **Sixteen percent (16.2%)** of SJO students from the Childhood Obesity Prevention and Intervention Program, Healthy for Life, decreased their weight status to a healthier category (93 of 575). The percentage of **dental treatment completion** for low-income children by year end was 36%. The Postpartum Depression Program (PPD), the only screening and treatment hospital-based program in Orange County, screened 700 women for PPD. Of those who began treatment, 100% recovered from postpartum depression.

In FY 12, SJO provided **\$62,832,581 for community benefit programs/activities**. This includes services for the poor, vulnerable and at risk populations as well as for the broader community. Unpaid costs of **Medicare totaled \$20,470,171**.

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, St. Joseph Hospital Orange has a **Patient Financial Assistance Program** that provides free or discounted services to eligible patients. In FY 12, SJO provided **\$10,722,862 in charity care to 24,846 persons served**.

St. Joseph Health, St. Joseph Hospital Orange enhanced its process for determining charity care by adding an assessment for presumptive charity care. This assessment uses a predictive model and public records to identify and qualify patients for charity care, without a traditional charity care application.

Community Plan Priorities

The following information provides a brief summary of accomplishments associated with each of the four Community Benefit Initiatives for FY 12:

Initiative #1: Access to Primary Care

- La Amistad Medical, Puente a la Salud Medical and Vision services provided a combined total of **12,828 patient encounters** to the Disproportionate Unmet Health Needs (DUHN) population in the hospital's Community Benefit Service Area.
- **376 patients** received low-cost prescription frames (cost per frame is \$6 - \$16).

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- **110 patients diagnosed with Glaucoma** received Perimeter Testing (using new grant funded equipment).
- Puente Case Management provided **110 patients with one on one** specialty care referrals for patients needing surgeries.

Initiative #2: Access to Dental Care

- The average number of **preventive dental treatment encounters** provided to children and adults was 1.1 visits per year.
- The average number of **restorative dental treatment encounters** provided to children and adults was 1.2 visits per year.
- The percentage of **dental treatment completion** for children by year end was 36%.
- La Amistad Dental Clinic provided **2,388 patients** with **3,297 dental encounters**.
- Puente a la Salud Pediatric Dental Mobile Clinic provided **1,386 children** 0-18 with **1,662 dental encounters**.

Initiative #3: Wellness, Prevention and Intervention

- **Sixteen percent (16.2%)** of SJO students decreased their weight status to a healthier category (93 of 575).
- **Twenty one percent (21.5%)** of the diabetic participants decreased their Hemoglobin A1C level by at least one percentage point over the 12-month period.
- **Forty four percent (44.7%)** of the diabetic participants experienced an improvement of at least 0.1% point in the same timeframe.
- **Twenty one (21%)** of cardiovascular screening participants were screened and referred for treatment to appropriate clinic partners.

Initiative #4: Postpartum Depression Program

- **100% of mothers** who entered treatment for Postpartum Depression recovered.
- On average, **5 sessions** were provided to mothers who completed treatment.
- **100% of mothers** who required medication during the program recovered from postpartum depression.
- PPD provided **700 individual and/or group sessions** to mothers with postpartum depression.

INTRODUCTION

Who We Are and What We Do

For over 80 years, St. Joseph Health, St. Joseph Hospital of Orange (referred to in this document at St. Joseph Hospital Orange (SJO)) 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, SJO is a 525-bed not-for-profit, acute care facility with approximately 3,800 employees and 971 physicians on Staff. SJO has the second busiest Emergency Room in the state of California and the busiest in Orange County (101,945 visits). It is the first in Orange County and second in the State of California for surgical volume (28,027 procedures). SJO is second in Orange County for the number of deliveries (5,149 live births), and first in Orange County for cardiac catheterizations (3,221).

SJO provides a comprehensive range of services, centers and programs: Anesthesia Services, Bariatric Surgery Program, In-patient Behavioral Health Services, Blood Donor Center, The Center for Breast Imaging and Diagnosis, The Center for Cancer Prevention and Treatment, Clinical Education, Colorectal Program, Emergency, Endoscopy, Heart and Vascular Center, Home Health, Kidney Dialysis Center, Kidney Transplant Center, Maternity, Minimally Invasive Urology & Stone Center, Nasal & Sinus Center, Neurosurgical Services, Nursing Excellence, Ophthalmology, Orthopedics, Pathology Services, Radiology & Imaging Services, Rehabilitation Services, Research, Respiratory Services, Robotics and Minimally Invasive Treatment, Sleep Disorders Center, Stroke Program, Surgical Services, Technology, Women's Services, and Wound Care Center.

In FY 12, SJO provided **\$62,832,581 for community benefit programs/activities**. This includes services for the poor, vulnerable and at-risk populations as well as for the broader community. Unpaid costs to **Medicare totaled \$20,470,171**.

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

- ✚ The California Hospital Assessment and Reporting Taskforce (CHART) presented St. Joseph Hospital with a third consecutive "Certificate of Excellence" based on quality data through August 2010. Only three Orange County hospitals earned the accolade.
- ✚ In the October 2010 issue of *Consumer Reports*, thoracic and cardiovascular surgeons based at St. Joseph Hospital were listed as one of the nation's top 50 groups, one of the three top groups in California, and were the only group in Orange County named. This was the first ever rating of doctors in *Consumer Reports*.
- ✚ *U.S. News & World Report* has recognized St. Joseph Hospital as one of the top hospitals in Los Angeles/ Orange County for 2011, providing clinical excellence in seven specialties.

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- ✚ 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.
- ✚ St. Joseph Hospital was named among the top 60 hospitals in the nation for its outstanding orthopedic program by *Becker's Hospital Review*.
- ✚ St. Joseph Hospital has been named one of Orange County's most trusted brands in 2010 and 2011, based on an independent survey of consumer attitudes and opinions conducted by The Values Institute at Santa Ana-based DGWB Advertising and Communications and *OC METRO*.

In FY 12, our community benefit programs provided direct medical services, offered preventive care and education, and participated in various collaborative partners to deliver a greater impact on the communities we serve. One example of such success is the Joint Health Education Program, El Club de Salud. In its 5th year, El Club de Salud identifies behaviors related to such things as diet, exercise and stress management that contribute to a patient's risk for serious chronic disease – especially diabetes. El Club provides ongoing education, activities and personal support to participants to help them achieve individual health improvement goals that each of them develops with their healthcare provider at SJO Community Clinics. The following is provided by the program's Health Educator.

Back in 2010 a patient by the first name of Otilia was told at La Amistad Clinic that her blood sugars were starting to become elevated. Unfamiliar with diabetes and its consequences she was unnerved and became concerned. At the time she was overweight, did not have the best eating and exercise habits and was unsure of what to do to control her blood sugar level. During the consult at the clinic she asked her medical provider for guidance and she was then referred to Patty's education classes. Patty is El Club's Health Educator. The patient called Patty and they spoke via telephone. The patient expressed that although she was very interested in attending the classes, transportation was an issue. Patty then proposed that they begin to have education classes via telephone and the patient agreed. The patient diligently tracked everything she ate and would call Patty to report back. They spoke regularly on the phone for a little over a month. By the time she was due for lab work again (about 3 months later) her blood sugar levels had decreased and she had lost a significant amount of weight (roughly 30 lbs.). The patient has since kept the weight off and her daughters, as well as her husband, have drastically changed their eating habits. Currently, the patient attends the group Diabetes classes as well as Cooking Demo and Exercise Class. Patty states that one of the things that stand out for her about this particular patient is her determination and desire for change. All she needed was a little encouragement and some guidance to reach her goal of better health. Patty shared that she fondly remembers that shortly before Mother's Day the patient called her to check in and she excitedly shared how her kids had asked what she wanted for Mother's Day and she had requested a bicycle to exercise, and she got it!!

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, St. Joseph Hospital Orange has a **Patient Financial Assistance Program** that provides free or discounted services to eligible patients. In FY 12, SJO provided **\$10,722,862 in charity care to 24,846 persons served.**

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Community Benefit Governance Structure

The Community Benefit Committee meets six times a year. Two of the hospital's senior Executive Management Team (EMT) members serve on the Community Benefit Committee: the Chief Executive Officer/ President and the Vice President of Mission Integration. The Community Benefit Committee consists of at least eight (8) members. The Committee includes at least three (3) members of the Board of Trustees. A majority of the Committee consists of members from the community who have knowledge and experience with populations who have Disproportionate Unmet Health Needs. The Trustees and EMT receive regular updates on Community Benefit Programs' progress and outcomes status. Per the new Community Benefit Committee Charter, this fiscal year, the Committee's involvement with Community Benefit programs included overseeing and providing general direction to the Hospital's Community Benefit activities including:

- a. Budgeting decisions- Review, approve, and recommend the Care for the Poor budget and all community benefit expenditures annually.
- b. Program content- Review, approve, and recommend new community benefit program content.
- c. Program design- Review, approve, and recommend overall program design that will best meet the need of the community(ies) served.
- d. Geographic/population targeting- Insure that community benefit programs target communities with disproportionate unmet health needs in the service area of the Corporation.
- e. Program continuation/termination- Review and recommend programs for continuation/ discontinuation annually.
- f. Fund Development support- Identify funding sources and partnerships for community benefit programs. Provide letters of support or introduction as appropriate.
- g. Community wide Engagement- Assure effective communication and engagement of diverse stakeholders in community benefit planning and implementation.

Overview of Community Needs and Assets Assessment

The Orange County Health Needs Assessment (OCHNA) is a community-based, not-for-profit collaborative that was created and designed to meet the requirements of SB697 for all not-for-profit hospitals in Orange County; the collaborative is jointly funded by the Health Care Agency of Orange County, the Children and Families Commission, CalOptima, and the nine Orange County not-for-profit HASC member hospitals.

Due to the economic downturn, county hospitals and governmental partners were unable to provide sufficient funding to conduct the random digit dial telephone survey of 5,000 households for the Orange County 2010 health needs assessment. An alternative needs assessment plan was developed that incorporated a mix mode approach to data collection that included a trend analysis of four previous OCHNA health needs surveys (1998, 2001, 2004, and 2007), as well as additional primary data from the Census Bureau's American Community Survey and the California Health Information Survey. Population estimates for OCHNA 1998 and 2001 were updated with the latest estimates from the State of California Department of Finance, so the estimates provided for the county will differ from county estimates provided in previous reports released by OCHNA. In addition, OCHNA incorporated objective/secondary data sources, demographics/census data, and a key informant survey that OCHNA administered online, to be used as the source of qualitative data.

Objective/secondary data came from numerous sources (all cited within the report), including Dept. of Finance, 2009 Census estimates by Nielsen Claritas, Orange County Health Care Agency, and Healthy People 2010 (used as benchmarks). Qualitative data was obtained through a key informant survey of community based organizations, foundations, health advocates, community clinics, local political/policy leaders, public health organizations, and other hospitals.

In addition, OCHNA conducted a web-based survey for key informants (local health care leaders) in the community. Key informants provided their opinions about the health needs of the county, barriers faced by patients accessing care, challenges in the county health care system, as well as the forms and quality of collaborative relationships among their organizations, service area hospitals and other groups.

SJO's Community Benefit Service Area (CBSA) strictly focuses on the most vulnerable members of our community and it is comprised of key communities and zip codes where health disparities and socioeconomic indicators demonstrate the highest need and significant barriers to health care access.

These communities and zip codes include: Santa Ana (92701, 92703, 92704, 92706, 92707); Anaheim (92801, 92802, 92804, 92805, 92806, 92807); Garden Grove (92840, 92841, 92843, 92844); Orange (92865, 92866, 92867, 92868, 92869); Tustin (92780, 92782); Westminster (92683) Costa Mesa (92626, 92627); Huntington Beach (92647); Stanton (90680)

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Secondary CBSA include: Fullerton (92831, 92832, 92833, 92835); Placentia (92870); La Habra (90631); Brea (92821); Buena Park (90620, 90621).

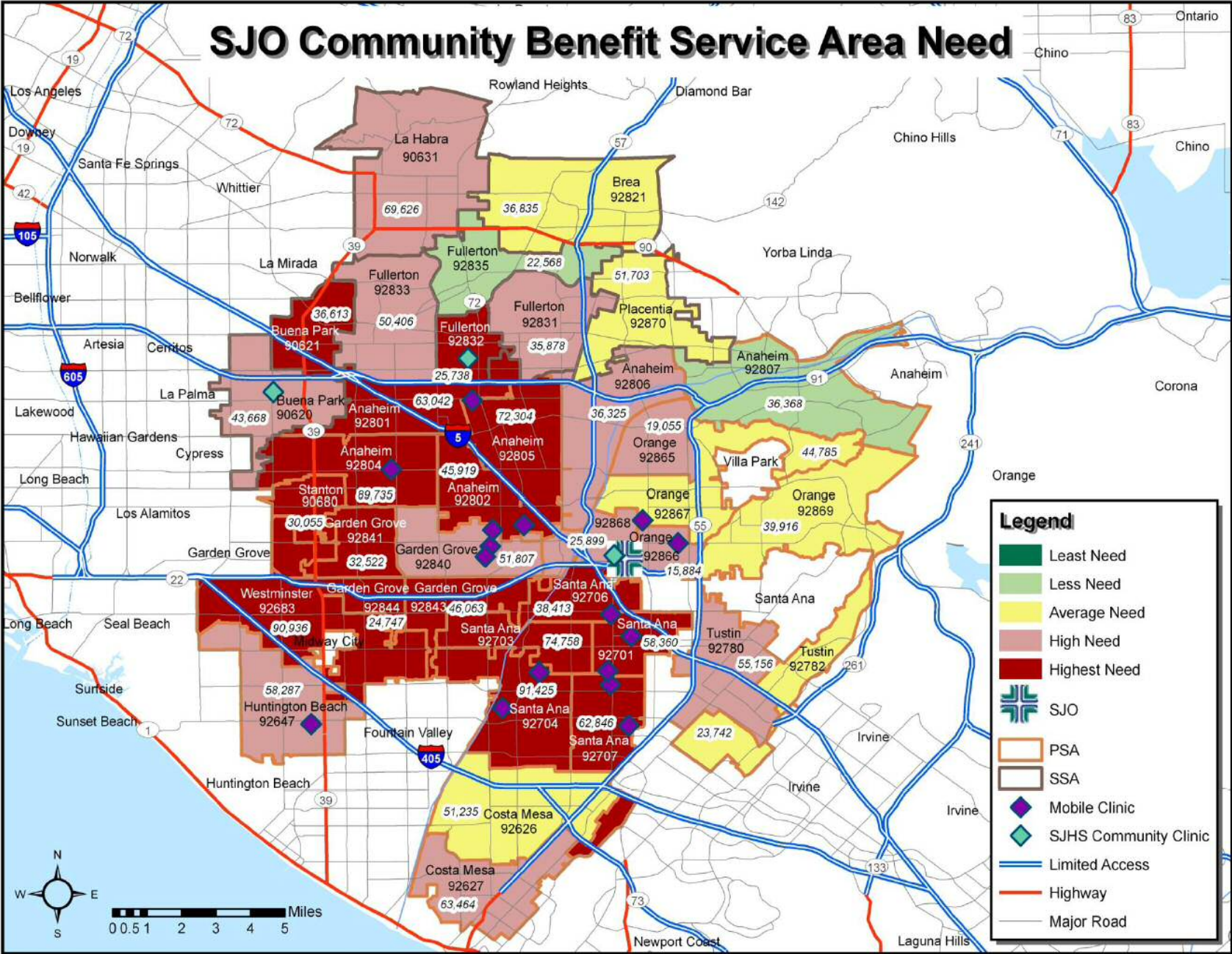
Community Benefit are programs or activities that promote health and healing in response to identified community needs. In order to accurately define community need, we used two tools provided by St. Joseph Health. The first tool, The Community Need Index (CNI) was developed by Catholic Healthcare West (CHW) and Solucient (an information products company). CNI aggregates five socioeconomic indicators that contribute to health disparity (also known as barriers). Barriers include: Income; elder poverty, child poverty and single parent poverty; Culture, non-Caucasian limited English; Education, % population without HS diploma; Insurance, unemployed and uninsured; and Housing, renting percentage.

CNI demonstrates need at the zip-code level where each zip is assigned a score from 1 (low need) to 5 (high need) for each barrier. For barriers with more than one measure, the average of the measures is used as the barrier score. Once each zip code is assigned a score from 1 to 5 for each of the five barriers, the average score is calculated to yield the CNI.

Color-Coded Maps

- **Red- Highest Need (CNI scores: 4.2-5)**
- **Pink- High Need (CNI scores: 3.4-4.1)**
- **Yellow- Average Need (CNI scores: 2.6-3.3)**
- **Light Green- Less Need (CNI Scores: 1.8-2.5)**
- **Dark Green- Least Need (CNI Scores: 1-1.7)**

The second tool, Intercity Hardship Index (IHI) was developed by the Urban & Metropolitan Studies Program at the Nelson A. Rockefeller Institute of Government. IHI aggregates six socioeconomic indicators that contribute to health disparity (at the block group level). Indicators include: Income level, per capita Income; Crowded Housing, % of households with 7+ people; Unemployment, % of those 16 and over without employment; Education, % of those 25 and over without a HS diploma; Poverty, % of people living below FPL; and Dependency, % of the population under 18 years and over 64 years.



Source: Community Need Index, Catholic Healthcare West, 2011

Prepared by the St. Joseph Health System Community Health Department

ST. JOSEPH HOSPITAL, ORANGE

FY 12 – FY 14 Community Benefit Plan/Implementation Strategies

FY 12 CB Priority Initiatives Accomplishments

Initiative Name: *Access to Primary Care*

Key Community Partners: *Corbin FRC, Santa Ana; Friendly Center, Orange; St. Ann’s Catholic Church, Santa Ana; Delhi FRC, Santa Ana; Lestonnac Free Clinic, Orange; American Diabetes Association; Braille Institute; OC Health Care Agency, Santa Ana; St. Jude Neighborhood Health Center, Fullerton; Latino Health Access, Santa Ana; Children’s Health Initiative of Orange County.*

Scope: *Disproportionate Unmet Health Need (DUHN) population (low-income adults and children) living in the hospital’s Community Benefit Service Area.*

Goal: *Expand access to primary care to residents at or below 200% FPL in the SJO Community Benefit Service Area.*

How will we measure success?: *The total number of unduplicated patients served (medical and vision).*

Three-Year Target: *Increase total number by 5%.*

Strategy 1: *Partner with community sites in Santa Ana and Anaheim where mobile medical and vision services can be provided.*

Strategy Measure 1: *Number of site partnerships as established by Memorandum of Understanding.*

Strategy 2: *Provide Medical Services for adults.*

Strategy Measure 2: *Number of patient encounters in Medical Services.*

Strategy 3: *Provide Vision screening, treatment for eye disease and injury, and optical supplies including corrective lenses and frames.*

Strategy Measure 3: *Number of optometry visits for eye disease, injury and refractive error.*

Strategy 4: *Provide individualized education about treatment plan for vision and eye care at patient visits.*

Strategy Measure 4: *% of participants who adhere to treatment plans.*

Strategy 5: *Provide enrollment assistance and care coordination for low-income children in appropriate health insurance programs.*

Strategy Measure 5: *Number of low-income children enrolled in appropriate health insurance programs.*

FY 12 Accomplishments: The goal of increasing access to the underserved population was achieved through La Amistad Medical services and Puente Medical & Vision services. The number of unduplicated patients served by Medical and Vision services totaled **12,828**. A total of **376 patients** received low-cost prescription frames (cost per frame is \$6 - \$16). Puente Medical and Vision mobile services engaged 5 new community partners to provide access to care to the underserved in their communities. Adult

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patients receiving medical services totaled **11,900**. On average, **83%** of diabetic patients completed their annual eye exam. The number of low-income children enrolled in appropriate health insurance programs totaled **2,045**.

Initiative Name: Access to Dental Care

Key Community Partners: *Crittenton Family Services, Fullerton; Northgate Gonzalez Supermarket, Anaheim; Valley High School, Santa Ana; Parkview Elementary School, Garden Grove; Oakview Preschool, Huntington Beach; Ponderosa FRC and School, Anaheim and Garden Grove city line; Garfield Elementary School, Santa Ana; Santa Ana Police Officers Association, Santa Ana; and Corbin FRC, Santa Ana; Healthy Smiles of Orange County.*

Scope: *Disproportionate Unmet Health Need (DUHN) population living in the hospital's Community Benefit Service Area.*

Goal: *Reduce dental decay prevalence among low-income residents in SJO Community Services Area.*

How will we measure success?: *% of children and adults with dental caries (cavities).*

Three-Year Target: *Decrease by 34.8% of dental caries to meet National/State and Local benchmarks.*

Strategy 1: *Provide preventive dental treatment to children.*

Strategy Measure 1: *# of preventive dental treatment provided to children.*

Strategy 2: *Provide restorative dental treatment to children.*

Strategy Measure 2: *# of restorative dental treatment provided to children.*

Strategy 3: *Ensure complete dental treatment for children.*

Strategy Measure 3: *% of dental treatments completed for children.*

Strategy 4: *Provide restorative dental treatment for adults.*

Strategy Measure 4: *# of restorative dental treatment provided for adults.*

Strategy 5: *Collaborate with new community partners focused on children's oral health.*

Strategy Measure 5: *Number of new collaborative.*

FY 12 Accomplishments: The percentage of children and adults with caries was **39%** by year end compared to 43% at baseline. The average number of preventive dental treatment encounters provided to children and adults was 1.1 visits per year compared to baseline at 1.3 visits per year. The average number of restorative dental treatment encounters provided to children and adults was 1.2 visits per year compared to baseline at 1.5 visits per year. The percentage of dental treatment completion for children by year end was **36%** compared to 43% at baseline. Puente Dental mobile services engaged 7 new collaborative partners to provide access to care to the underserved in their communities.

Initiative Name: *Wellness, Prevention and Intervention*

Key Community Partners: *Local Unified School Districts in OC; Family Resource Centers in OC; SJO Heart and Vascular Center and Puente a la Salud Mobile Clinics; The Cambodian Family, Jamboree Housing, and Alta Med to provide technical and advisory support for the Office of Minority Health Partnerships Active in Communities (PAC) to Achieve Health Equity Grant.*

Scope: *Disproportionate Unmet Health Need (DUHN) population (adults and children) living in the hospital's Community Benefit Service Area.*

Goal: *Improve health of residents living in the SJO Community Benefit Service Area by reducing their risk of negative health outcomes.*

How will we measure success?: *Percent of persons defined as at risk of negative health outcomes.*

Three-Year Target: *Decrease persons at risk by 33%.*

Strategy 1: *Reduce childhood obesity by promoting a healthier lifestyle.*

Strategy Measure 1: *# of children who maintain or decrease their Body Mass Index (BMI).*

Strategy 2: *Use clinical measures to determine health improvement associated with behavioral changes for diabetic population.*

Strategy Measure 2: *# of patients diagnosed with diabetes that decrease their Hemoglobin A1C by at least one percent point from baseline.*

Strategy 3: *Educate population diagnosed with diabetes on the value of encouraging family members to eat better and exercise more.*

Strategy Measure 3: *# of patients diagnosed with diabetes who report that information received in program resulted in a positive health behavior change within their family.*

Strategy 4: *Provide access to cardiovascular education, screening and treatment.*

Strategy Measure 4: *Number of cardiovascular screenings and treatment referrals to appropriate clinic partners.*

Strategy 5: *Collaborate with new community partners focused on chronic disease risk reduction.*

Strategy Measure 5: *Number of new collaborations with key community partners.*

FY 12 Accomplishments: The percentage of persons defined as at risk for negative health outcomes was 55% compared to 45% at baseline. The 10% increase of at risk persons is due to multiple efforts to identify persons at risk. For instance, the Cardiovascular Screening Program increased the number of community sites where they provided care increasing the number of persons identified at risk. **Twenty one (21%)** of cardiovascular screening participants were screened and referred for treatment to appropriate clinic partners. **Sixteen percent (16.2%)** of SJO students decreased their weight status to a healthier category (93 of 575). **Twenty one percent (21.5%)** of the diabetic participants decreased their A1C level by at least one percentage point over the 12-month period. While overall, 44.7% of the

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diabetic participants experienced an improvement of at least 0.1% point in the same timeframe. Of the 445 diabetic participants, **400 (90.5%)** agreed that their participation in El Club Program resulted in a positive health change within their family. Community Benefit Programs addressing at risk populations **engaged 5 new collaborative partners** to provide access to care to the underserved in their communities.

Initiative Name: Postpartum Depression Program

Key Community Partners: MOMS of Orange County; local physicians (OBGYNs and Pediatricians); SJO inpatient psychiatry unit; and SJO Mother Baby Assessment Center.

Scope: Mothers who deliver at SJO who are a) screened by Bridges Program using a psycho-social screening tool, and b) are at 10 or above on the Edinburgh scale prior to discharge; or any mothers referred by physicians; and any mothers referred Bridges or other professionals.

Goal: To reduce postpartum maternal depression.

How will we measure success?: The percent of clients who have recovered from Postpartum Depression.

Three-Year Target: 100% of mothers recover.

Strategy 1: Increase # of sessions per client in treatment.

Strategy Measure 1: Average # of session per client in treatment.

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

Strategy Measure 2: % of improvement/recovery score for women who are taking medication and those who are not taking medication.

Strategy 3: Reduce the financial burden to clients.

Strategy Measure 3: Average financial cost to the patient for treatment. Excludes FAP qualifying patients.

FY 12 Accomplishments: **100% of mothers** who entered treatment for Postpartum Depression recovered compared to 85% at baseline. On average, **5 sessions** were provided to mothers who completed treatment. PPD implemented a low cost fee program for individual and group sessions in an effort to reduce the financial burden to clients. **100% of mothers**, who required medication during the program, received appropriate medication, used their medication, and recovered from postpartum depression. PPD provided **700 individual and/or group sessions** to mothers with postpartum depression.

Community Benefit Investment FY 2012

FY12 COMMUNITY BENEFIT INVESTMENT
ST. JOSEPH HEALTH, ST. JOSEPH HOSPITAL OF ORANGE
(ending June 30, 2012)

CA Senate Bill (SB) 697 Categories	Community Benefit Program & Services ²	FY12 Net Benefit
Medical Care Services for Vulnerable³ Populations	Financial Assistance Program (FAP) (Charity Care-at cost)	\$10,722,862
	Unpaid cost of Medicaid ⁴	\$32,061,431
	Unpaid cost of other means-tested government programs	\$5,037,675
Other benefits for Vulnerable Populations	Community Benefit Operations	\$0
	Community Health Improvements Services	\$5,582,941
	Cash and In-Kind contributions for Community Benefit	\$174,805
	Community Building	\$0
	Subsidized Health Services	\$1,886,379
Totals Community Benefit for the Vulnerable		\$55,466,093
Other benefits for the Broader Community	Community Benefit Operations	\$492,381
	Community Health Improvements Services	\$4,555,960
	Cash and In-kind Contributions for Community Benefit	\$0
	Community Building	\$0
	Subsidized Health Services	\$109,458
Health Professions Education, Training and Health Research	Health Professions Education, Training & Health Research	\$2,208,689
	Total Community Benefit for the Broader Community	\$ 7,366,488
TOTAL COMMUNITY BENEFIT (excluding Medicare)		\$62,832,581
Medical Care Services for the Broader Community	Unpaid cost of Medicare ⁵ <i>(not included in CB total)</i>	\$20,470,171
TOTAL COMMUNITY BENEFIT (including Medicare)		\$83,302,752

² Catholic Health Association-USA Community Benefit Content Categories, including Community Building.

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 Medicaid, Medicare, California Children's Services Program, or county indigent programs. For SJH, we exclude Medicare as part of Community Benefit total and only include it below the line for SB697 reporting purposes.

⁴ Accounts for Hospital Fee. The pledge/grant (separate from the quality assurance fee) is reported in Cash and In-kind Contributions for other vulnerable populations.

⁵ Unpaid cost of Medicare is calculated using our cost accounting system. In Schedule H, we use the Medicare cost report.

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

SJO's Executive and Management Team members lent 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.

- Chair for the Southern California region of Hospital Association of Southern California
- Board of Trustees member for Taller San Jose
- Western University Advisory Board member and California State University, Fullerton Advisory Board member
- California Hospital Patient Safety Organization Board member
- Southern California Association for Healthcare Risk Management Board member
- Children's Health Initiative of Orange County Advisory Committee member
- El Sol/SOS Wellness Center Advisory Committee
- Orange County Coalition of Community Health Centers member
- Bethany House Board member
- Casa Teresa Board member
- CNI Career Network Institute Advisory Board member
- California State University, Fullerton Nursing Advisory Board member
- MOMS of Orange County Board member
- Sigma Theta Tau Nursing Honor Society Board member
- Leadership Orange Executive Committee member
- Chairman of Health Associates Federal Credit Union Board member
- National Philanthropy Day Committee
- Association of Fundraising Professionals, Orange County Board member
- National Renal Administrators Association Board member
- National Kidney Foundation Public Policy Committee
- Association for the Advancement of Medical Instrumentation- Board member Water Treatment and Dialysis Equipment
- Kidney Care Partners Advocacy Committee
- Orange County of the Association for Clinical Laboratory Management
- Pet Therapy Program volunteer
- No One Dies Alone Program volunteer
- Volunteer Advisory Board member
- Mock interviewer volunteer for Taller San Jose
- National Kidney Foundation Council of Nephrology Nurses & Technicians Executive Committee Board member
- Renal Disease and Detoxification Committee
- Home Care Applications Committee
- Fistula First Breakthrough Initiative
- County of Orange Health Care Agency Dialysis Advisor
- Focus Orange County volunteer
- Endoscopy and Surgery Center staff volunteer for Access OC (free surgeries for the uninsured)
- Association of Fundraising Professionals Orange County Board member
- Advisory Council, State of California, Breast and Cervical Cancer Chair
- American Liver Foundation Greater LA and Orange County Medical Advisory Board
- Physician Engagement Team Member, American Cancer Society, California Division

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

St. Joseph Health

**500 S. Main St., Ste. 1000
Orange, CA**

<http://www.stjhs.org/>

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