2023

COMMUNITY BENEFIT REPORT/

PROGRESS ON 2021-2023 COMMUNITY HEALTH IMPROVEMENT PLAN

Providence St. Jude Medical Center

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Providence

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EXECUTIVE SUMMARY

Providence 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, California. The hospital's service area is the entirety of 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. In FY23, the hospital provided $54,377,417 in Community Benefit in response to unmet needs. For FY23, Providence St. Jude Medical Center had an unpaid cost of Medicare of $95,776,607.

2021-2023 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 focused on the following areas for its 2021-2023 Community Benefit efforts:

PRIORITY 1: MENTAL HEALTH AND SUBSTANCE ABUSE

Improved system to access mental health and substance use services to ensure that patients received care at the appropriate level of care not in the Emergency Department, reduced mental health stigma in the community and increase in resources for youth.

2023 Accomplishments

A success this year included St. Jude Medical Center and Be Well leadership establishing a protocol/pathway with the residential rehabilitation program to design a seamless referral process to decrease avoidable ED visits. A Charge Nurse at Be Well will be informed if any SJMC patients are declined admission and will escalate approval. There's a new substance use treatment program that SJMC can refer to as well. The program includes withdrawal management and sobering as well as a detox program. In addition, Be Well's new mobile van is operated by Care Navigation and opens 7 days a week, 8AM-8PM. The van will pick up patients and transport them to Be Well. The MAT Program continues to be fully implemented in the hospital Emergency Department since 2021. Emergency Room implemented community Naloxone distribution. 726 patients received MAT services in the ED. Promise to Talk acquired 5.3M impressions across all social media and web platforms during FY23. The year ended with 53,215 total encounters and 995 total promises. Provided a total of 114 Psychiatry visits to St. Jude Neighborhood Health Centers in Fullerton and Anaheim sites.

PRIORITY 2: ACCESS TO CARE AND CARE NAVIGATION

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

2023 Accomplishments

In FY23 there were delays in construction due to COVID-19 supply chain challenges that moved date of the opening of the Ponderosa Park site of St. Jude Neighborhood Health Centers, the site opened July 1, 2022. The Manchester site of the St. Jude Neighborhood Health Centers is still on target to finish construction at the end of 2023 and slated to open in March of 2024. COVID-19 required that the clinic pivot to virtual operations since then tele-health visits have helped decrease barriers in accessing care. In FY23 approximately 18% of clinic visits were virtual. St. Jude Neighborhood Health Center provided 27,734 primary care, dental, and mental health visits to the uninsured and underinsured population of North Orange County.

PRIORITY 3: HOMELESSNESS AND AFFORDABLE 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.

2023 Accomplishments

In FY23, 807 housing champions were trained by our partners OC United Way and OC People for Housing/YIMBY and engaged in housing element work to promote stronger policies that will result in affordable housing. In FY23, two new housing developments opened and one broke ground June 2023, adding a total of 60 affordable housing and 106 permanent supportive housing units in OC. As a result of these efforts 913 people have been housed through WelcomeHomeOC. 43,044 individuals have been engaged through public awareness and education and 135 property owners are in the network.

PRIORITY 4: HEALTH EQUITY AND RACIAL DISPARITIES

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

2023 Accomplishments

The Move More Eat Healthy Initiative continued in a virtual format to reach low-income families providing 24,007 encounters. The Fitnessgram results for body composition is no longer collected in the State of California. However, we have gained commitment from schools to survey 5th grade students.

The Medical Center is working with HASC/Communities Lifting Communities, the County of Orange Health Care Agency and other partners to align efforts for collective impact.

Providence

At Providence, we use our voice to advocate for vulnerable populations and needed reforms in health care. We are also pursuing innovative ways to transform health care by keeping people healthy, and making our services more convenient, accessible and affordable for all. In an increasingly uncertain world, we are committed to high-quality, compassionate health care for everyone – regardless of

coverage or ability to pay. We help people and communities benefit from the best health care model for the future – today.

Together, our 117,000 caregivers (all employees) serve in 51 hospitals, 1,000 clinics and a comprehensive range of health and social services across Alaska, California, Montana, New Mexico, Oregon, Texas and Washington.

Providence across five western states:

- Alaska
- Montana
- Oregon
- Northern California
- Southern California
- Washington

The Providence affiliate family includes:

- Covenant Health in West Texas
- Facey Medical Foundation in Los Angeles, CA.
- Kadlec in Southeast Washington
- Pacific Medical Centers in Seattle, WA.
- Swedish Health Services in Seattle, WA.

As a comprehensive health care organization, we are serving more people, advancing best practices and continuing our more than 100-year tradition of serving the poor and vulnerable. Delivering services across seven states, Providence is committed to touching millions of more lives and enhancing the health of the American West to transform care for the next generation and beyond.

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 care hospital founded in 1957 and located in Fullerton, California. The hospital has 320 licensed beds, a staff of more than 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 Fiscal Year 2023 (July 1, 2022 – June 30, 2023), Providence St. Jude Medical Center provided $54,377,417 in Community Benefit[1] 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.

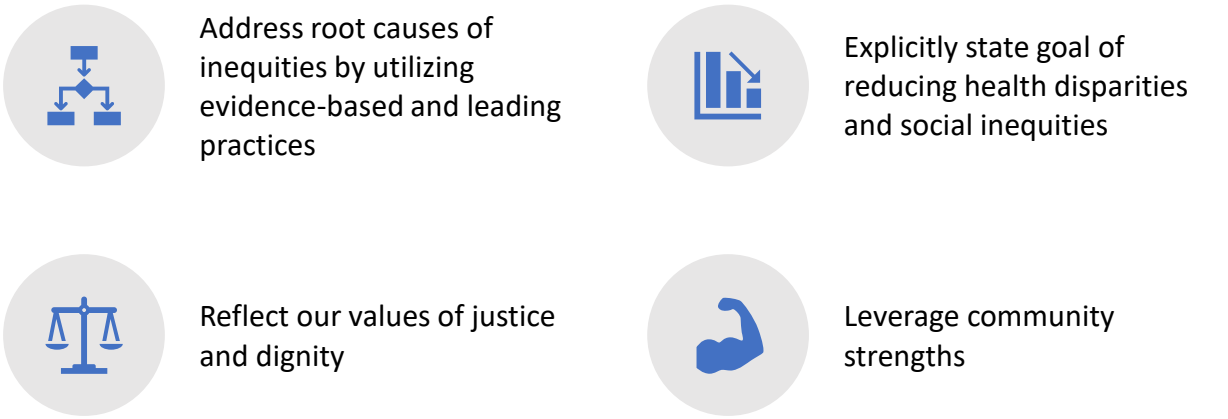
Health Equity

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 hospitals 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 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 17 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 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. In FY23, Providence St. Jude Medical Center provided $1,472,855 free (charity care) and discounted care.

Medi-Cal (Medicaid)

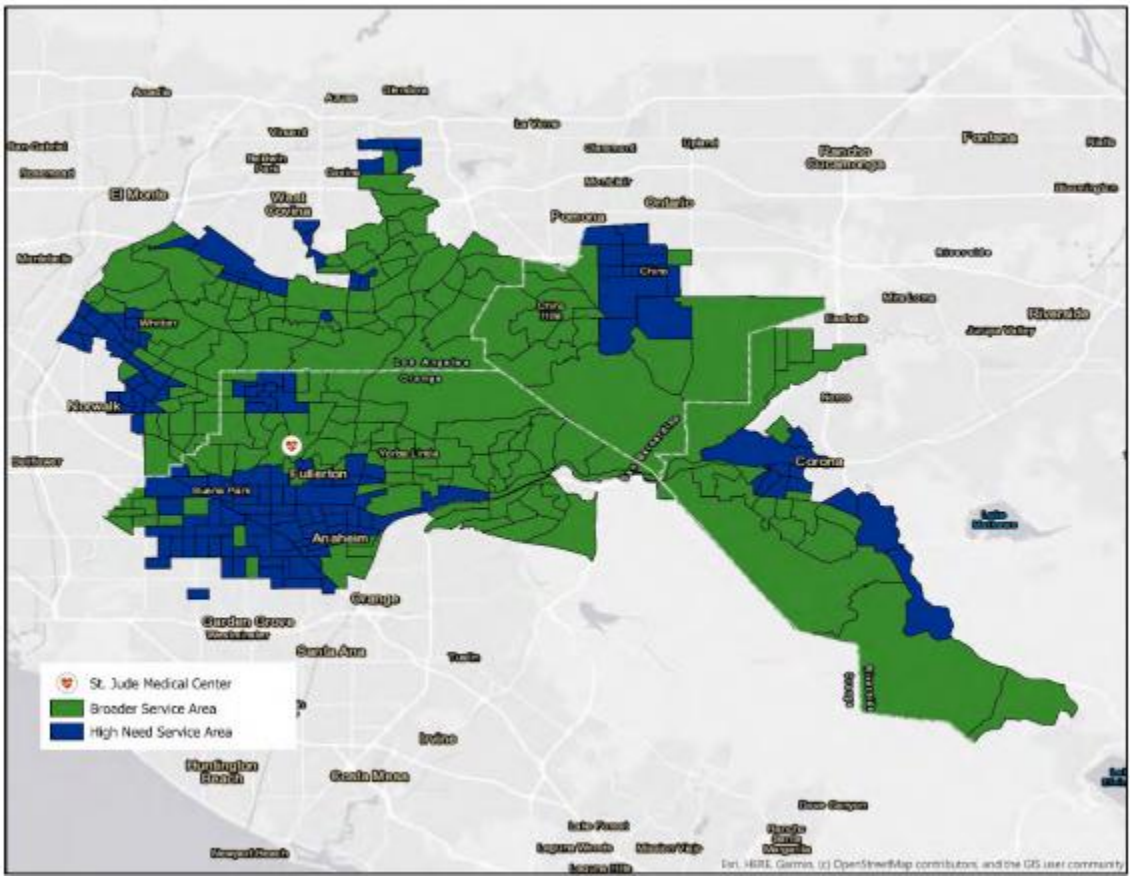
Providence St. Jude Medical Center provides access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California. In FY23, Providence St. Jude Medical Center provided $49,310,105 in Medicaid shortfall.

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's 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*** 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 July 15, 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 member 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 AND SUBSTANCE ABUSE

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

PRIORITY 2: ACCESS TO CARE AND CARE NAVIGATION

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

PRIORITY 3: HOMELESSNESS AND AFFORDABLE 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 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 Hope Builders 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. 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 technical assistance to 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 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.

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

2023 Accomplishments

COMMUNITY NEED ADDRESSED #1: MENTAL HEALTH AND SUBSTANCE ABUSE

Initiative Name

Access to Mental Health Services

Population Served

Underserved persons residing in Northern Orange County and adjacent parts of Los Angeles, Riverside and San Bernardino counties

Long-Term Goal(s)/ Vision

Improved system to access mental health and substance use services to ensure that patients receive care at the appropriate level of care not in the Emergency Department, reduced mental health stigma in the community and increase in resources for youth.

Table 2. Strategies and Strategy Measures for Addressing Mental Health and Substance Abuse

Strategy	Population Served	Strategy Measure	Baseline	FY23 Accomplishments
1. Participate in the Be Well Clinical Campus Steering Committee and ensure strong referral protocols are in place to reduce inappropriate 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 (chemical dependency)	FY2019 – 2,558 ED visits	SJMC and Be Well leadership established a protocol/pathway with the residential rehabilitation program to design a seamless referral process to decrease avoidable ED visits. A Charge Nurse at Be Well will be informed if any SJMC patients are declined admission and will escalate approval. There's a new substance use treatment program that SJMC can refer to as well. In addition, Be Well's new mobile van is operated by Care Navigation and open 7 days a week, 8AM-8PM. The van will pick up patients and transport them to Be Well.
2. Implement MAT Program in	Patients with opioid disorder	# of patients receiving MAT services in ED	0	726 patients received MAT services in the ED.

Emergency Department				Received Dept. of Health Care Services (DHCS) approval to implement Naloxone distribution to community from ED. Naloxone rapidly reverses an opioid overdose in emergency situations.
3. Adapt Each Mind Matters Campaign/Promise to Talk in response to COVID-19		# of residents active on the EMM/PTT social media site	12,898 in FY2020	53,215 total encounters and 995 total promises
4. Implement Work2BeWell Program	Middle and High School Students	# of schools engaged in Work2Be Well in North Orange County	0	Postponed due to COVID-19. Follow up will occur with Fullerton Joint Union High School District

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

Resource Commitment

$500,284 per year was invested for a Chemical Dependency Counselor, to support Each Mind Matters, grants for Psychiatry services for low-income population, Fullerton School District, and CSUF Center for Healthy Neighborhoods in FY23.

Key Community Partners

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.

2023 Accomplishments

A success this year included St. Jude Medical Center and Be Well leadership establishing a protocol/pathway with the residential rehabilitation program to design a seamless referral process to decrease avoidable ED visits. A Charge Nurse at Be Well will be informed if any SJMC patients are declined admission and will escalate approval. There's a new substance use treatment program that SJMC can refer to as well. The program includes withdrawal management and sobering as well as a detox program. In addition, Be Well's new mobile van is operated by Care Navigation and open 7 days a week, 8AM-8PM. The van will pick up patients and transport them to Be Well.

The MAT Program continues to be fully implemented in the hospital Emergency Department since 2021. Emergency Room implemented community Naloxone distribution. 726 patients received MAT services in the ED.

Promise to Talk acquired 5.3M impressions across all social media and web platforms during FY23. The year ended with 156,000 total encounters and almost 3,000 total promises. In December, Promise To Talk, continued to integrate GreenBenchOC.org into our content, featuring the launch on social media channels and on the Promise to talk website. To date GreenBenchOC.org represents 70% of the total website visits encouraging open conversations to reduce the stigma surrounding mental health. In the first six months since its launch, the website garnered nearly 3,500 visits and fourteen green benches were installed throughout North and South Orange County between July 2022 and June 2023. Building lasting partnerships with local organizations is key for making strong connections and a positive impact within the community. In 2022, Promise To Talk partnered with Tiger Woods (TGR) Learning Lab to participate in their Community Fest and Family Conversations about Mental Health. The success from this event led the TGR organization to install a green bench on their campus and celebrated the unveiling at the Empowered Wellness Fair in May 2023. Promise To Talk's participation in events such as the Wellness Fair, Día Del Niño hosted by UNIDOS South OC has resulted in meaningful conversations with community members who talk to us about their own struggles with mental health and make a promise to talk about these issues with a trusted friend or family member. These events also provide media coverage opportunities which help spread awareness with our target audiences. This campaign allows us to continue having important conversations with members of the community and create interest around the stigma reduction movement.

Provided a total of 114 Psychiatry visits to St. Jude Neighborhood Health Centers in Fullerton and Anaheim sites.

Preliminary discussions with school districts regarding Work2BeWell were initiated but due to COVID, the implementation was postponed.

COMMUNITY NEED ADDRESSED #2: ACCESS TO CARE AND CARE NAVIGATION

Initiative Name

Access to Care and Care Navigation

Population Served

Underinsured and uninsured in Orange County

Long-Term Goal(s)/ Vision

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

Table 3. Strategies and Strategy Measures for Addressing Access to Care and Care Navigation

Strategy	Population Served	Strategy Measure	Baseline	FY23 Accomplishments
1. Open the Ponderosa Park site in 2021	Low Income uninsured and underinsured persons	# visits	0	467 Behavioral health visits 731 Dental visits 1,142 Pediatric medical visits 233 OB/GYN visits 5,963 Adult medical visits (total 8,536 visits).
2. Open the Manchester site in 2023	Low Income uninsured and underinsured persons	Clinic opened # visits	Clinic not open	Not opened yet. Target date is March 2024
3. Assess the integration of virtual visits into clinic operations as a way to reduce barriers to care.	Low-income uninsured and underinsured persons	% of virtual visits at St. Jude Neighborhood Health Center	0 before COVID-19	18% of visits are virtual.

Evidence Based Sources

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

Resource Commitment

$181,153 was invested in Access to care and care navigation programs and grants in FY23.

Key Community Partners

St. Jude Neighborhood Health Centers, City of Anaheim, CHIOC

2023 Accomplishments

Ponderosa Park site of St. Jude Neighborhood Health Centers opened July 1, 2022. The Manchester site of the St. Jude Neighborhood Health Centers is currently under construction and expected completion is December 2023. Furniture and equipment are scheduled to move into the clinic in January 2024. The clinic is expected to officially open in March of 2024. COVID-19 required that the Fullerton clinic pivot to virtual operations since then tele-health visits have helped decrease barriers in accessing care. In FY23 approximately 18% of clinic visits were virtual. St. Jude Neighborhood Health Center provided 27,734 primary care, dental, and mental health visits to the uninsured and underinsured population of North Orange County.

Partnered with Community Health Initiative of Orange County (CHIOC) to enroll newly eligible Medi-Cal recipients 50+ year old. For the duration of the grant period, CHIOC faced several challenges and opportunities with education and enrollment of the new eligible population for Medi-Cal. They implemented text message campaigns for those individuals who were on emergency Medi-Cal and were going to shift to Full Scope Medi-Cal. They conducted Know Your Benefits education sessions to support and offer an understanding of CalOptima and choosing a managed care plan with Primary Care Doctor. The grant allowed CHIOC to open 4 older adults serving enrollment sites, such as Anaheim Senior Center, Brea Resource Center, H. Louis Senior Center to name a few. CHIOC was represented at several community events targeting this population such as flu clinics for the City of Tustin and senior summits hosted by county supervisors. Digital marketing was utilized to bring awareness about Medi-Cal expansion, especially on Facebook which is a platform the target market uses to get their news and stay informed. The 2 barriers that persist is the fear of Public Charge and many working older adults who are undocumented are not qualifying for Medi-Cal because they are over income. **Client Success Story:** Bertha, Health Access Assister saw one of her clients this week that has now been approved for Medi-Cal and is utilizing medical services. He is undocumented, 59-year-old diabetic who was having alcohol abuse issues. He shared with Bertha that he now is doing much better than when she helped him apply. He has his diabetes under control and has switched from his 40oz alcoholic beverage to a cup of coffee. He is very appreciative of the help he received and had a friend give him a ride to visit Bertha to thank her.

Deliverable- 920 enrollments of 50+ undocumented adults into Medi-Cal – Goal Met

- Successfully Enrolled 958

Deliverable-Care Coordination goal 3,680 – Goal Met

- Successful Care Coordination of 6,069 connections to health home and education of navigation of new health coverage

Deliverable-goal to reach 1,702 individuals- Goal Met

- Outreach to - 6,602

Deliverable- goal 230 satisfaction survey- Goal Met

- Completed 230

Community Need Addressed #3: HOMELESSNESS AND AFFORDABLE HOUSING

Initiative Name

Homelessness and Affordable Housing

Population Served

People experiencing homelessness and those on the brink of homelessness

Long-Term Goal(s)/ Vision

Reduce chronic homelessness by 2022 as measured by the rate of individuals experiencing chronic homelessness in the Annual Point in Time Count.

Table 4. Strategies and Strategy Measures for Addressing Homelessness and Affordable Housing

Strategy	Population Served	Strategy Measure	Baseline	2023 Accomplishment
1. Train a minimum of 100 additional housing champions in North Orange County cities.	Residents of Northern Orange County	# of housing champions trained in North Orange County	151	807 Housing Champions
2. Engage with housing champions in local city housing element public element to promote stronger policies in the 2021-2028 housing elements that will result in more	Resident engagement with Planning and City Council	# of cities with inclusionary housing ordinances and other strong policies promoting affordable housing in North OC	0	The OC Housing Finance Trust continues to work with existing partners. However, non-member cities are welcome to join. As of FY22, 35 cities committed to either conduct studies, adopt policies or programs to promote inclusionary housing ordinances, or increase the amount required for ordinances in

affordable housing.				the housing element
3. Support the approval of affordable housing projects in the pipeline so that at least 200 new units are built by 2023 in North Orange County.	Advocacy with Planning Commissions and City Councils.	# of affordable housing units built by 2023 in North Orange County	0	Two new housing projects opened and one broke ground. 166 units have been added and are in process
4. Continue homeless care navigation program and implement best practices identified in the region.	Chronic homeless	Decrease in administrative days in homeless population	N/A	566 days

Evidence Based Sources

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

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

Resource Commitment

A total of $250,000 was invested in the homeless and housing initiative in FY23.

Key Community Partners

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

2023 Accomplishments

In FY23, 807 housing champions were trained by our partners OC United Way and OC People for Housing, YIMBY and engaged in housing element work to promote stronger policies that will result in affordable and permanent supportive housing. Two new housing developments opened and one broke ground June 2023, adding a total of 60 affordable housing and 106 permanent supportive housing units in OC. As a result of these efforts 913 people have been housed through WelcomeHomeOC. 43,044

individuals have been engaged through public awareness and education and 135 property owners are in the network.

In **2019** based on the Point in Time Summary there were a total of **6,860 individuals** experiencing homelessness (North: 2,765 | Central: 3,332 | South: 763). In **2022** per the Point in Time Summary there were a total of **5,718** individuals experiencing homelessness (North: 2,419 | Central: 2,714 | South: 585) the data. According to The Point in Time Count (conducted by the Orange County Partnership to End Homelessness) 11% of individuals returned to homelessness from transitional housing within two years, a 9% reduction from 2022. While that's not to say that our efforts alone have impacted the reduction in homelessness, it speaks to the work that is being done to address it. We work closely with Case Management department. It is best practice for Case Managers to identify when delays of care/discharge occur by consistently tracking patient nights that may be avoidable and/or medically necessary long length of stay (MNLOS). In addition, we track, review, and update encounters, custodial days, discharge destinations, and resources provided.

The Homeless Care Navigation program continued with two care navigators who provided service to over 814 unique homeless clients with a total of 4,704 encounters. A regional homeless care navigator work group continues to meet to share the best practices and collect common metrics.

COMMUNITY NEED ADDRESSED #4: HEALTH EQUITY & RACIAL DISPARITIES

Initiative Name

Health Equity/Race Disparities

Population Served

Low-income people of color

Long-Term Goal(s)/ Vision

Reduce one health disparity selected by either the regional Health Equity Initiative or another regional equity initiative from a community perspective.

Table 5. Strategies and Strategy Measures for Addressing Health Equity

Strategy	Population Served	Strategy Measure	Baseline	2023 Accomplishment
1. Develop a plan to address one issue that interferes with the API population	Low Income uninsured and underinsured persons	Partner with one API CBO		SJMC partnered with Korean Community Services to provide mental health and substance use disorder services in north Orange County.

2. Increase the % of target schools whose Latino/a 5th graders have demonstrated improvement in the Healthy Fitness Zone for Body Composition	Low-income Latino 5th graders	% of schools whose Latino/a 5th graders have demonstrated improvement in the Healthy Fitness Zone for body composition	Will use school year 2019 HFZ data as baseline year	The Fitnessgram results for body composition is no longer collected in the State of California. However, we have gained commitment from schools to survey 5th grade students. SJMC will partner with schools in the coming school year to determine if we can collect and share data.
3. Align health equity work to address at least one community adopted equity initiative, such as HASC or HCA	Low-income population with health disparity	Partner with HCA		Worked with OC Health Care Agency to align health equity efforts to be included in upcoming CHNA and CHIP.

Evidence Based Sources

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

Resource Commitment

$103,231 was invested in grants addressing Health Equity and Racial Disparities Initiative.

Key Community Partners

Cities of Fullerton, Placentia, La Habra, Buena Park. Fullerton Collaborative, La Habra Collaborative, Placentia Collaborative, Buena Park Collaborative. Fullerton School District, La Habra Elementary School District, Buena Park School District, Placentia/Yorba Linda School District. Cal State Fullerton University. Equity in OC Taskforce.

2023 Accomplishments

The Move More Eat Healthy Initiative continued in a virtual format to reach low-income families providing 24,007 encounters. The Fitnessgram results for body composition is no longer collected in the State of California. However, we have gained commitment from schools to survey 5th grade students.

St. Jude Medical Center is working with HASC/Communities Lifting Communities, the County of Orange Health Care Agency and other partners to align efforts for collective impact.

Other Community Benefit Programs

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

Initiative (Community Need Addressed)	Program Name	Description	Population Served (Low Income, Vulnerable or Broader Community)	FY23 Accomplishments
1. Engaging community partners to address health disparities	Healthy Communities	Technical assistance to support community collaboratives	Low-income	5 community collaboratives are addressing disparities
2. Lack of public transportation	Transportation Program	Provide non-emergency medical transportation	Low-income	2,576 encounters
3. Lack of access to medical services	Post Hospital Transition Care for Indigent Patients	Hospital costs incurred to take care of indigent patients, both the uninsured and underinsured – including long-term facility, homecare, hospice, mental health,	Low-income	3 encounters

		ambulance fees and taxicab vouchers among others		
4. Lack of support services for frail elderly	Senior Services	Information and referrals, support groups, classes, Caring Neighbors Volunteer Program	Low-income	4,431 encounters
5. Need for professional nursing and ancillary professional staff in the community	Health Education Professions – Nursing, Rehabilitation, and Ancillary	Clinical rotations for nursing and rehabilitation students in med-surg, critical care, OB, OR leadership, and community health; clinical rotations for ancillary students in respiratory, labs and imaging	Broader Community	477 students served
6. Access to Care	Rehab Community Reintegration	Provides recreational, exercise, communication, and other groups for individuals with a disability to assist in their re-entry into the community	Broader community; people with disabilities	1,315 encounters
7. Lack of resources for homeless population	Community Care Navigation	Identification and intervention to assist the homeless and underserved population	Low-income	3,268 encounters
8. Support for family caregivers overwhelmed with needs of	Family Caregiver Support Program/Orange Caregiver Resource Center	Partnership to provide family caregivers with assessment, advice for	Broader Community	640,469 encounters

person they are caring		developing a respite program, referrals, education, legal and support services that assist them in their role as a caregiver		
9. Coordination of services for traumatic brain injury patient population	St. Jude Brain Injury Network	Provide case management, support services to assist adult survivors of traumatic brain injury with assistance in vocational, housing, health and financial needs	Low-income	14,181 encounters
10. Need for education and health screenings	Community Education & Health Fairs	Partnership to provide family caregivers with assessment, advice for developing a respite program, referrals, education, legal and support services that assist them in their role as a caregiver	Broader Community	1,612 encounters
11. Medi-Cal Avoidable ED Visit Pilot	Medi-Cal AED Visit Pilot Program	Community Case Management of high risk Medi-Cal patients	Low-income	739 encounters
12. Food Insecurity	Meals on Wheels Food Finders	Special diets for home delivery and food donation	Broader Community	3,080 meals

13. Neuro Rehab	Neuro Rehab Continuum	Inpatient and Outpatient rehab	Broader Community	2,261 encounters

FY23 COMMUNITY BENEFIT INVESTMENT

In FY23 Providence St. Jude Medical Center invested a total of $54,377,417 in key community benefit programs. Invested $1,415,911 in community health programs and grants for the poor and vulnerable. Provided $1,472,855 in charity care, $49,310,105 in unpaid cost of Medi-Cal. Providence St. Jude Medical Center applies a ratio of cost to charge to quantify financial assistance at cost, unreimbursed Medicaid, other means-tested government programs. The cost to charge ratio is aligned with the IRS Form 990, Schedule H Worksheet 2. Our community benefit program expenses are reported in alignment with the total cost incurred to run our programs, and we offset any restricted revenue received to arrive at our net community benefit expense.

FY2023 PROVIDENCE ST. JUDE MEDICAL CENTER
(July 1, 2022-June 30, 2023)

CA Senate Bill (SB) 697 Categories	Community Benefit Program Categories	Net Benefit
Medical Care for Vulnerable Populations	Financial Assistance at cost	$1,472,855
	Unpaid cost of Medicaid	$49,310,105
	Unpaid other govt. programs	-
Other Benefits for Vulnerable Populations	Community Health Improvement Services	$1,415,911
	Subsidized Health Services	-
	Cash and In-Kind Contributions	$554,237
	Community Building	-
	Community Benefit Operations	$168,628
	Total Benefits for Vulnerable Populations	$52,919,126
Other Benefits for the Broader Community Populations	Community Health Improvement Services	$422,757
	Subsidized Health Services	$983,136
	Cash and In-Kind Contributions	-
	Community Building	-
	Community Benefit Operations	-
Health Profession Education, Training and Research	Health Professions Education and Research	$52,398
	Total Benefits for the Broader Community	$1,458,291
	Total Community Benefit	$54,377,417
Medical Care Services for the Broader Community	**Total Medicare shortfall**	$95,776,607

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

In addition to the financial investments made by the Medical Center, there are non-quantifiable benefits that are provided by the organization. Going out into the community and being of service to those in need is part of the tradition of our founders and is carried out by our staff and physicians every day.

As part of the Medical Center's strategy to address homelessness, the former Convent, which is attached to the hospital was leased pro bono to Illumination Foundation to open a 20-bed recuperative care program for older women experiencing homelessness. This unique partnership is in response to the increasing number of older women who find themselves homeless. The program opened in October 2021 and has been successful in stabilizing and finding permanent housing for its clients. Medical Center staff have provided holiday gifts and items to assist the women who transition to housing. Nursing students are providing health education and senior service interns are providing recreational activities.

In addition, Medical Center leaders serve on the Boards of Directors of many non-profit organizations, including Catholic Charities, Women's Transitional Living Center, Anaheim YMCA, Fullerton Collaborative, La Habra Collaborative and acting Chairperson for St. Jude Neighborhood Health Centers. Caregivers support many special events with their time, including Serve Days, Race for the Cure and the Heart Walk. When there is a need in the community, our staff respond with their time, expertise, and financial support. They truly demonstrate the value of services to the community.

2023 CB REPORT GOVERNANCE APPROVAL

This 2023 Community Benefit Report was adopted by the Providence St. Jude Medical Center Community Health Committee of the hospital on November 15, 2023. The final report was made widely available by December 1, 2023.

Sister Mary Rogers CSJ 11/17/23

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

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Providence

At Providence, we use our voice to advocate for vulnerable populations and needed reforms in health care. We are also pursuing innovative ways to transform health care by keeping people healthy, and making our services more convenient, accessible and affordable for all. In an increasingly uncertain world, we are committed to high-quality, compassionate health care for everyone – regardless of coverage or ability to pay. We help people and communities benefit from the best health care model for the future – today.

Together, our 117,000 caregivers (all employees) serve in 51 hospitals, 1,000 clinics and a comprehensive range of health and social services across Alaska, California, Montana, New Mexico, Oregon, Texas and Washington.

Providence across five western states:

- Alaska
- Montana
- Oregon
- Northern California
- Southern California
- Washington

The Providence affiliate family includes:

- Covenant Health in West Texas
- Facey Medical Foundation in Los Angeles, CA.
- Kadlec in Southeast Washington
- Pacific Medical Centers in Seattle, WA.
- Swedish Health Services in Seattle, WA.

As a comprehensive health care organization, we are serving more people, advancing best practices and continuing our more than 100-year tradition of serving the poor and vulnerable. Delivering services across seven states, Providence is committed to touching millions of more lives and enhancing the health of the American West to transform care for the next generation and beyond.