ST. JUDE MEDICAL CENTER

2017 Community Health Assessment Report

To provide feedback about this Community Health Needs Assessment, email Barry.Ross@stjoe.org

St. Joseph Health
St. Jude Medical Center
A member of the St. Joseph Hoag Health alliance

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[1] A community benefit is an initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives:

a. Improves access to health services;
b. Enhances public health;
c. Advances increased general knowledge; and/or
d. Relieves government burden to improve health.

Community benefit includes both services to the poor and broader community.

[2] To be reported as a community benefit initiative or program, **community need must be demonstrated**. Community need can be demonstrated through the following: 1) community health needs assessment developed by the ministry or in partnership with other community organizations; 2) documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; 3) or the involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

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ACKNOWLEDGEMENTS

St. Jude Medical Center is pleased to share our 2017 Community Health Needs Assessment. For the past several months we have worked diligently to gather the appropriate and most complete data on the health and needs of our service area. In gathering our data, we spoke with key stakeholders, community residents, and health care leaders about what they felt were critical needs in their communities. We also analyzed and examined data that demonstrates how health disparities affect certain zip codes and neighborhoods more so than others. The data identifies the needs that exist in the communities we serve and inspires us to continue our work in addressing social determinants of health and their influence on the health and wellbeing of our communities. This data enables us and our partners to make informed and thoughtful decisions about how best to serve and provide resources to areas with the highest needs and to the most vulnerable populations.

I invite you to study the findings, share them with others and most importantly to join us in our efforts to restore the health and improve quality of life of our Dear Neighbors.

Sincerely,

Joe Lins

Chair, Community Benefit Committee

EXECUTIVE SUMMARY

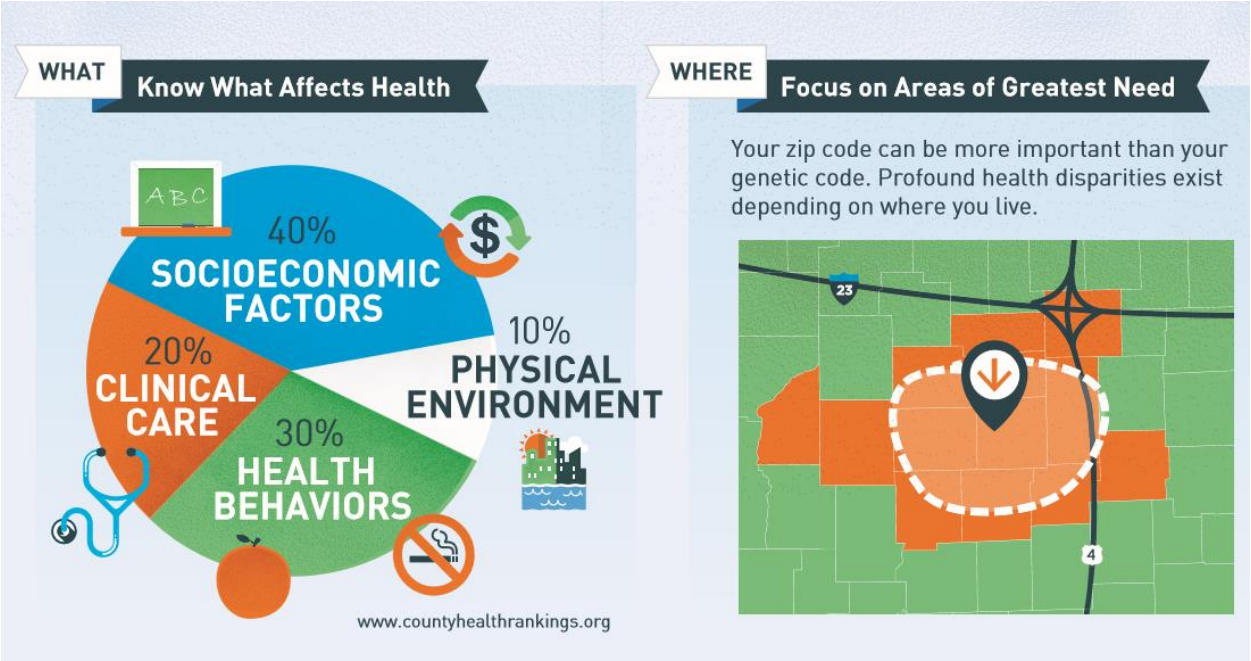
St. Joseph Health, St. Jude Medical Center, an acute-care hospital founded in 1957, is located in Fullerton, California. It became a member of St. Joseph Health in September 1983. The facility has 320 licensed beds, all of which are currently available, and a campus that is approximately 40 acres in size. St. Jude Medical Center has a staff of more than 2,575 people and professional relationships with more than 652 local physicians. Major programs and services include cardiac care, stroke/neuro, orthopedics, rehabilitation, oncology, emergency medicine and obstetrics.

In response to identified unmet health-related needs in the community needs assessment, during FY18-FY20, St. Jude Medical Center will focus on access to health care for the uninsured and underinsured, mental health (including substance abuse) and obesity (including food and nutrition, lack of exercise and walkability) for the broader and underserved members of the surrounding community.

OVERVIEW OF COMMUNITY HEALTH NEEDS ASSESSMENT

The Community Health Needs Assessment (CHNA) process was guided by the fundamental understanding that much of a person's and community's health is determined by the conditions in which they live, work, play, and pray. In gathering information on the communities served by the hospital, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, health behaviors, and the availability of clinical care. This framework, depicted in the graphic below from County Health Rankings and Roadmaps, focuses attention on the social determinants of health to learn more about opportunities for intervention that will help people become and stay healthy within their community.

In addition, we recognized that where people live tells us a lot about their health and health needs, and that there can be pockets within counties and cities where the conditions for supporting health are substantially worse than nearby areas. When data was publicly available, it was collected at the zip code level to show the disparities in health and the social determinants of health that occur within the hospital service area.



Examples of the types of information that was gathered, by health factor, are:

Socioeconomic Factors – income, poverty, education, and food insecurity
Physical Environment – crowded living situations, cost of rent relative to incomes, long commutes, and pollution burden
Health Behaviors – obesity[3], sugary drink consumption, physical exercise, smoking, and substance abuse
Clinical Care – uninsured, prenatal care, and the number of people per physician or mental health worker
In addition to these determinants of health, we also looked at the health outcomes of the people living in the service area, by zip code whenever possible. The health conditions that were examined included:
Health Outcomes – overall health condition, asthma, diabetes, heart disease, cancer, and mental health

COLLABORATING ORGANIZATIONS

The Olin Group is a socially conscious consulting firm working across nonprofit, public, private, and philanthropic sectors to bring about community transformation. Based in Santa Ana, California, The Olin Group has 15 years of experience working on evaluation, planning, assessment, fundraising, communication, and other services for nonprofit organizations, and had previously supported the CHNA process of multiple hospitals in the St. Joseph Health

[3] Per County Health Rankings obesity is listed under the health behavior category of diet and exercise. http://www.countyhealthrankings.org/our-approach/health-factors/diet-and-exercise

system. The Olin Group served as the lead consultant in the CHNA process, coordinating the quantitative and qualitative data collection processes and assisting in the prioritization and selection of health needs.

Community Partners:

St. Jude Medical Center partnered with the following community groups to recruit for and host the Focus Groups.

Habitat for Humanity, Santa Ana. Habitat for Humanity of Orange County is part of a global, nonprofit housing organization operated on Christian principles that seek to put love and faith into action by building homes, communities and hope. Habitat for Humanity of Orange County is dedicated to eliminating substandard housing locally and worldwide through constructing, rehabilitating and preserving homes; by advocating for fair and just housing policies; and by providing training and access to resources to help families improve their shelter conditions. Habitat for Humanity hosted and recruited for a resident focus group in Fullerton.

Korean Community Services, Buena Park. Korean Community Services' (KCS) mission is to assist and empower Korean American individuals, families, and the greater immigrant community through the promotion of projects and programs that provide culturally and professionally competent human services to unserved and underserved Korean Americans. KCS believes that healthier individuals and communities result from a combination of outreach, treatment, and prevention efforts. KCS hosted, recruited for, and facilitated a Korean language focus group in Buena Park.

La Habra Family Resource Center, La Habra. The La Habra Family Resource Center's (FRC) mission is to "empower people to better health." They do this by providing a complete, family-centered support system, working with community resources that can address the health, emotional, social, and academic needs of children and their families. The FRC hosted and recruited for a focus group in La Habra.

COMMUNITY INPUT

The process of collecting qualitative community input took two main forms: Community Resident Focus Groups and a Nonprofit and Government Stakeholder Focus Group. Each type of focus group was designed to capture the collected knowledge and opinions of people who live and work in the communities served by St. Jude Medical Center. We developed a protocol (noted in Appendix 3b) for each group to ensure consistency across individual focus groups, although the facilitators had some discretion on asking follow-up questions or probes as they saw fit. Invitation and recruitment procedures varied for each type of group. Appendix 3 includes a full report of the community input process and findings along with descriptions of the participants.

SIGNIFICANT HEALTH NEEDS

The list below shows the 15 health needs identified through the selection process:

1. Obesity
2. Mental Health
3. Housing
4. Poverty
5. Drug Abuse
6. Immigration Status
7. Jobs and Salaries
8. Diabetes
9. Food and Nutrition
10. Lack of exercise
11. Walkability
12. Crimes and Gangs
13. Parks
14. Language Barriers
15. Long commutes

PRIORITY HEALTH NEEDS

St. Jude Medical Center will address the following priority areas as part of its FY 18-FY 20 Community Benefit Plan/Implementation Strategy Report:

- Obesity (including Food and Nutrition, Lack of Exercise and Walkability)
- Mental Health (including Substance Abuse)
- Access to care for the Uninsured and Underinsured

INTRODUCTION

WHO WE ARE AND WHY WE EXIST

As a ministry founded by the Sisters of St. Joseph of Orange, St. Jude Medical Center lives out the tradition and vision of community engagement set out hundreds of years ago. The Sisters of St. Joseph of Orange trace their roots back to 17th century France and the unique vision of a Jesuit Priest named Jean-Pierre Medaille. Father Medaille sought to organize an order of religious women who, rather than remaining cloistered in a convent, ventured out into the community to seek out "the Dear Neighbors" and minister to their needs. The congregation managed to survive the turbulence of the French Revolution and eventually expanded not only throughout France but throughout the world. In 1912, a small group of the Sisters of St. Joseph traveled to Eureka, California, at the invitation of the local Bishop, to establish a school. A few years later, the great influenza epidemic of 1918 caused the sisters to temporarily set aside their education efforts to care for the ill. They realized immediately that the small community desperately needed a hospital. Through bold faith, foresight and flexibility, in 1920, the Sisters opened the 28 bed St. Joseph Hospital Eureka and the first St. Joseph Health ministry.

St. Joseph Health, St. Jude Medical Center has been meeting the health and quality of life needs of the local community for over 60 years. Serving the communities of Anaheim, Brea, Buena Park, Chino, Chino Hills, Diamond Bar, Fullerton, Hacienda Heights, La Habra, La Mirada, Placentia, Rowland Heights, Walnut, Whittier, and Yorba Linda, St. Jude Medical Center is an acute care hospital that provides quality care in the areas of STROKE/NEURO/ ORTHO/CARDIO PERINATAL/ONCOLOGY/AND REHABILITATION. With over 2,575 employees committed to realizing the mission, St. Jude Medical Center is one of the largest employers in the region.

In FY 16, St. Jude Medical Center invested $56,318,477 in community benefit. This included services to the poor, vulnerable and at-risk populations as well as for the broader community. For FY 16, St. Jude Medical Center had unpaid cost of Medicare that totaled $19,237,242.

MISSION, VISION, VALUES AND STRATEGIC DIRECTION

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.

Strategic Direction

As we move into the future, St. Jude Medical Center is committed to furthering our mission and vision while transforming healthcare to a system that is health-promoting and preventive, accountable in its inevitable rationing decisions, integrated across a balanced network of care and financed according to its ability to pay. To make this a reality, over the next five years FY '18-'23 St. Joseph Health and St. Jude Medical Center are strategically focused on two key areas to which the Community Benefit (CB) Plan strongly align: population health management and network of care.

OUR COMMITMENT TO COMMUNITY

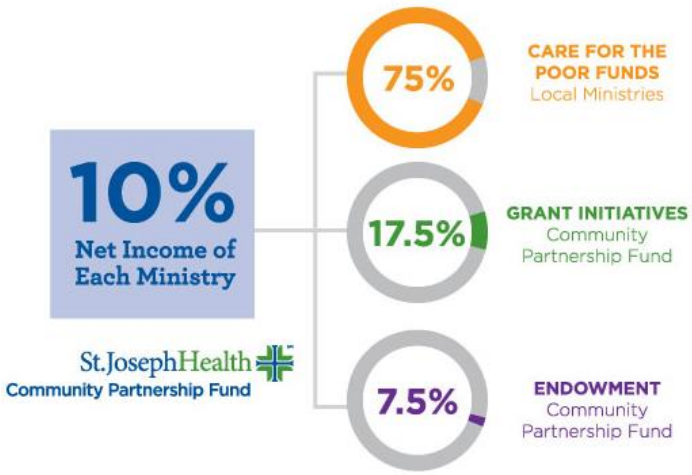
Organizational Commitment

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 underserved.

In 1986, St. Joseph Health created the St. Joseph Health Community Partnership Fund (SJH CPF) (formerly known as the St. Joseph Health System Foundation) to improve the health of low-income individuals residing in local communities served by SJH hospitals.

Each year St. Jude Medical Center allocates 10% of its net income (net unrealized gains and losses) to the St. Joseph Health Community Partnership Fund. (See Figure

Figure 1. Fund distribution



1). 7.5% of the contributions are used to support local hospital Care for the Poor programs. 1.75% is used to support SJH Community Partnership Fund grant initiatives. The remaining .75% is designated toward reserves, which helps ensure the Fund's ability to sustain programs into the future that assist low-income and underserved populations.

Furthermore, St. Jude Medical Center will endorse local non-profit organization partners to apply for funding through the St. Joseph Health Community Partnership Fund. Local non-profits that receive funding provide specific services and resources to meet the identified needs of underserved communities throughout St. Joseph Health hospitals' service areas.

Community Benefit Governance

St. Jude Medical Center further demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration. The Vice President of Mission Integration and Vice President of Healthy Communities) are responsible for coordinating implementation of California Senate Bill 697 provisions and Federal 501r requirements as well as providing the opportunity for community leaders and internal hospital Executive Management Team members, physicians and other staff to work together in planning and implementing the Community Benefit Plan.

The Community Benefit (CB) Management Team provides orientation for all new Hospital employees on Community Benefit programs and activities, including opportunities for community participation.

A charter approved in 2007 establishes the formulation of the St. Jude Medical Center Community Benefit Committee. The role of the Community Benefit 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 Benefit 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 and Community Benefit Plan/Implementation Strategy Reports, and overseeing and directing the Community Benefit activities.

The Community Benefit Committee has a minimum of eight members including three members of the Board of Trustees. Current membership includes 3 members of the Board of Trustees and 20 community members. A majority of members have knowledge and experience with the populations most likely to have disproportionate unmet health needs. The Community Benefit Committee generally meets quarterly.

Roles and Responsibilities

Senior Leadership

- CEO and other senior leaders are directly accountable for CB performance.

Community Benefit Committee (CBC)

- CBC 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 CBC serve as 'board level champions'.
- The committee provides recommendations to the Board of Trustees regarding budget, program targeting and program continuation or revision.

Community Benefit (CB) Department

- Manages CB efforts and coordination between CB and Finance departments on reporting and planning.
- Manages 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.

OUR COMMUNITY

Community

Description of Community Served

St. Jude Medical Center provides North Orange County and parts of Los Angeles, Riverside, and San Bernardino counties' communities with access to advanced care and advanced caring. The hospital's service area extends from Walnut in the north, Anaheim in the south, Corona in the east and Buena Park in the west. Our Hospital Total Service Area includes the cities of Anaheim, Brea, Buena Park, Chino, Chino Hills, Diamond Bar, Fullerton, Hacienda Heights, La Habra, La Mirada, Placentia, Rowland Heights, Walnut, Whittier, and Yorba Linda This includes a population of approximately 1.35 million people, an increase of 8% of from the prior assessment.

Community Profile

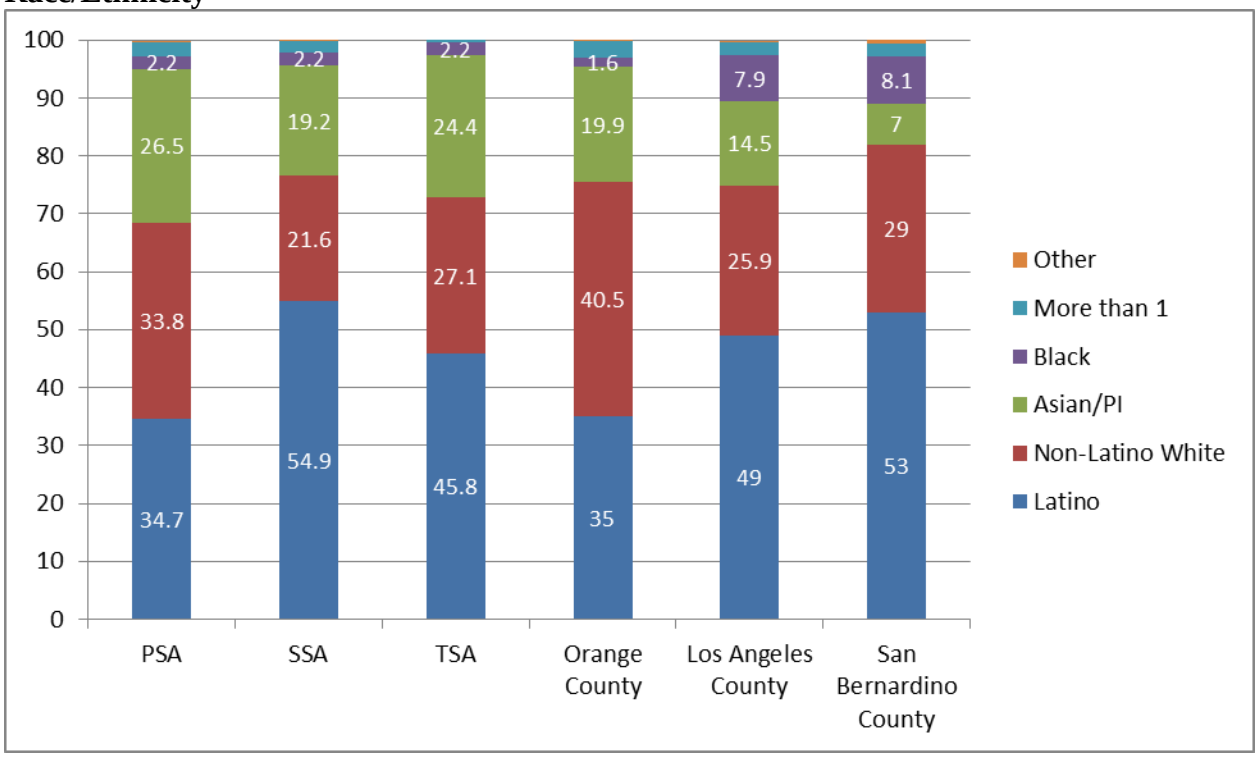
The table and graph below provide basic demographic and socioeconomic information about the St. Jude Medical Center Service Area and how it compares to Orange County, Los Angeles County, San Bernardino County, and the state of California. While 62% of the Total Service Area

(TSA) population resides in Orange County, 32% lives in Los Angeles County and 6% is in San Bernardino County. However, most comparisons of the TSA will be made to Orange County because the areas in Los Angeles and San Bernardino Counties are adjacent to Orange County and more similar to it than their own home counties.

The TSA of St. Jude Medical Center has over 1.3 million people, with a median income of just over $73,000. Compared to Orange County, the TSA has more people who do not speak English "very well" and fewer people who speak only English at home, as well as slightly higher rates of poverty. The TSA, like Orange County, has no majority race or ethnicity. The Secondary Service Area (SSA), which includes the entirety of Anaheim and Whittier as well as some smaller cities, has more children and fewer older adults than the Primary Service Area (PSA) and is socioeconomically worse off than the PSA, with lower incomes and higher rates of poverty. Over half of the population of the SSA is Latino and 24% of the SSA reported that they did not speak English "very well."

Indicator	PSA	SSA	TSA	Orange County	Los Angeles County	San Bernardino County	California
Total Population	609,863	739,348	1,349,211	3,172,848	10,147,765	2,118,866	38,986,171
Under Age 18	21.7%	24.5%	23.2%	22.9%	23.1%	27.0%	23.6%
Age 65+	14.3%	11.8%	12.9%	13.5%	12.4%	10.5%	13.2%
Speak only English at home	53.4%	42.5%	47.4%	54.4%	43.2%	58.9%	56.2%
Do not speak English "very well"	21.1%	23.5%	22.4%	20.6%	25.8%	16.2%	19.1%
Median Household Income	$78,307	$68,010	$73,166	$78,612	$57,190	$55,726	$62,554
Households below 100% of FPL	8.0%	10.8%	9.5%	9.2%	14.6%	15.3%	12.3%
Households below 200% FPL	21.9%	28.5%	25.4%	23.5%	35.2%	36.0%	29.8%
Children living below 100% FPL	15.1%	19.6%	17.7%	17.6%	26.0%	26.4%	22.7%
Older adults living below 100% FPL	8.5%	10.1%	9.3%	8.7%	13.4%	11.5%	10.2%

Race/Ethnicity



Race/Ethnicity data is based on self-reported responses in accordance with US Census categories.

Hospital Total Service Area

The community served by the Hospital is defined based on the geographic origins of the Hospital's inpatients. The Hospital Total Service Area is comprised of both the Primary Service Area (PSA) as well as the Secondary Service Area (SSA) and is established based on the following criteria:

PSA: 70% of discharges (excluding normal newborns)

SSA: 71%-85% of discharges (draw rates per ZIP code are considered and PSA/SSA are modified accordingly)

Includes ZIP codes for continuity

Natural boundaries are considered (i.e., freeways, mountain ranges, etc.)

Cities are placed in PSA or SSA, but not both

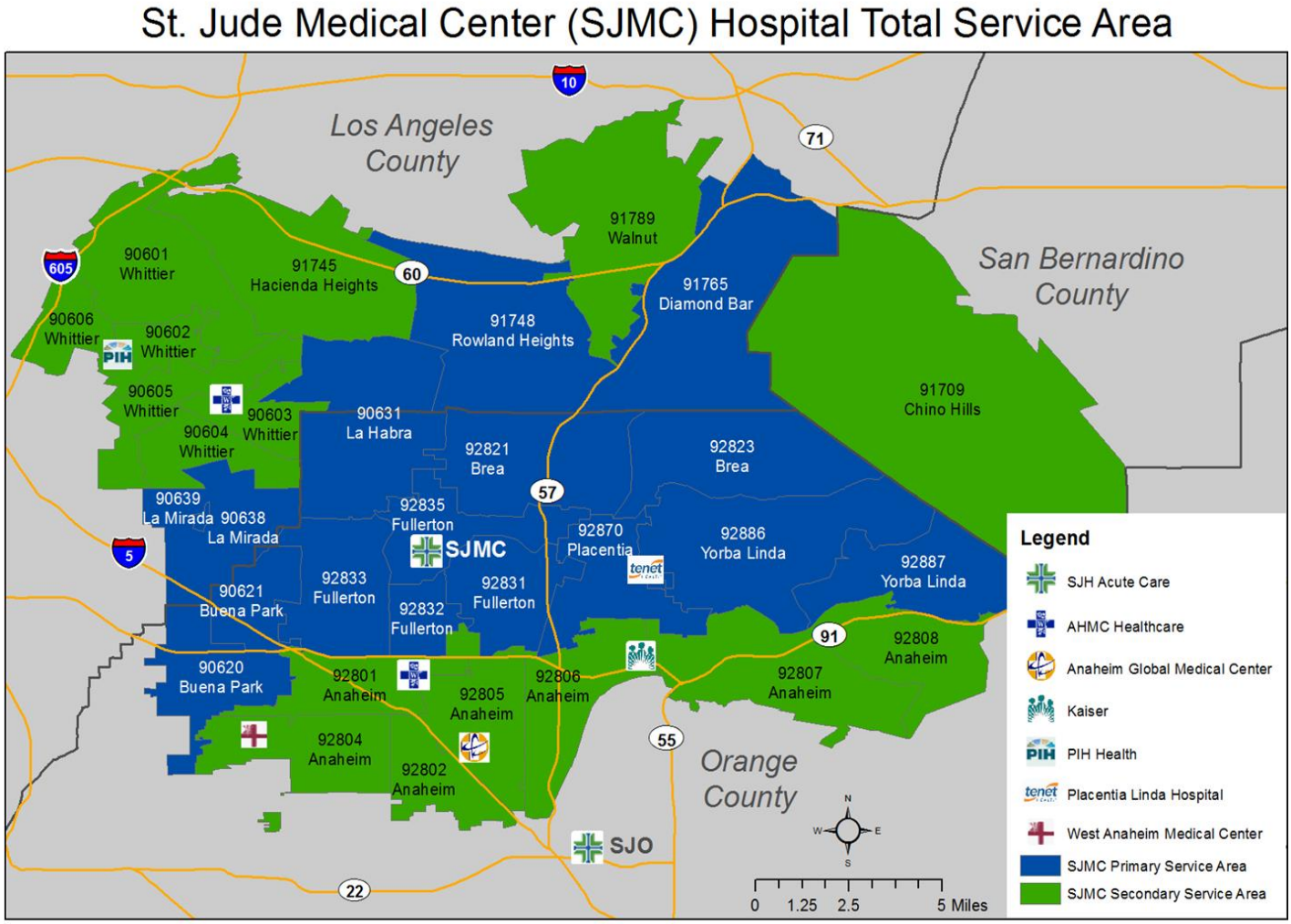
The Primary Service Area ("PSA") is the geographic area from which the majority of the Hospital's patients originate. The Secondary Service Area ("SSA") is where an additional population of the Hospital's inpatients reside. The PSA is comprised of Brea, Diamond Bar, Fullerton, La Habra, La Mirada, Placentia, Rowland Heights, and Yorba Linda. The SSA is comprised of Chino, Chino Hills, Corona, Anaheim, Buena Park, Whittier, Hacienda Heights, and Walnut.

Table 1. Cities and ZIP codes

Cities/ Communities	ZIP Codes	PSA or SSA
Brea	92821, 92822, 92823, 92835, 92886	PSA
Diamond Bar	91765, 91789	PSA
Fullerton	90621, 90631, 92801, 92831, 92832, 92833, 92834, 92835, 92836, 92837, 92838	PSA
La Habra	90004, 90631, 90632, 90633	PSA
La Mirada	90637, 90638, 90639	PSA
Placentia	92811, 92870, 92871	PSA
Rowland Heights	91748	PSA
Yorba Linda	92885, 92886, 92887	PSA
Chino	91708, 91710, 92880	SSA
Chino Hills	91708, 91709, 91765, 92880, 92887	SSA
Corona	92877, 92878, 92879, 92880, 92881, 92882, 92883	SSA
Anaheim	92801, 92802, 92803, 92804, 92805, 92806, 92807, 92808, 92809, 92812, 92814, 92815, 92816, 92817, 92825, 92831, 92850, 92868, 92870, 92880, 92887, 92899	SSA
Buena Park	90620, 90621, 90622, 90623, 90624, 92833,	SSA
Hacienda Heights	91745	SSA
Whittier	90601, 90602, 90603, 90604, 90605, 90606, 90607, 90608, 90609	SSA
Walnut	91724, 91788, 91789, 91792	SSA

Figure 1 (below) depicts the Hospital's PSA and SSA. It also shows the location of the Hospital as well as the other hospitals in the area that are a part of St. Joseph Health.

Figure 1. St. Jude Medical Center Hospital Total Service Area



Map represents Hospital Total Service Area (HTSA). The Primary Service Area (PSA) comprises 70% of total discharges (excluding normal newborns). The Secondary Service Area (SSA) comprises 71% - 85% of total discharges (excluding normal newborns). The HTSA combines the PSA and the SSA. Includes zip codes for continuity. Cities are placed in either PSA or SSA, but not both. SJO = St. Joseph Hospital of Orange.
Prepared by the St. Joseph Health Strategic Services Department, April 2016.

Community Need Index (Zip Code Level) Based on National Need

The Community Need Index (CNI) was developed by Dignity Health (formerly known as Catholic Healthcare West (CHW)) and Truven Health Analytics. The Community Needs Index (CNI) identifies the severity of health disparity for every zip code in the United States and demonstrates the link between community need, access to care, and preventable hospitalizations.

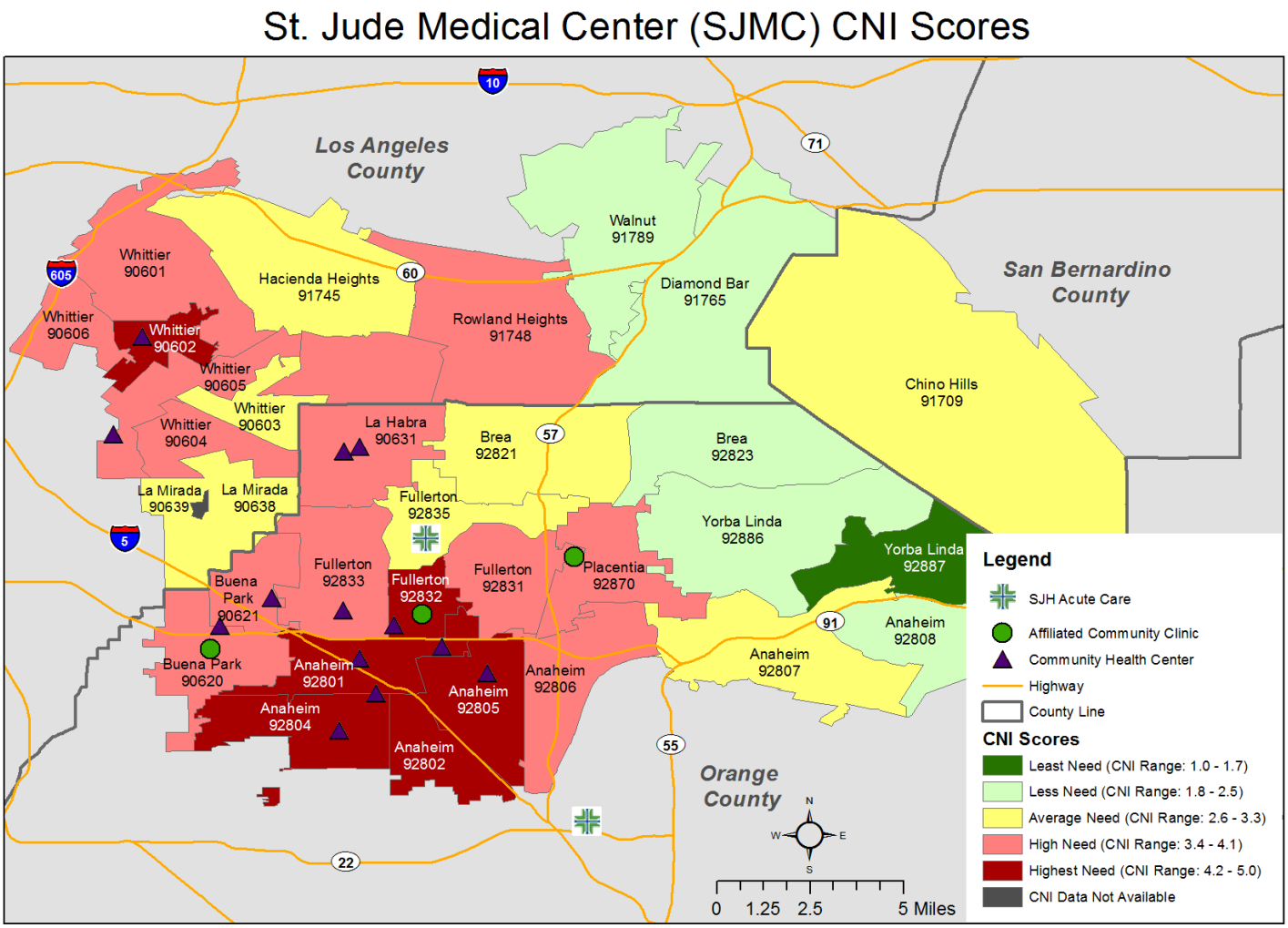
CNI aggregates five socioeconomic indicators that contribute to health disparity (also known as barriers):
Income Barriers (Elder poverty, child poverty and single parent poverty)
Culture Barriers (non-Caucasian limited English);
Educational Barriers (% population without HS diploma);
Insurance Barriers (Insurance, unemployed and uninsured);
Housing Barriers (Housing, renting percentage).

This objective measure is the combined effect of five socioeconomic barriers (income, culture, education, insurance and housing). A score of 1.0 indicates a zip code with the fewest socioeconomic barriers, while a score of 5.0 represents a zip code with the most socioeconomic barriers. Residents of communities with the highest CNI scores were shown to be twice as likely to experience preventable hospitalizations for manageable conditions such as ear infections, pneumonia or congestive heart failure compared to communities with the lowest CNI scores. (*Ref (Roth R, Barsi E., Health Prog. 2005 Jul-Aug; 86(4):32-8.)* The CNI is used to a draw attention to areas that need additional investigation so that health policy and planning experts can more strategically allocate resources.

For example, the ZIP code 92832 on the CNI map is scored 4.2, making it a High Need community. Within zip codes that may score average or better there may be very high need block groups, such as the Whitten neighborhood in Placentia.

Figure 2 (below) depicts the Community Need Index for the ***hospital's geographic service area based on national need***. It also shows the location of the Hospital as well as the other hospitals in the area that are a part of St. Joseph Health.

Figure 2. St. Jude Medical Center Community Need Index (Zip Code Level)

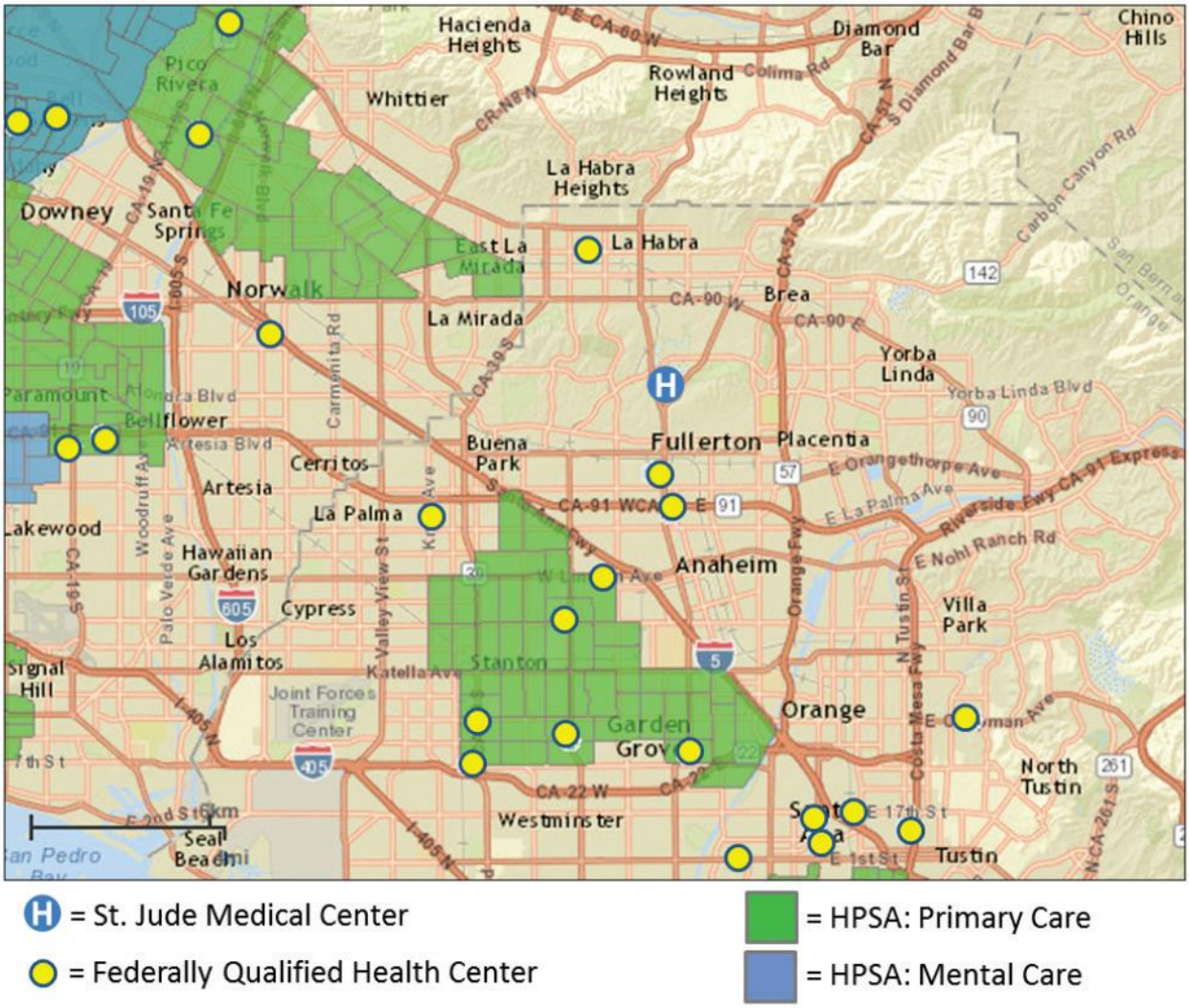


Sources: Dignity Health Community Need Index (cni.chw-interactive.org), 2015 (accessed March 2016); The Coalition of Orange County Community Health Centers (coccc.org); Community Clinic Association of Los Angeles County (ccalac.org) (accessed Sept. 2016). Prepared by the St. Joseph Health Strategic Services Department, April 2016.

See Appendix 1: Community Needs Index data

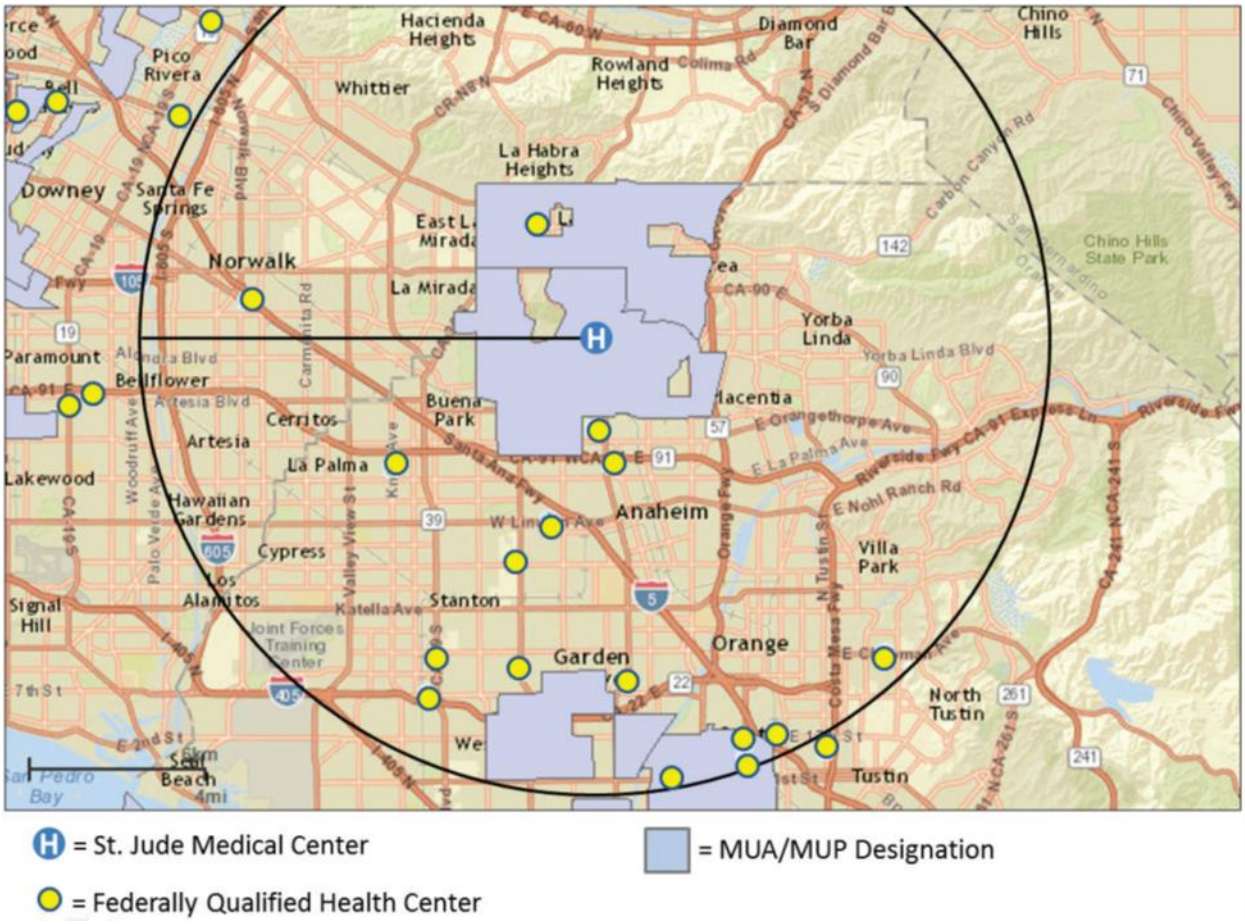
Health Professions Shortage Area – Mental, Dental, Other

The Federal Health Resources and Services Administration designate Health Professional Shortage Areas as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). Although St. Jude Medical Center is not located in a shortage area, large portions of the service area to the South are designated as shortage areas. The map below depicts these shortage areas relative to St. Jude Medical Center's location.



Medical Underserved Area/Medical Professional Shortage Area

Medically Underserved Areas and Medically Underserved Populations are defined by the Federal Government to include areas or population groups that demonstrate a shortage of healthcare services. This designation process was originally established to assist the government in allocating community health center grant funds to the areas of greatest need. Medically Underserved Areas are identified by calculating a composite index of need indicators compiled and compared with national averages to determine an area's level of medical "under service." Medically Underserved Populations are identified based on documentation of unusual local conditions that result in access barriers to medical services. Medically Underserved Areas and Medically Underserved Populations are permanently set, and no renewal process is necessary. The map below depicts the Medically Underserved Areas/Medically Underserved within a 30 mile radius from St. Jude Medical Center.

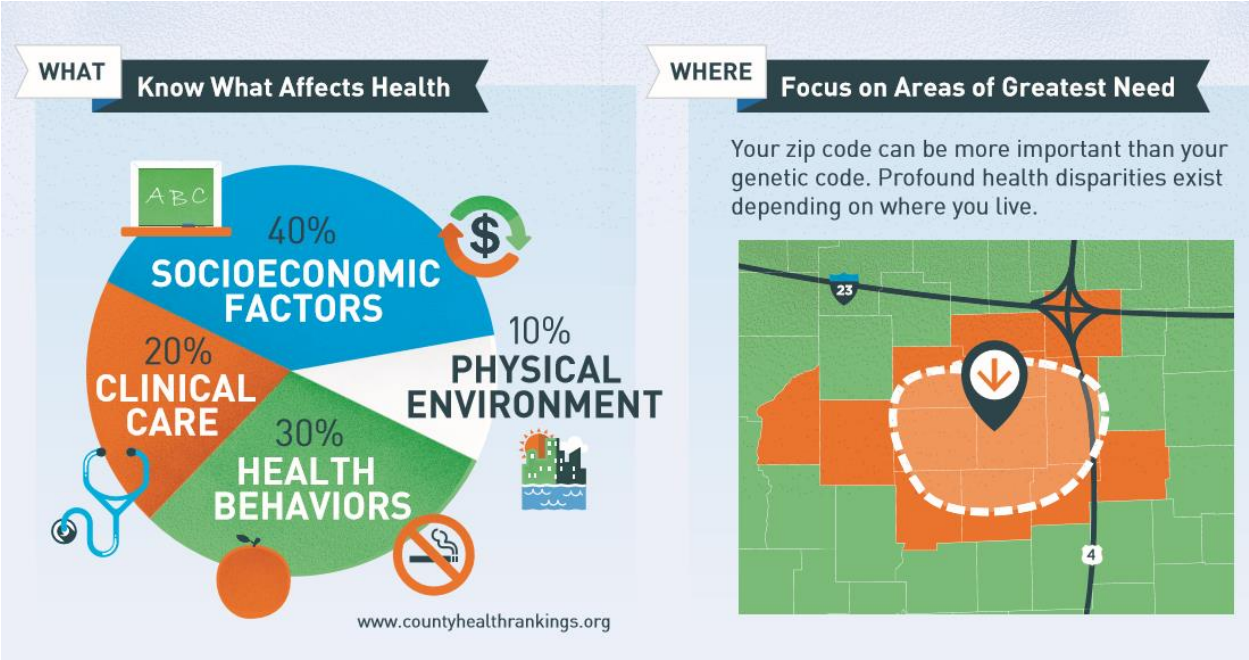


OVERVIEW OF THE CHNA PROCESS

Overview and Summary of the Health Framework Guiding the CHNA

The CHNA process was guided by the fundamental understanding that much of a person's health is determined by the conditions in which they live. In gathering information on the communities served by the hospital, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, health behaviors, and the availability of clinical care. This framework, depicted in the graphic below from County Health Rankings and Roadmaps, focuses attention on the social determinants of health to learn more about opportunities for intervention that will help people become and stay healthy within their community.

In addition, we recognized that where people live tells us a lot about their health and health needs, and that there can be pockets within counties and cities where the conditions for supporting health are substantially worse than nearby areas. To the extent possible, we gathered information at the zip code level to show the disparities in health and the social determinants of health that occur within the hospital service area.



Examples of the types of information that was gathered, by health factor, are:

Socioeconomic Factors – income, poverty, education, and food insecurity

Physical Environment – crowded living situations, cost of rent relative to incomes, long commutes, and pollution burden

Health Behaviors – obesity, sugary drink consumption, physical exercise, smoking, and substance abuse

Clinical Care – uninsured, prenatal care, and the number of people per physician or mental health worker

In addition to these determinants of health, we also looked at the health outcomes of the people living in the service area, by zip code whenever possible. The health conditions that were examined included:

Health Outcomes – overall health condition, asthma, diabetes, heart disease, cancer, and mental health

METHODOLOGY

Collaborative Partners

The Olin Group is a socially conscious consulting firm working across nonprofit, public, private, and philanthropic sectors to bring about community transformation. Based in Santa Ana, California, The Olin Group has 15 years of experience working on evaluation, planning, assessment, fundraising, communication, and other services for nonprofit organizations, and had previously supported the CHNA process of multiple hospitals in the St. Joseph Health system. The Olin Group served as the lead consultant in the CHNA process, coordinating the quantitative and qualitative data collection processes and assisting in the prioritization and selection of health needs.

Community Partners:

St. Jude Medical Center partnered with the following community groups to recruit for and host the Focus Groups.

Habitat for Humanity, Santa Ana. Habitat for Humanity of Orange County is part of a global, nonprofit housing organization operated on Christian principles that seek to put love and faith into action by building homes, communities and hope. Habitat for Humanity of Orange County is dedicated to eliminating substandard housing locally and worldwide through constructing, rehabilitating and preserving homes; by advocating for fair and just housing policies; and by providing training and access to resources to help families improve their shelter conditions. Habitat for Humanity hosted and recruited for a resident focus group in Fullerton.

Korean Community Services, Buena Park. Korean Community Services' (KCS) mission is to assist and empower Korean American individuals, families, and the greater immigrant community through the promotion of projects and programs that provide culturally and professionally competent human services to unserved and underserved Korean Americans. KCS believes that healthier individuals and communities result from a combination of outreach, treatment, and prevention efforts. KCS hosted, recruited for, and facilitated a Korean language focus group in Buena Park.

La Habra Family Resource Center, La Habra. The La Habra Family Resource Center's (FRC) mission is to "empower people to better health." They do this by providing a complete, family-centered support system, working with community resources that can address the health, emotional, social, and academic needs of children and their families. The FRC hosted and recruited for a focus group in La Habra.

Secondary Data/Publicly available data

Within the guiding health framework for the CHNA, publicly-available data was sought that would provide information about the communities and people within our service area. In addition, comparison data was gathered to show how the service area communities are faring compared to the county or state. Indicators were chosen if they were widely accepted as valid and appropriate measures and would readily communicate the health needs of the service area. Preference was given to data that was obtained in the last 5 years and was available at the zip code level. The data sources used are highly regarded as reliable sources of data (e.g., ESRI Business Analyst Online, US Census Bureau American FactFinder, and California Health Interview Survey). In total, 81 indicators were selected to describe the health needs in the hospital's service area. Appendix 2 includes a complete list of the indicators chosen, their sources, the year the data was collected, and details about how the information was gathered.

If an indicator had zip code level data available, data was pooled to develop indicator values for the Total Service Area (TSA), Primary Service Area (PSA), and Secondary Service Area (SSA) of the hospital. This enabled comparisons of zip code level data to the hospital service area and comparisons of the hospital service area to county and state measures.

After the data was gathered, the zip code level data was compared to the Total Service Area values and color coded light pink to dark red depending on how much worse a zip code area was compared to the TSA value. This made it easier to visualize the geographic areas with greater health needs. The criteria for color-coding the zip code level data is explained in the spreadsheets in Appendix 2.

Community Input

The process of collecting qualitative community input took two main forms: Community Resident Focus Groups and a Nonprofit and Government Stakeholder Focus Group. Each type of focus group was designed to capture the collected knowledge and opinions of people who live and work in the communities served by St. Jude Medical Center. We developed a protocol (noted in Appendix 3b) for each group to ensure consistency across individual focus groups, although the facilitators had some discretion on asking follow-up questions or probes as they saw fit. Invitation and recruitment procedures varied for each type of group. Appendix 3 includes a full report of the community input process and findings along with descriptions of the participants.

Resident Focus Groups

For Community Resident Groups, Community Benefit staff, in collaboration with their committees and the system office, identified geographic areas where data suggested there were significant health, physical environment, and socioeconomic concerns. This process also identified the language needs of the community, which determined the language in which each focus group was conducted. Community Benefit staff then partnered with community-based organizations that serve those areas to recruit for and host the focus groups. The community-based organization developed an invitation list using their contacts and knowledge of the area, and participants were promised a small incentive for their time. Two consultants staffed each focus group, serving as facilitators and note takers. These consultants were not directly affiliated with the ministry to ensure candor from the participants.

Nonprofit and Government Stakeholder Focus Group

For the Nonprofit and Government Stakeholder Focus Group, Community Benefit staff developed a list of leaders from organizations that serve diverse constituencies within the hospital's service area. Ministry staff sought to invite organizations with which they had existing relationships, but also used the focus group as an opportunity to build new relationships with stakeholders. Participants were not given a monetary incentive for attendance. As with the resident focus groups, this group was facilitated by outside consultants without a direct link to St. Joseph Health.

Data Limitations and Information Gaps

While care was taken to select and gather data that would tell the story of the hospital's service area, it is important to recognize the limitations and gaps in information that naturally occur.

- Not all desired data was readily available, so sometimes we had to rely on tangential or proxy measures or not have any data at all. For example, there is little community-level data on the incidence of mental health or substance abuse.
- Data that is gathered through interviews and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population as a whole.
- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents and how honest people are in providing their answers.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly (such as rates of uninsured) and the most recent data available is not a good reflection of the current state.

- Zip code areas are the smallest geographic regions for which many indicators have data, but even within zip codes, there can be populations that are disproportionately worse off than neighboring communities and these do not show up in the data.
- Information gathered during focus groups is dependent on who was invited and who showed up for the event. Efforts were made to include people who could represent the broad interests of the community and/or were members of communities of greatest need.
- Fears about deportation kept many undocumented immigrants from participating in focus groups and made it more difficult for their voice to be heard.

Process for gathering comments on previous CHNA

The CHNA which was posted on our website and made available in local public libraries, indicated that comments should be sent to the medical center's Vice President of Healthy Communities. No comments have been received.

SELECTED HEALTH INDICATORS: SECONDARY DATA

Selected Health Indicators

For each set of indicators shown below, there are two types of tables. The first table shows the values for the Primary Service Area (PSA), the Secondary Service Area (SSA), the Total Service Area (TSA), the counties that have communities in the service area, and California. The second table(s) shows the areas of greatest need by zip code. For the second table type, the cells are colored red, orange, yellow, or white based on how much worse the indicator value is for that zip code compared to the TSA. The specific definitions for the color coding are shown in the table below.

Indicator	Much Worse	Moderately Worse	Slightly Worse	Not Worse
Household Income	80% or more below the TSA median household income	80.1% - 90% below the TSA median household income	90.1%-95% below the TSA median household income	No color means the value is about the same as, or better than, the TSA
Any indicator shown as a percent	4.0 or more percentage points worse than the TSA value	2-3.9 percentage points worse than the TSA value	1-1.9 percentage points worse than the TSA value	
Pollution Burden	4 or more higher than the TSA value	2-3.999 higher than the TSA value	1-1.999 higher than the TSA value	
Violent Crime	40% or more above the value for the county in which the city is located	20%-39% above the value for the county in which the city is located	10%-19% above the value for the county in which the city is located	

Socioeconomic Indicators

While the TSA is similar to Orange County on the socioeconomic indicators shown, the differences between the PSA and the SSA are striking, with the SSA worse on all socioeconomic indicators. Within the TSA, there are 9 zip codes where more than one quarter of the children live in poverty and 7 zip codes where more than one quarter of the adults do not have a high school diploma. The cities with the most socioeconomic challenges are Buena Park, Rowland Heights, Fullerton, Whittier, and Anaheim.

Indicator	PSA	SSA	TSA	Orange County	Los Angeles County	San Bernardino County	California
Socioeconomic Indicators							
Median Household Income	$78,307	$68,010	$73,166	$78,612	$57,190	$55,726	$62,554
Households below 100% of FPL	8.0%	10.8%	9.5%	9.2%	14.6%	15.3%	12.3%
Households below 200% FPL	21.9%	28.5%	25.4%	23.5%	35.2%	36.0%	29.8%
Children living below 100% FPL	15.1%	19.6%	17.7%	17.6%	26.0%	26.4%	22.7%
Older adults living below 100% FPL	8.5%	10.1%	9.3%	8.7%	13.4%	11.5%	10.2%
Age 25+ and no HS diploma	12.8%	20.2%	16.8%	16.0%	23.2%	21.7%	18.5%
Enrolled in Medi-Cal	13.8%	18.9%	16.6%	15.5%	22.5%	24.3%	20.3%
Low-income food insecurity	5.9%	9.0%	7.6%	6.8%	9.9%	8.5%	8.1%

Areas of Greatest Concern – Cities/communities that are much worse than the Total Service Area average on at least two of the eight socioeconomic indicators shown.

Indicator	Buena Park	Rowland Heights	Fullerton		
	90621	91748	92831	92832	92833
Median Household Income					
Households below 100% of FPL					
Households below 200% FPL					
Children living below 100% FPL					
Older adults living below 100% FPL					
Age 25+ and no HS diploma					
Enrolled in Medi-Cal					
Low-income food insecurity					

Indicator	Whittier			Anaheim				
	90602	90605	90606	92801	92802	92804	92805	92806
Median Household Income								
Households below 100% of FPL								
Households below 200% FPL								
Children living below 100% FPL								
Older adults living below 100% FPL								
Age 25+ and no HS diploma								
Enrolled in Medi-Cal								
Low-income food insecurity								

Physical Environment

People in the SSA are much more likely to live in crowded housing conditions with the percentage of households with more than 1 occupant per room over 20% in three Anaheim zip codes. The data on rent is an indicator of both the high cost of housing and low incomes; the percentage of renters who pay more than 30% of their income for rent is high throughout the

TSA. In 6 zip code areas, the rate tops 65%. Pollution Burden takes into account air and water quality, toxic waste, traffic, and socioeconomic indicators to identify areas that are disproportionately burdened by multiple sources of pollution. While Orange County is below the California rate, communities in Buena Park, Fullerton, Whittier, and Anaheim are much more burdened by pollution. Violent crime is relatively low in Orange County, compared to California, but the rates in Buena Park, Fullerton, and Anaheim are high. Anaheim has more than 300 violent crimes per 100,000 inhabitants.

Indicator	PSA	SSA	TSA	Orange County	Los Angeles County	San Bernardino County	California
Physical Environment Indicators							
More than 1 occupant per room	8.6%	12.6%	10.8%	9.2%	12.1%	8.8%	8.2%
Renters pay more than 30% of household income for rent	59.2%	62.0%	60.8%	58.1%	59.8%	60.6%	57.2%
Pollution Burden	25.11	30.575	27.931	22.233	31.759	29.709	25.312
Violent crimes (rate per 100,000 inhabitants)	NA	NA	NA	202.7	428.4	398.4	397.8

Areas of Greatest Concern - Cities/communities that are much worse than the Total Service Area average on at least one of the physical environment indicators shown.

Indicator	Buena Park	La Habra	Brea	Fullerton		Yorba Linda
	90621	90631	92823	92832	92833	92887
More than 1 occupant per room						
Renters pay more than 30% of household income for rent						
Pollution Burden						
Violent Crime (City-level data)						

Indicator	Whittier				Hacienda Heights	Anaheim				
	90601	90602	90605	90606	91745	92801	92802	92804	92805	92806
More than 1 occupant per room										
Renters pay more than 30% of household income for rent										
Pollution Burden										
Violent Crime (City)										

Health Outcomes

The rates at which people describe their health as fair or poor are much higher in the SSA than the TSA, Orange County, or California for all age groups. The rates of fair or poor health are especially high in Buena Park, and parts of Whittier and Anaheim. The TSA has higher rates of asthma in children and diabetes in adults than are found in Orange County. The highest rates of asthma in both children and adults are in the northern parts of the TSA, from Hacienda Heights to Chino Hills. The rate of serious psychological distress is higher in the SSA than in the PSA, with rates topping 10% in parts of Whittier.

Indicator	PSA	SSA	TSA	Orange County	Los Angeles County	San Bernardino County	California
Health Outcome Indicators							
Fair or poor health (ages 0-17)	6.5%	8.0%	7.4%	7.0%	5.8%	2.8%	5.2%
Fair or poor health (ages 18-64)	19.2%	22.9%	21.2%	20.3%	21.1%	20.1%	19.2%
Fair or poor health (ages 65+)	29.5%	33.7%	31.6%	29.4%	32.7%	28.6%	27.8%
Disabled population (all ages)	8.4%	8.3%	8.4%	8.1%	9.6%	10.9%	10.3%
Asthma in children (ages 1-17)	11.9%	12.2%	12.1%	10.6%	13.1%	16.0%	14.6%
Asthma in adults (ages 18+)	13.9%	13.7%	13.7%	14.3%	12.6%	13.8%	13.9%
Diabetes in adults (ages 18+)	8.1%	9.8%	9.0%	7.4%	9.9%	11.2%	8.8%
Heart disease (Ages 18+)	5.7%	5.1%	5.4%	5.6%	5.2%	5.2%	5.9%
Serious psychological distress (ages 18+)	6.9%	7.8%	7.4%	7.1%	9.1%	8.0%	8.1%

Areas of Greatest Concern - Cities/communities that are much worse than the Total Service Area average on at least one of the health outcome indicators shown.

Indicator	Buena Park		La Mirada	Rowland Heights	Diamond Bar
	90620	90621	90638	91748	91765
Fair or poor health (ages 0-17)					
Fair or poor health (ages 18-64)					
Fair or poor health (ages 65+)					NA
Disabled population (all ages)					
Asthma in children (ages 1-17)					
Asthma in adults (ages 18+)					
Diabetes in adults (ages 18+)					
Heart disease (Ages 18+)					
Serious psychological distress (ages 18+)					

Indicator	Whittier				Chino Hills	Walnut	Anaheim			
	90601	90602	90605	90606	91709	91789	92801	92802	92804	92805
Fair or poor health (ages 0-17)										
Fair or poor health (ages 18-64)										
Fair or poor health (ages 65+)										
Disabled population (all ages)										
Asthma in children (ages 1-17)										
Asthma in adults (ages 18+)										
Diabetes in adults (ages 18+)										
Heart disease (Ages 18+)										
Serious psychological distress (ages 18+)										

Health Behaviors

The TSA has higher rates of overweight and obesity at all age groups and sugary drink consumption among adults than Orange County, with the highest rates in the SSA. Fewer children in the TSA and SSA get regular physical activity. Whittier has the highest rates of overweight and obesity in the SSA; rates in parts of Anaheim are moderately worse than the TSA.

Indicator	PSA	SSA	TSA	Orange County	Los Angeles County	San Bernardino County	California
Health Behavior Indicators							
Overweight (ages 2-11)	12.4%	15.3%	14.0%	12.3%	12.4%	19.9%	13.3%
Overweight or obese (ages 12-17)	23.2%	30.4%	27.2%	20.9%	37.9%	36.2%	33.1%
Obese (ages 18+)	18.5%	25.1%	22.0%	18.4%	25.9%	35.0%	25.8%
Sugary drink consumption (ages 18+)	13.3%	17.5%	15.5%	13.1%	17.7%	24.6%	17.4%
Regular physical activity (ages 5-17)	16.9%	15.7%	16.2%	16.9%	18.9%	23.9%	20.7%
Youth alcohol/ drug use in the past month (grades 7, 9, and 11)	NA	NA	NA	26.9%	24.5%	N/R*	27.8%
Births per 100,000 teens (ages 15-19)	NA	NA	NA	16.7	23.5	29.2	23.2

Areas of Greatest Concern - Cities/communities that are much worse than the Total Service Area average on at least one of the health behavior indicators shown.

Indicator	La Mirada	Whittier						Chino Hills	Hacienda Heights	Anaheim
	90638	90601	90602	90603	90604	90605	90606	91709	91745	92805
Overweight (ages 2-11)										
Overweight or obese (ages 12-17)										
Obese (ages 18+)										
Sugary drink consumption (ages 18+)								NA		
Regular physical activity (ages 5-17)										

Clinical Care

A greater percentage of Orange County children are uninsured than at the state level. However, the data on uninsured has not caught up with changes in enrollment due to the Affordable Care Act and should be viewed in that context. A higher percentage of adults are uninsured in the SSA than the TSA, Orange County, or California, with the highest rates in parts of Buena Park, Whittier, and Anaheim. Orange County has better ratios of people to physicians and dentists than the state, but is worse off with regards to non-physician primary care providers and mental health providers.

Indicator	PSA	SSA	TSA	Orange County	Los Angeles County	San Bernardino County	California
Clinical Care Indicators							
Uninsured (ages 0-17)	5.5%	5.4%	5.5%	5.3%	4.3%	2.3%	3.2%
Uninsured (ages 18-64)	18.7%	22.0%	20.5%	19.4%	21.5%	21.3%	19.3%
First trimester prenatal care	82.8%	84.3%	83.6%	89.9%	85.0%	83.4%	83.8%
# of people per primary care physician	NA	NA	NA	1048:1	1374:1	1740:1	1274:1
# of people per non-physician primary care provider	NA	NA	NA	2,392:1	2,331:1	2,014:1	2,192:1
# of people per dentist	NA	NA	NA	963:1	1,256:1	1,543:1	1,264:1
# of people per mental health provider	NA	NA	NA	480:1	372:1	563:1	356:1

Areas of Greatest Concern - Cities/communities that are much worse than the Total Service Area average on at least one of the clinical care indicators shown.

Indicator	Buena Park	Rowland Heights	Whittier	Hacienda Heights	Walnut	Anaheim			
	90621	91748	90606	91745	91789	92801	92802	92805	92806
Uninsured (ages 0-17)	NA	NA		NA	NA				NA
Uninsured (ages 18-64)									
First trimester prenatal care									

See Appendix 2: Secondary Data /Publicly available data

SUMMARY OF COMMUNITY INPUT

Summary of Community Input

To better understand the community's perspective, opinions, experiences, and knowledge, St. Jude Medical Center held four sessions in which community members and nonprofit and government stakeholders discussed the issues and opportunities of the people, neighborhoods, and cities of the service area. Below is a high-level summary of the findings of these sessions; full details on the protocols, findings, and attendees are available in Appendix 3. These sessions were scheduled as follows:

Session	City	Date	Language
Community Resident Focus Group	La Habra	2/7/17	Spanish
Community Resident Focus Group	Buena Park	2/15/17	Korean
Community Resident Focus Group	Fullerton	2/22/17	Spanish
Nonprofit/Government Stakeholder Focus Group	Fullerton	2/23/17	English

Review of Findings

The following concerns were identified as important by participants in BOTH the community resident and nonprofit/government stakeholder focus groups:

Mental Health: Community members are experiencing stress, anxiety, and depression from a number of factors, including low incomes, the high cost of housing, unemployment, undocumented status, and community and family violence. The continuing stigma around

mental health makes people reluctant to acknowledge their problems and seek help. Immigrants, regardless of legal status, are susceptible to mental health concerns because of stigma within their culture and because they live far from their families.

Housing: Concerns about housing focused on both cost and quality and the downstream effects of both. The high cost of housing leads families to double or triple-up in housing, or rent space in garages. People move frequently, which makes it difficult to meet neighbors or feel connected to the community. Unmaintained apartments have mold, dirt, dust, old carpets, and insect and rodent infestations. Slumlords do not respond to the needs of their tenants or raise the rent without much advance notice. Undocumented residents do not know their rights and are afraid to speak up. Housing concerns were cited as a cause of stress among community members.

Homelessness: The stakeholder focus group participants defined homelessness as including families who live in motels or garages or are double or tripled-up in apartments. At several focus groups, participants described how homeless people in parks make them unsafe for children.

Jobs and Salaries / Poverty: There are too few jobs in the community that pay a living wage, causing people to travel long distances for work or to take on multiple jobs, both of which reduce time with family or for pursuing healthy activities. It is difficult for undocumented immigrants to get hired and fears of deportation raids keep them from working, which leads to stress and anxiety. Low wages in an area with a high cost of living and housing mean families cannot afford healthier foods or dental and health care. Stress and depression from economic hardship also contribute to overeating of unhealthy foods and weight gain.

Immigration Status: Stress and fear of arrest and deportation have grown considerably since November 2016. Undocumented immigrants are afraid to access resources, including health services, and cannot purchase health insurance, so they end up using the emergency room when their health situation becomes dire. Landlords and employers take advantage of the undocumented, knowing they are afraid to complain about exploitation. The immigrant community also is extremely cautious about their relationships with the police and service organizations, which means it takes a long time to build trust.

Food and Nutrition: While the benefits of healthy eating are well known to community members, the cost of a healthy diet is prohibitive for many. Fast, processed foods are much less expensive and readily available in low-income neighborhoods. Children quickly develop a taste for processed foods and prefer them to healthier options. Free food is often outdated or of poor quality. The Korean group noted that food banks rarely distribute food that is typical for an Asian diet. In some cultures, traditional diets are high in fat and it can be difficult to get people to adopt healthy substitutes.

Lack of Exercise / Parks / Walkability: These issues are closely linked. It can be difficult for people to get enough exercise because some parks, streets, and sidewalks are unsafe. Some parks are frequented by homeless people, are sites of drug and alcohol use, have gang activity,

and are full of trash. There are apartment complexes that do not allow children to play outside and some school districts close their yards after school hours. It is hard to walk in some neighborhoods because there are too few streetlights, speeding cars, loose dogs, dog waste left on sidewalks, unmaintained roads and sidewalks, gangs, drugs, crime, and a lack of trust in the police.

Obesity and Diabetes: The easy availability of sodas and sweetened juices, diets high in fat, and lack of exercise were discussed as contributors to both obesity and diabetes in the community, especially among children. Participants in the stakeholder focus group also mentioned poverty, anxiety, and depression as causes.

Crime and Gangs: Gangs are involved in drug sales and other criminal activities that make neighborhoods unsafe, especially after dark. Focus group participants were cautious in these discussions, making it clear that residents are afraid to report criminal activity by gang members. Many community members do not trust the police, which compound the problem.

Drug Abuse: Participants at the Spanish-language focus groups described widespread problems with excessive alcohol consumption throughout the community and specifically at apartments and parks. They noted that homeless people and other adults will purchase alcohol for minors and there are too many liquor stores in their neighborhoods. Participants also mentioned that young teens and preteens both use drugs and are used to carry and deliver drugs for dealers. Drug use and sales were cited as reasons parks are unsafe.

The following concerns were identified as concerns for the community by the community resident focus groups but were not discussed at the nonprofit/government stakeholder focus group.

Health Conditions: In addition to obesity and diabetes, participants described asthma and allergies as problems in the community, especially as a result of poorly maintained housing.

Language Barriers: The Korean-language focus group participants mentioned that they often face a language barrier at health care appointments and need translators, which are not always readily available.

The following concerns were identified by the nonprofit/government stakeholder focus group but were not discussed at the community resident focus groups.

Lack of Connection/Community: While many people have a strong connection to their families, they are not always as connected to their community. This is especially true for people who move frequently. The lack of connection to the community makes it difficult for service providers to organize in neighborhoods.

See Appendix 3: Community Input

SIGNIFICANT HEALTH NEEDS

The graphic below depicts both how the compiled data and community input were analyzed to generate the list of significant health needs, as well as the prioritization process that allowed the selection of three significant health needs around which St. Jude Medical Center will build its implementation plan. Details of the selection and prioritization process are provided in the sections that follow and in Appendix 5.

	Generating List of Significant Health Needs	Prioritization Step 1	Prioritization Step 2	Prioritization Step 3	Prioritization Step 4
Who	**2 external raters**	**2 external raters**	**Community Benefit Lead and internal Work group**	**Community Benefit Lead**	**Community Benefit Committee**
What	A comprehensive review of data & community input	Apply the following criteria per significant health need	Apply the following criteria per significant health need	Review through two filters	Review List of issues and narrow to 1-3 priority areas for FY18-FY20 CB Plan/ Implementation Strategy investment
Criteria	All sources were analyzed for severity of the problem and level of community concern.	1. Seriousness of the problem 2. Scope of the problem – # of people affected 3. Scope of the problem –compared to other areas 4. Health disparities among population groups 5. Importance to the community 6. Potential to affect multiple health issues (root cause) 7. Implications for not proceeding	1. Sustainability of impact 2. Opportunities for coordination/ partnership 3. Focus on prevention 4. Existing efforts on the problem 5. Organizational competencies	1. Is it aligned with the Mission of St. Joseph Health? 2. Does it adhere to the Catholic Ethical and Religious Directives?	1. Is the health need relevant to the ministry? 2. Is there potential to make meaningful progress on the issue? 3. Is there a meaningful role for the ministry on this issue? 4. Where do we want to invest our time and resources over the next three years?
Scale	**Multiple**	**1-5 scale**	**1-5 scale**	**Yes or No**	**CB Committee Dialogue**

Selection Criteria and Process

Evaluators from The Olin Group performed a rigorous review of the publicly-available data and community input to identify 16 significant health needs for St Jude Medical Center.

The selection process began with the development of a general list of potential health needs, derived from a broad review of the indicator data, focus group findings, and literature around health concerns and social determinants of health. The goal of the selection process was to analyze the wide variety and large quantity of information obtained through the quantitative and qualitative processes in a consistent manner. Each source of input was considered as follows:

- Quantitative Data: Weighting was based on how the service area compared to California and county averages and how individual cities and zip codes compared to

the service area averages. Note that for some health needs, data was not readily available.

- Resident Focus Groups: Focus Group transcripts and notes were reviewed and considered both at the individual focus group level and collectively across focus groups. Weighting was related to how often and how extensively an issue was discussed by the participants.
- Stakeholder Focus Group: Weighting for the stakeholder group was based on how strongly the problem was discussed by the participants, and the extent of agreement among the participants about the problem.

In developing the list of significant health needs, the quantitative data was given equal weight to the community input. After reviewing and rating all the available information, the list of potential health needs was ranked from greatest to lowest need for the ministry and the top 16 were recommended by The Olin Group for further consideration.

Before the final selection of significant health needs, two reviews took place. First, The Olin Group reviewed the list to determine if there were needs that were identified as priorities through the community process but not highlighted by the data, or for which no data was available. In some cases, a significant health need may have been added to the list due to this review. In the second review, the Community Benefit Lead examined the list, using his ministry-specific knowledge to determine if the significant health needs should be consolidated or added. Once the review was completed, the list was finalized and prioritized.

PRIORITY HEALTH NEEDS

Prioritization Process and Criteria

To prioritize the list of significant health needs and ultimately select the three health needs to be addressed by St. Jude Medical Center; a four-step process was followed that incorporated the experience, expertise, and perspective of both internal and external stakeholders of the ministry. The criteria and rating scales can be found in Appendix 5.

Step 1: Using criteria that were developed in collaboration with the St. Joseph Health System Office and the Community Benefit Lead, The Olin Group Evaluation Team scored each health need on seven criteria.

- Seriousness of the Problem: The degree to which the problem leads to death, disability, and impairs one's quality of life
- Scope of the Problem 1: The number of people affected, as a percentage of the service area population
- Scope of the Problem 2: The difference between the percentage of people affected in the service area compared to regional and statewide percentages

- Health Disparities: The degree to which specific socioeconomic or demographic groups are affected by the problem, compared to the general population
- Importance to the Community: The extent to which participants in the community engagement process recognized and identified this as a problem
- Potential to Affect Multiple Health Issues: Whether or not this issue is a root cause, and the extent to which addressing it would affect multiple health issues
- Implications for Not Proceeding: The risks associated with exacerbation of the problem if it is not addressed at the earliest opportunity

Step 2: The Community Benefit Lead for St. Jude Medical Center convened a working group of stakeholders to complete the second stage of prioritization. This working group applied 4 criteria to each need.

- Sustainability of Impact: The degree to which the ministry's involvement over the next 3 years would add significant momentum or impact, which would remain even if funding or ministry emphasis on the issue were to cease.
- Opportunities for Coordination and Partnership: The likelihood that the ministry could be part of collaborative efforts to address the problem.
- Focus on Prevention: The existence of effective and feasible prevention strategies to address the issue.
- Existing Efforts on the Problem: The ability of the ministry to enhance existing efforts in the community.

The Community Benefit Staff participating in the working group also considered a fifth criterion:

- Organizational Competencies: The extent to which the ministry has or could develop the functional, technical, behavioral, and leadership competency skills to address the need.

Step 3: Two final criteria were considered by the Community Benefit Lead for each health need.

- Relevance to the Mission of St. Joseph Health: Is this area relevant to or aligned with the Mission of St. Joseph Health?
- Adherence to Ethical and Religious Directives: Does this area adhere to the Catholic Ethical and Religious Directives?

If the answer was "No" to either question, the health need was dropped from further consideration. None of the needs were dropped at this step.

Step 4: The final step of prioritization and selection was conducted by the St. Jude Medical Center Community Benefit Committee, which reviewed the list of identified health needs rank-ordered by the results of the first three steps of the prioritization process. The Committee discussed each need and its relevance to the ministry, the potential for progress on the issue,

and the potential role of the ministry in addressing the need. After extensive discussion, the Committee selected three priorities for inclusion in the plan.

Rank-ordered significant health needs

The matrix below shows the 16 health needs identified through the selection process, and their scores after the first three steps of the prioritization process. The check marks indicate each source of input and whether this issue was identified as a need by that input process.

Significant Health Need	Health Category	Total Rank Score	Community Data	Resident Focus Group	Non-profit/ Govt. Stakeholder FG
Mental Health	Health Outcome	47.4	✓	✓	✓
Obesity	Health Behavior	47.0	✓	✓	✓
Access to care for the Uninsured	Clinical Care	45.2	✓	✓	
Housing	Physical Environment	45.0	✓	✓	✓
Food and Nutrition	Socioeconomic	44.5	✓	✓	✓
Diabetes	Health Outcome	44.4	✓	✓	✓
Lack of Exercise	Health Behavior	43.7	✓	✓	✓
Walkability	Physical Environment	43.0		✓	✓
Drug Abuse	Health Behavior	40.8	✓	✓	✓
Parks	Physical Environment	40.3	✓	✓	✓
Poverty	Socioeconomic	36.7	✓	✓	✓
Immigration Status	Socioeconomic	36.3	✓	✓	✓
Jobs and Salaries	Socioeconomic	35.5	✓	✓	✓
Crime and Gangs	Physical Environment	35.2		✓	✓
Language Barriers	Socioeconomic	32.2	✓	✓	✓
Long Commutes	Physical Environment	28.5	✓	✓	

Definitions:

Mental Health: Covers all areas of emotional, behavioral, and social well-being for all ages. Includes issues of stress, depression, coping skills, as well as more serious health conditions such as mental illness and Adverse Childhood Experiences.

Obesity: Primarily defined as the health condition in which individuals are sufficiently overweight as to have detrimental effects on their overall health. This does not include issues of exercise or food choices, which are listed as separate issues.

Access to Care for the Uninsured: Providing access to health care for those without insurance.

Housing: Includes affordability, overcrowding, and quality of housing.

Food and Nutrition: Concerns about healthy eating habits, nutrition knowledge, and challenges of cost and availability of healthy options.

Diabetes: Specifically focused on the health condition of diabetes, and awareness and prevention of it.

Lack of Exercise: Includes issues around access to safe places to exercise and people not having enough time to exercise, or choosing not to.

Walkability: The lack of walkable areas and streets, including the lack of sidewalks, crosswalks, and street lights, as well as concerns about safety due to crime, speeding cars, and loose dogs.

Drug Abuse: Pertains to the misuse of all drugs, including alcohol, marijuana, opiates, prescription medication, and other legal or illegal substances. It does not encompass cigarette smoking, which was considered separately and not identified as a significant health need.

Parks: Issues around a shortage of parks, or existing parks being poorly maintained, inaccessible, or unsafe.

Poverty: Poverty can have a detrimental effect on the health of low income individuals and families, and serve as a root cause of several other issues.

Immigration Status: Individuals who are or are connected to undocumented immigrants feel afraid and stressed, which affects their health. They also may not be able to access necessary health services or resources.

Jobs and Salaries: A root cause of other health issues, this covers difficulties around finding jobs that pay livable salaries and are close to home.

Crime and Gangs: Encompasses the incidence of crime, gang activity, and violence as well as the fear of it, which prevent people from using open spaces or enjoying their community.

Language Barriers: The challenges with accessing services and feeling welcomed that are faced by non-English speakers.

Long Commutes: Lengthy commutes can cause stress, increase the risk of accidents, reduce air quality, and take time away from healthier pursuits such as exercise or preparing healthier food.

COMMUNITY ASSETS AND RESOURCES

Significant Health Need and Assets Summary
Communities with Disproportionate Unmet Health Needs (DUHN) are communities defined by zip codes where there is a higher prevalence or severity for a particular health concern than the general population within St. Jude Medical Center Service Area.

Communities with DUHN generally meet one of two criteria: *either* there is a high prevalence or severity for a particular health concern to be addressed by a program activity, or there is evidence that community residents are faced with multiple health problems and have limited access to timely, high quality health care.

The following table lists the DUHN communities/groups and identified significant health needs and community resources/assets.

Significant Health Need	Target Population	Geographic Area (City, Zip Code, County)	Community Resources (Name of Organization(s)
Housing	Low and middle income families	PSA, parts of SSA	Kennedy Commission; NeighborWorks; Habitat for Humanity; Mercy House
Mental Health	Broader Community	PSA, parts of SSA	OCHCA Mental Health; Providence St. Joseph; NAMI; National Council on Mental Health; CSUF Interns; CalOptima
Obesity	Low income families	Low income neighborhoods; Title 1 schools	Cities of Fullerton, Placentia, Buena Park and La Habra; La Habra City School District; Placentia-Yorba Linda School District; Buena Park School District; Fullerton School District; Fullerton Joint Union HS District; Fullerton College; CSUF; Fullerton Collaborative; Placentia Collaborative; Buena Park Collaborative; La Habra Collaborative; CAPOC; Second Harvest Food Bank
Poverty	Low income families	PSA, parts of SSA	CAPOC
Drug Abuse	Children and teens, parents, persons with drug addiction	PSA, parts of SSA	Providence St. Joseph Health; OC Health Care Agency, CalOptima
Immigration Status	Undocumented immigrants and their families	PSA, part of SSA	OCCCO; OC Opportunity; Immigrant Legal Resource Center; CHIRLA; OC Human Relations
Jobs and Salaries	Low income persons	PSA, part of SSA	None
Diabetes	Low income persons	PSA, part of SSA	American Diabetes Association; OC Health Improvement Partnership
Food and Nutrition	Low income families	PSA	Second Harvest; OC Food Access Coalition; Waste Not OC; UC Cooperative Extension; OC Health Care Agency - NEOP
Lack of Exercise	Low income families	PSA	Cities of Fullerton, Placentia, Buena Park and La Habra; La Habra City School District; Placentia-Yorba Linda School District; Buena Park School District; Fullerton School District; Fullerton Joint Union HS District; Fullerton College; CSUF;

Existing Health care Facilities in the Community
See Appendix 4: Existing Health care Facilities in the Community

PRIORITY HEALTH NEEDS

St. Jude Medical Center will address the following priority areas as part of its FY18-FY20 CB Plan/Implementation Strategy Report:

- Mental Health (including Substance Abuse) : Implement innovative solutions and partnerships that eliminate the stigma of mental illness and ease access to care, build resilience in children, teens, families, and seniors, reduce suffering from depression, anxiety, and social isolation, curtail substance abuse and create hope for people with serious and persistent mental illness.
- Obesity (including Food and Nutrition, Lack of Exercise and Walkability): Implement policy, system, and environmental changes that make the healthy choice the easy choice in low income neighborhoods in North Orange County.
- Increase access to health care: provide support to affiliated community health center and other programs, increasing access to care for the underserved.

Mental Health and Substance Abuse were combined by the Community Benefit Committee. At the conclusion of Step 3 of the prioritization process, mental health was the highest ranked concern and substance abuse was ranked ninth. Both concerns were raised by community residents and stakeholders during the community input process, where they spoke in particular about stress due to low incomes, the high cost of living, crime, and immigration status. Data on mental health and substance abuse is difficult to obtain and often only at the county level. The emergency room utilization rate due to mental illness across Orange County is 59.2 per 10,000 inhabitants, compared to rates of 85.6, 98.9, and 130.2 in three zip codes of Anaheim. Data from the California Health Interview Survey-Neighborhood Edition shows high rates of serious psychological distress in Whittier (as high as 10.9%), although the rate for the TSA (7.4%) is below the state average (8.1%). The percentage of adults reporting binge or heavy drinking in Orange County is 19.5% compared to 17.2% throughout California. Mental health and substance abuse were combined as one priority to reflect both the approach of the regional and system wide Institutes for Mental Health and Wellness. Mental health and substance abuse were selected by the Committee as a priority because of the high score based on need and the regional and system-wide focus of this issue.

Access to Care for the Uninsured and Underinsured was the third highest ranked health need after the first three steps of the prioritization process. Participants at the community focus groups mentioned that undocumented immigrants are unable to purchase health insurance and the high cost of living affects the ability to pay for health care. In 2014, the TSA had a slightly higher rate of uninsured adults than Orange County (20.5% compared to 19.4%) and six zip

codes had rates at or above 25% (in Buena Park, Whittier, and Anaheim). Orange County also had higher rates of uninsured children than California (5.3% compared to 3.2%), with rates in eight zip code areas over 6%. More updated data is not currently available, and while insurance rates have likely improved since then, these geographic areas are likely still below average. The Committee selected this need because of its high ranking and due to the uncertainty of the ACA and MediCal expansion at the federal level.

Obesity (Food and Nutrition, Lack of Exercise and Walkability) was the second highest ranked health need after the first three steps of the prioritization process; Food and Nutrition was ranked fifth. These were combined as food and nutrition, lack of exercise and walkability are viewed as strategies to address obesity. Rates of overweight children and obese adults in the TSA are higher than Orange County rates for all age groups. For example, 27% of teenagers are overweight or obese in the TSA compared to 21% in Orange County. In some zip codes in the SSA, the rates are over 40% (all in Whittier). Similarly, the rate of obesity in adults is 22% in the TSA And over 25% in nine zip code areas (primarily in Whittier and Anaheim), compared to 18% in Orange County. 8% of people in the TSA reported low-income food insecurity, compared to 7% in Orange County. Rates of food insecurity were at or above 10% in 12 zip code areas, including parts of Buena Park, Fullerton, Whittier, and Anaheim. Community members recognized that obesity is prevalent in their neighborhoods and associated it with challenges to affording healthy food, easy access to less healthy processed and fast foods, and lack of safe places to exercise in their neighborhoods. The Committee selected Obesity as a top priority because of its prevalence, particularly in low income communities and its impact on health status.

See Appendix 5: Prioritization protocol and criteria / worksheets

EVALUATION OF IMPACT ON FY15-FY17 CB PLAN/IMPLEMENTATION STRATEGY REPORT: FY16 ACCOMPLISHMENTS

Planning for the Uninsured and Underinsured
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 we have a **Patient Financial Assistance Program**[4] that provides free or discounted services to eligible patients.

One way, St. Jude Medical Center informs the public of the Patient Financial Assistance Program 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. In FY16, St. Jude Medical Center ministry, provided 4,874,274 free (charity care) and discounted care and 13,589 encounters.

For information on our Financial Assistance Program click here

Medicaid (Medi-Cal) and Other Local Means-Tested Government Programs

St. Jude Medical Center provided access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California, and other local means-tested government programs. In FY16, St. Jude Medical Center ministry, provided $42,737,936 in Medicaid (Medi-Cal) shortfall.

[4] Information about St. Jude Medical Center's Financial Assistance Program is available http://www.stjudemedicalcenter.org/Patients-Visitors/Billing-Information/Patient-Financial-Assistance.aspx

Addressing the Needs of the Community: FY15 –17 Key Community Benefit Plan
FY16 Accomplishments

Initiative (community need being addressed): The FY14 CHNA shows a significant number of uninsured in the Community Benefit Service Area (CBSA). 18.7% of adults in the CBSA do not have insurance, and there are over 47,000 people with CalOptima.

Goal (anticipated impact): Expand access to medical care for the underserved in the SJMC CBSA

Outcome Measure	Baseline	FY16 Target	FY16 Result
Number of persons served (encounters) Heritage CalO network #	25,204 encounters 0	25,501 encounters 1000	24,964 encounters 0
Strategy(ies)	**Strategy Measure**	**FY16 Target**	**FY16 Result**
1. Provide grant and in-kind support to the SJNHC	Number of encounters served at SJNHC	23,870	24,903
2. Provide subsidy for specialists in ER to serve uninsured encounters	Number of uninsured patient encounters provided subsidized care by specialists in ER	631 encounters	61 encounters*
3. Hospital and Heritage to participate as CalOptima Network	Number of CalOptima patients cared for by integrated delivery systems (IDS) in Heritage CalOptima network.	1000 members	0 members

Key Community Partners: St. Jude Neighborhood Health Center, St. Jude Heritage HealthCare, CalOptima, SJMC Medical Staff, City of Fullerton, Fullerton School District.

FY16 Accomplishments: St. Jude Neighborhood Health Centers provided 24,903 encounters which is 4.3% more than the FY 16 target. The subsidy for ER physicians to serve the indigent decreased from 93 to 61. The CalOptima Heritage network implementation was postponed for a variety of reasons both because of CalOptima and Heritage needs. Although the CalOptima Heritage network implementation was postponed, Heritage did join the CalOptima Community Network, as did St. Jude Neighborhood Health Centers with a current enrollment of over 1,500.

Addressing the Needs of the Community: FY15 –17 Key Community Benefit Plan
FY16 Accomplishments

Move More Eat Healthy Initiative

Initiative (community needs being addressed): FY14 CHNA showed that 60.9 percent of adults and 30 percent of children are overweight or obese in the CBSA.

Goal (anticipated impact): Increase the number of targeted schools which show an increased percentage of 5th and 7th grade students who are in the Healthy Fitness Zone for body composition; strengthen city, school, and organizational policies that promote healthy lifestyles

Outcome Measure	Baseline	FY16 Target	FY16 Result
Number of schools which show an increased percentage of 5th and 7th graders in the Healthy Fitness Zone for body composition.	2013 Fitnessgram scores for body composition	20 percent of targeted schools have an increase in the per cent of 5th and 7th graders in the Healthy Fitness Zone for body composition.	25% of targeted school showed an increase in Fitnessgram scores for body composition in School Year 2015 (7 out of 28)
Strategies	**Strategy Measure**	**FY 16 Target**	**FY16 Results**
1. Number of schools who have an increased percentage of healthy weight 5th and 7th grade students in the Healthy Fitness Zone.	# of schools with percentage of 5th and 7th grade children attending schools in target neighborhoods whose body composition are in the Healthy Fitness Zone on the Fitnessgram	Current scores will be baseline.	25 percent of targeted schools showed an improvement in the per cent of children who are in the Healthy Fitness Zone for body composition

Addressing the Needs of the Community: FY15 –17 Key Community Benefit Plan
FY16 Accomplishments

Move More Eat Healthy Initiative (continued)

2. Engage four school districts in implementing policies that promote a healthy lifestyle	Number of active Wellness Councils; number of new policies or administrative rules that strengthen the Wellness Policy	4 Active Wellness Councils; 4 updated Wellness Policies	4 Active Wellness Councils; 4 updated Wellness Policies
3. Partner with four targeted cities to enhance their level of commitment in HEAL or Let's Move	Number of HEAL cities that achieve Active or Fit City recognition and/or number of Let's Move Cities that meet all recommended criteria	3 HEAL cities that achieve Active or Fit recognition or Let's Move-recognized cities	1 city (La Habra) achieved HEAL Fit City designation. 2 Cities (Fullerton and Placentia) are Active HEAL cities and Buena Park received Bronze Let's Move designation.

Addressing the Needs of the Community: FY15 –17 Key Community Benefit Plan
FY16 Accomplishments

Behavioral Health Initiative

Initiative (community need being addressed): FY14 CHNA shows that 31.9% of 11th graders reported alcohol use in past month, and 20.5% of 11th graders reported drug use in past month. Additionally, in 2012, SJMC established a full-time social worker to work with the homeless population that access the ED. 31% of the homeless patients seen in the Emergency Department had mental health issues, and 24% had substance abuse issues. The top mental health issues were post-traumatic stress disorder, depression, and anxiety.

Goal (anticipated impact): Improve behavioral health in low-income populations though prevention and access

Outcome Measure	Baseline	FY16 Target	FY16 Result
Number of behavioral health programs offered to the community	1 programs	3 programs	3 programs

Strategy(ies)	Strategy Measure	FY16 Target	FY16 Result
1. Integrate behavioral health services at St. Jude Heritage and SJNHC	Number of behavioral health tools used for screening at SJNHC and SJHH	2	2 tools
2. Collaborate with targeted school districts to enhance management of children with behavioral problems	Number of Title 1 schools participating in PBIS program in North Orange County	24	29
3. Address the needs of homeless patients with mental health and substance abuse problems	% of patients with mental health and substance abuse issues connected to services	Baseline to be established in FY 16	32.6% per cent of homeless patient with mental health and substance abuse issues that were able to be connected to services

Addressing the Needs of the Community: FY15 –17 Key Community Benefit Plan
FY16 Accomplishments

Behavioral Health Initiative (continued)

Key Community Partners: Fullerton Collaborative, St. Jude Neighborhood Health Center, Orange County Behavioral Health, School Districts, St. Jude Heritage HealthCare, Pathways of Hope

Progress in FY16

Both the St. Jude Neighborhood Health Center and St. Jude Heritage introduced behavioral health screening tools in the primary care setting. St. Jude Neighborhood Health Center introduced the Staying Health Assessment and the Staying Healthy Assessment 50+ which address mental health issues. St. Jude Heritage utilizes the PHQ-9 for seniors and an ADHD assessment. The PBIS program had 29 Title 1 schools participating in FY16 exceeding the goal that was established. One-third of homeless patients who have mental health or substance abuse issues were able to be connected to services.

FY15 - FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY16 Accomplishments

Infant and Child Health Initiative

Initiative (community need being addressed): The percentage of children aged two and under in the SJMC CBSA immunized with dTAP and MMR vaccines are currently far below Healthy People 2020 goals. Only 48 percent of children received dTAP vaccines at Heritage North; 36 percent of children received dTAP vaccines at the clinic; and 67 percent of children received dTAP vaccines at Heritage Central. At Heritage North, 86 percent of children aged two and under were MMR-immunized versus only 73 percent at the SJNHC.

Goal (anticipated impact): Enhance infant and child health through improved immunization rates.

Outcome Measure	Baseline	FY16 Target	FY16 Result
Percent of children ages 2 and under receiving dTAP and MMR immunizations	DTAP immunization rate: - Heritage North: 48% - SJNHC: 36% MMR immunization rate: - Heritage North: 86% - SJNHC: 73%	DTAP immunization rate: -Heritage North: 80% -SJNHC: 45% MMR rate: -Heritage North: 90% - SJNHC: 80%	DTAP immunization rate: - Heritage North: 79.3%% - SJNHC: 96.02% MMR immunization rate: - SJNHC: 100%

FY15 - FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan

FY16 Accomplishments

Infant and Child Health Initiative (continued)

Strategy(ies)	Strategy Measure	FY16 Target	FY16 Results
1. Strengthen the reminder/recall system for immunizations.	System in place to effectively remind and recall patients for immunizations.	Continue system implementation	System implemented.
2. Track reasons why parents are refusing immunizations and develop plan to address these reasons.	Tracking system in place and data available.	System implemented	System implemented
3. Evaluate the effectiveness and the delivery of educational materials and improve where needed.	Evaluation of educational materials and delivery available.	Evaluation completed	Completed in FY 15

Key Community Partners: Fullerton Collaborative, St. Jude Neighborhood Health Center

Progress in FY16

The immunization rate for Diphtheria, Tetanus and Pertussis (DTaP) at St. Jude Neighborhood Health Centers increased from 70% to 96.02% and for St. Jude Heritage Medical Group was stable. The immunization rate for MMR at St. Jude Neighborhood Health Centers increased from 88% to 100%,

The reminder systems, tracking parent refusals and the educational materials were all evaluated. At Heritage posters were introduced in the exam rooms that highlighted the consequences of not being immunized.

Other Community Benefit

Initiative (community need being addressed)	Program	Description	FY16 Accomplishments
Emergency Food and Shelter, Community Building and Disaster Relief	St. Joseph Health Community Partnership Fund	2.5% of hospital net income contributed to provide emergency food and shelter grants, community building grants and disaster relief grants.	Four emergency food and shelter grants were provided to organizations in North Orange County. These grants were: Grandma's House of Hope for food distribution; Illumination Foundation for housing support; Interval House for shelter services; and Pathways of Hope for housing.
Transportation and support services to low income seniors	Senior Services	Provide non-emergency medical transportation, volunteer home assistance, chronic disease, depression and bereavement support	6,834 non-emergency transportation trips provided. 9,760 encounters provider for services to low income and frail seniors.

Other Community Benefit (Continued)

Initiative (community need being addressed):	Program	Description	FY16 Accomplishments
Technical assistance and support to local and county collaboratives	Healthy Communities	Provides technical assistance and support to four city collaboratives and several county-wide groups focused on reducing health disparities.	Provided leadership to Alliance for a Healthy Orange County which is the community collaborative for a CDC prevention grant, Chair of La Habra Collaborative; Treasurer of Fullerton Collaborative; Co-Chair of OC Health Improvement Partnership.
Indigent patients being discharged from the hospital lacking funds for medication, equipment and support.	Indigent Patient Discharge Needs	Provide medication, durable medical equipment, transportation and other services on discharge.	84 encounters provided by program.
Community Support for Persons with Disabilities	Rehabilitation Community Exercise and Rehab Community Follow-Up Programs	Provides low cost and no cost exercise programs, communication recovery group and nurse follow-up to persons with a disability.	6,587 encounters in exercise and communication recovery program; 708 encounters in rehab community follow-up program.

Other Community Benefit (Continued)

Initiative (community need being addressed):	Program	Description	FY16 Accomplishments
Support to family caregivers	Family Caregiver Support Program/Caregiver Resource Center	In-kind support to government funded program providing supportive services to family caregivers.	131,578 encounters provided in FY16. Received UCI Campus Community Research Incubator grant to re-design Journey to Caregiving program.
Adults with traumatic brain injury	St. Jude Brain Injury Network	Financial support for community re-integration services to adults with a traumatic brain injury.	916 encounters provided in FY16.
Food Access	Food for the Hungry and Meals on Wheels	Provide cooked food that is not sold to FoodFinders and special diets to Fullerton Meals on Wheels	Provided 3,864 lbs. of food for the hungry.
Persons with Disabilities	Neuro-Rehab Continuum of Care	Subsidy for neuro-rehab continuum of care services to community	4,896 encounters provided.
Education and screening	Community Education and Health Fairs	Education classes and preventive health screening	6,735 encounters provided.

GOVERNANCE APPROVAL

This FY17 Community Health Needs Assessment Report was approved at the June 15, 2017 meeting of the St. Jude Medical Center Community Benefit Committee a sub-Committee of the Board of Trustees.

Community Benefit Committee Chair's Signature confirming approval of St. Jude Medical Center's FY17 Community Health Needs Assessment Report

6-15-17

Date

See Appendix 6: Ministry Community Benefit Committee

Appendix 1: Community Needs Index data

Community Need Index (CNI) Scores

St. Jude Medical Center Hospital Total Service Area (HTSA)

ZIP Code[1]	Service Area[2]	CNI Score[3]	Population	City	County	State
92832	PSA	4.6	24,809	Fullerton	Orange	California
92801	SSA	4.6	63,624	Anaheim	Orange	California
92805	SSA	4.6	73,628	Anaheim	Orange	California
92804	SSA	4.4	92,024	Anaheim	Orange	California
92802	SSA	4.4	44,235	Anaheim	Orange	California
90602	SSA	4.4	25,677	Whittier	Los Angeles	California
92833	PSA	4.0	54,974	Fullerton	Orange	California
90621	PSA	4.0	36,329	Buena Park	Orange	California
92806	SSA	4.0	41,159	Anaheim	Orange	California
90605	SSA	4.0	40,660	Whittier	Los Angeles	California
90606	SSA	4.0	33,033	Whittier	Los Angeles	California
90631	PSA	3.8	69,813	La Habra	Orange	California
92831	PSA	3.8	35,780	Fullerton	Orange	California
90620	PSA	3.8	46,342	Buena Park	Orange	California
90604	SSA	3.8	40,684	Whittier	Los Angeles	California
90601	SSA	3.8	33,039	Whittier	Los Angeles	California
92870	PSA	3.6	53,671	Placentia	Orange	California
91748	PSA	3.6	46,304	Rowland Heights	Los Angeles	California
92821	PSA	3.2	38,238	Brea	Orange	California
92835	PSA	2.8	26,133	Fullerton	Orange	California
90638	PSA	2.8	48,127	La Mirada	Los Angeles	California
91709	SSA	2.8	75,848	Chino Hills	San Bernardino	California
91745	SSA	2.8	54,797	Hacienda Heights	Los Angeles	California
92807	SSA	2.6	37,399	Anaheim	Orange	California
90603	SSA	2.6	20,666	Whittier	Los Angeles	California
91765	PSA	2.2	48,068	Diamond Bar	Los Angeles	California
92808	SSA	2.2	21,567	Anaheim	Orange	California
91789	SSA	2.2	43,919	Walnut	Los Angeles	California
92823	PSA	2.0	3,492	Brea	Orange	California

92886	PSA	1.8	49,702	Yorba Linda	Orange	California
92887	PSA	1.6	21,003	Yorba Linda	Orange	California
90632	PSA	PO Box	N/A	La Habra	Orange	California
90633	PSA	PO Box	N/A	La Habra	Orange	California
92834	PSA	PO Box	N/A	Fullerton	Orange	California
92838	PSA	PO Box	N/A	Fullerton	Orange	California
92836	PSA	PO Box	N/A	Fullerton	Orange	California
92837	PSA	PO Box	N/A	Fullerton	Orange	California
92822	PSA	PO Box	N/A	Brea	Orange	California
92871	PSA	PO Box	N/A	Placentia	Orange	California
92885	PSA	PO Box	N/A	Yorba Linda	Orange	California
90637	PSA	PO Box	N/A	La Mirada	Los Angeles	California
92817	SSA	PO Box	N/A	Anaheim	Orange	California
92803	SSA	PO Box	N/A	Anaheim	Orange	California
92812	SSA	PO Box	N/A	Anaheim	Orange	California
92816	SSA	PO Box	N/A	Anaheim	Orange	California
91788	SSA	PO Box	N/A	Walnut	Los Angeles	California
90609	SSA	PO Box	N/A	Whittier	Los Angeles	California
92809	SSA	PO Box	N/A	Anaheim	Orange	California
90639	PSA	Data Not Available	N/A	La Mirada	Los Angeles	California

1. CNI scores are not calculated for non-populated ZIP codes, including such areas as PO boxes, national parks, public spaces, state prisons, and large unoccupied buildings.

2. PSA = primary service area; SSA = secondary service area.

3. CNI scores are sorted from highest to lowest. A CNI score of 1 represents the lowest need nationally, while a score of 5 indicates the highest need nationally.

Source: Dignity Health Community Need Index (cni.chw-interactive.org), 2015; Accessed March 2016.

Appendix 2: Secondary Data /Publicly available data

Appendix 2A: Secondary Data/Publicly Available Data
https://www.stjudemedicalcenter.org

Appendix 2B: Secondary Data/Publicly Available Appendix
https://www.stjudemedicalcenter.org

Appendix 3: Community Input
Public Health Representative

St. Jude Medical Center's Community Benefit Committee includes a representative from Orange County Health Care Agency who participates in the prioritization process of community needs.

Name	Title	Organization
Joseph Vargas	Program Supervisor	Orange County Health Care Agency

Appendix 3a: Focus Group Participants Demographics

Residents who participated in focus groups completed an anonymous survey to allow reporting on demographics of the participants. In the table below, the number and percentages are shown for the totals of the three focus groups. Percentages were calculated using the number of respondents for each question, which may be less than the total number of respondents because people could choose to leave a question unanswered. Not all attendees completed a survey or answered every question.

St. Jude Medical Center	Resident Focus Groups	
Number of Respondents	52	52
Gender		
Female	49	94%
Male	3	6%
Race/Ethnicity*		
Hispanic/Latino	38	75%
Korean	11	22%
Non-Latino White	3	6%
Asian or Pacific Islander-unspecified	1	2%
Chronic Conditions		
Person with chronic conditions or a leader or representative of individuals with chronic conditions	8	17%
Age		
0-17 years	0	0%
18-44 years	24	46%
45-64 years	24	46%
65-74 years	4	8%
75 years or older	0	0%
Total Household Income before Taxes		
Less than $20,000	22	51%
$20,000 to $34,999	7	16%
$35,000 to $49,999	8	19%
$50,000 to $74,999	4	9%
$75,000 to $99,999	1	2%
$100,000 or more	1	2%
Decline to answer	9	**
Number of People in Household		
Average	4.2	NA
Median	4	NA
Range	1-8	NA

*The percentages for race/ethnicity add up to more than 100% because people could select more than one race/ethnicity.
**Decline to Answer responses were not included in the calculation of percentages

Appendix 3b. List of Stakeholder Focus Group Participants and Organizations

The Non-profit/Government Stakeholder Focus Group was held on February 23rd, 2017 in Fullerton. The list of participants is presented in the table below, along with information about their organizations and the population they serve.

Name	Organization	The population served by the organization includes people who have or represent:			
		Chronic Condition	Diverse Community	Medically Underserved	Low Income
Sandra Gonzalez	City of Placentia	x	x	x	x
Leonel Talavares	Habitat for Humanity		x	x	x
Helen Acevez	La Habra Family Resource Center	x	x	x	x
Steve Pitman	National Alliance of Mental Illness	x		x	
Wendy Dallin	Network Anaheim	x	x	x	x
Norma Lopez	OC Human Relations		x		x
Jay Williams	OC United		x		x
Mati Navarro	St. Jude Neighborhood Health Center	x	x	x	x

Appendix 3c. Focus Group Report

Community Focus Groups

St. Jude Medical Center held 3 Community Resident Focus Groups in three different cities of its Primary Service Area. Two focus groups were conducted in Spanish and one in Korean to ensure that people who face more challenges with having their voices heard could participate in the community input process. A total of 52 individuals participated in the Community Resident Focus Groups.

Location	Date and Time	Language	Attendees
La Habra	2/7/17, 6:00 PM	Spanish	12
Buena Park	2/15/17, 2:00 PM	Korean	12
Fullerton	2/22/17, 6:00 PM	Spanish	28

The Community Resident Focus Group attendees were 94% female and 6% male. 75% of attendees identified as Hispanic/Latino and 22% identified as Korean. Of those who responded, 67% said they earned less than $35,000 annually. More detailed demographic information is listed in Appendix 3a.

Resident participants were engaged and appreciated the opportunity to share their thoughts, as well as learn from others in the room. Attendees seemed to understand the purpose of the sessions, with most open to sharing their experiences and networking with one another to learn about available programs and services.

Identified Health Challenges

Food and Nutrition was discussed in all focus groups. Most participants understood the benefits of healthy eating and connected it to the development of obesity and diabetes. However, they shared their challenges in eating a healthy diet. Healthy, organic foods are more expensive than fast, processed foods. Children learn at an early age to prefer processed foods (like chicken nuggets at school), even when they are given healthy foods at home. Fast food eateries, donut shops, and food trucks that sell junk food are abundant in low-income neighborhoods. Food banks and churches often give out expired, dented canned goods and overripe produce that cannot be used and has to be thrown out. The Korean group also noted that food banks have mostly Western food, not Asian food.

Obesity, especially in children, was a concern among focus group participants. They cited the availability of sodas and sweetened juices, diets high in fat, and lack of exercise as contributing to the incidence of obesity.

Diabetes was mentioned as a health condition that is relatively common in the area. Poor diets, lack of exercise, and obesity were cited as contributing factors.

Lack of Exercise was cited as a contributor to obesity and diabetes. While one person noted that people do not like to exercise, participants also noted that conditions in the community (related to parks and walkability) make it difficult to exercise.

Appendix 3c. Focus Group Report (continued)

Parks were described in both positive and negative terms, with the most discussion in La Habra. Some parks are new and have exercise equipment for the public to use. But other parks are frequented by people using drugs and alcohol, selling drugs, and committing crime. Some parks have homeless populations living there. They are full of trash and not safe places for children to play or for adults to exercise.

A number of concerns affect the **Walkability** of the community. Too few streetlights, speeding cars, loose dogs, dog waste left on sidewalks, unmaintained roads and sidewalks, gangs, drugs, crime, and a lack of trust in the police all make walking in the community difficult. Some participants also confessed that it is hard to find the motivation to walk.

Participants in both La Habra and Fullerton noted that there are too few **Jobs** in the community so people have to travel long distances to find work. Fullerton participants also talked about how difficult it is for undocumented immigrants to get hired because of documentation requirements and how fears of deportation raids are keeping them from working. Not having a job causes stress and anxiety.

The effects of low incomes and **Poverty** are felt in a variety of ways. It affects access to quality housing and healthy food. Families cannot afford healthy food choices and end up eating more processed fast food. It affects the ability to pay for dental and health care, and causes stress as people try to make ends meet.

Housing was a major concern at the La Habra and Fullerton focus groups. The primary concern was apartments that are not maintained. They cited instances of mold, dirt, dust, old carpets, insect and rodent infestations, and neighbors who use marijuana and tobacco. These factors all contribute to **Asthma** and **Allergies** for the people who live there, particularly children. Tenants, especially undocumented immigrants, do not know their rights and are afraid to complain about the unsafe and unclean conditions. The high cost of rent adds to the stress in people's lives.

The challenges around **Immigration Status** that are faced by the undocumented community were discussed at the La Habra and Fullerton focus groups. Stress and fear of arrest and deportation has grown considerably since November 2016. Participants described how undocumented immigrants are afraid to access resources, including health services. Undocumented immigrants cannot purchase health insurance and end up using the emergency room when their health situation becomes dire. They explained how landlords and employers take advantage of the undocumented, knowing they are afraid to complain about exploitation. The Korean focus group participants (in Buena Park) mentioned that permanent residents are concerned that if they leave the country to visit their family they may not be able to return.

The Korean focus group participants mentioned that they often face **Language Barriers** at health care appointments and need translators, who are not always available.

Appendix 3c. Focus Group Report (continued)

Stress was mentioned at all of the focus groups as a contributor to poor **Mental Health**. Among the causes of stress, participants cited low incomes, the high cost of housing, unemployment, undocumented status, and cultural issues. The Korean focus group also mentioned the stress they experience from living so far from elderly family members.

Participants at La Habra and Fullerton described widespread problems with excessive **Alcohol** consumption throughout the community and specifically at apartments and parks. They noted that homeless people and other adults will purchase alcohol for minors and there are too many liquor stores in their neighborhoods. Participants also mentioned that young teens and preteens both use **Drugs** and are used to carry and deliver drugs for dealers. Drug use and sales were cited as reasons parks are unsafe.

The use and sale of drugs was linked to **Crime and Gangs.** Gang members hang around the neighborhoods and use young kids to sell drugs. Focus group members in La Habra were hesitant about describing the connections between gangs and drugs and made it clear that residents are afraid to report criminal activity by gang members. They also felt the legalization of marijuana has made the police less likely to arrest drug dealers. Their perception is that the police are only interested in issuing tickets that raise money for the city. Participants also mentioned crime in the neighborhoods and fears about being outside at night.

Insurance and Cost of Care were discussed at one focus group primarily in the context of undocumented immigrants being unable to purchase health insurance.

Long Commutes to work were mentioned at one focus group in connection to the lack of jobs in the community. People have to drive long distances for work and when the cost of gas is high, it does not make economic sense to drive far for a low-paying job.

Community Assets and Advantages

In addition to asking about issues facing the community, the facilitators explored what helps people stay healthy in the community. A number of positives were mentioned, including nearby parks with exercise equipment (mentioned at all three focus groups), the Family Resource Center (La Habra), and the Senior Center (Buena Park). The St. Jude Clinic was credited with offering dental and general health care and for organizing events, such as an annual walk and holiday events for children.

The availability of classes on health, nutrition, computing, or English was mentioned at all three focus groups. A person in Fullerton said having the university in town is an asset for the community. Residents also appreciated that there are Zumba classes in the community, a nearby gym that is affordable, and the Boys and Girls Club. Healthy food is available at the local Sprouts and the farmer's market.

At the Fullerton focus group, participants talked about how friendly people are in the community. The La Habra focus group found it more difficult to identify positives in their community, with one person stating, "There are more unhealthy things than there are healthy things."

Appendix 3c. Focus Group Report (continued)

Stakeholder Focus Group

The Stakeholder Focus Group was held at the St. Jude Urgent Care Building in Fullerton on February 23, 2017. There were 8 participants representing various community organizations and government entities (a complete list of participants is available in Appendix 3b). A few of the participants knew one another prior to participation in the focus group but others had an opportunity to meet new stakeholders and build relationships.

Identified Health Challenges

The stakeholders covered a wide range of topics during the 80-minute focus group, demonstrating their understanding of the social determinants of health and their impact on the communities served by St. Jude Medical Center. They also understood how intertwined the issues are, explaining, for example, how the high cost of living and low incomes are connected to crowded living conditions and landlords who do not take care of rental properties, which contribute to stress, safety, and trauma issues. All of these are described in more detail below.

Housing was discussed as a major challenge for low-income people in the service area. The high cost of housing leads families to double or triple-up in housing, or rent space in garages. People move frequently, which makes it difficult to meet neighbors or feel connected to the community. Slumlords do not respond to the needs of their tenants or raise the rent without sufficient advance notice. Undocumented residents are afraid to speak up and are taken advantage of. Investors come in and purchase homes to rent or flip, which drives prices up and makes home ownership out of reach for many local residents.

Homelessness was defined by the group as including families who live in motels or garages or are double or tripled-up in apartments. Participants also commented that homeless people in parks make the parks unsafe for children.

In an area with a high cost of living, many residents struggle to find **Jobs** that pay a living wage. Parents end up working multiple jobs to support their family. The focus group participants noted that economic hardship causes stress and depression, which contribute to overeating and weight gain. They also commented that extreme **Poverty** can lead to violence in the community. Incarceration of a parent also makes it difficult for families to get out of poverty. When one parent goes to jail, the other has to work harder for the family to make ends meet and cannot give the children the attention they need. After the incarcerated parent returns home, they are another mouth to feed and they may not be able to get work.

Appendix 3c. Focus Group Report (continued)

The challenges faced by low-income families around **Food and Nutrition** were discussed at some length. Some communities lack access to fresh fruits and vegetables, with the closest farmers' market too far from low-income neighborhoods. Local bodegas sell fried food and not a lot of produce. Fast food restaurants sell hamburgers for a dollar and salads for ten, so families with six children to feed buy the one dollar burgers. In some cultures, traditional foods are fried in lard and it is hard to get people to adopt healthy substitutes. The focus group also discussed concerns about large corporations sponsoring school events so they can market their products, such as soft drinks.

Getting enough **Exercise** is a challenge for many reasons. Some parks are unsafe because of homeless people, drug and alcohol use, poor lighting, and gang activity. Streets and sidewalks are not safe places to walk because of crime, traffic, and too few streetlights. There are apartment complexes that do not allow children to play outside and in some school districts, school yards are not open after school hours.

Participants recognized the prevalence of **Obesity** and **Diabetes** in the community and their connection to poor food and nutrition, lack of exercise, poverty, anxiety, and depression.

Mental Health was raised as a major concern in the community. They described how community and family violence cause trauma, anxiety, and depression. They also noted the continuing stigma around mental health which makes people reluctant to acknowledge their problems and seek help. It also was noted that patient privacy protections can lead to untreated and poorly treated mental illness because many people who need help do not seek treatment and family members cannot participate in that decision.

The participants included **Substance Abuse** among youth and adults as a problem in the service area and that it often occurs with mental illness. They noted that sometimes people start selling drugs to make a quick buck and then end up using drugs.

The vulnerability of **Undocumented Immigrants** was described in a couple of ways. They are afraid to exercise their rights for safe, affordable housing. Undocumented immigrants also are extremely cautious about their relationships with the police and service organizations. It takes a long time to build **Trust** in neighborhoods with undocumented immigrants. **Language** was also raised as a barrier to staying healthy in the community.

Many people have a strong connection to their families, but not to neighbors. This is compounded by frequent moves when people do not have stable housing. The lack of **Connection to the Community** makes it difficult to organize in neighborhoods. As one person said, "It's amazing how densely populated it can be and yet how socially isolated it can be."

Crime and Gangs make it hard to feel safe and contribute to stress and anxiety. These problems are compounded by a lack of trust in the police.

It can be difficult for people to get to resources such as community classes or the farmer's market because of challenges with **Transportation.** For those without cars, the bus system is difficult to use, but mostly people just put up with it rather than complain. As a result, people use cars if they can, which worsens traffic problems.

Appendix 3c. Focus Group Report (continued)

In closing comments, the participants talked about how they would like funders to invest in long-term solutions and long-term outcomes rather than expecting change to occur in just one or two years. For example, the gang problem will not be solved in a year. They also spoke about the importance of listening to local residents to learn about how people are living and managing day to day. They felt this is necessary for service providers to learn how to help.

Community Assets and Advantages

The facilitator asked participants what helps community members stay healthy. They pointed to several new outdoor gyms or parks with exercise equipment that have been built in vulnerable communities, with support from St. Jude and other community partners. St. Jude also has paid for people to be trained as Zumba instructors with a commitment to providing at least one free class in the community. These are well attended.

Participants pointed out the strong connection many community members have with their families, which can improve mental health.

The stakeholders also mentioned a number of organizations that serve the community, including the Fullerton Community Center, Fair Housing (which provides education and awareness around tenant and landlord rights), Family Oasis Family Resource Center, and My Safe Harbor program in Anaheim (empowering single moms). More importantly, they talked about how service providers are working together and developing partnerships with community members. They believe that it is essential to have community resident buy-in in order to build capacity in the area.

Appendix 3d: Focus Group Protocols and Demographic Survey

Community Resident Focus Group Protocol

Introduction:

Hello everyone and thank you for agreeing to be part of this focus group. We appreciate your time and willingness to participate.

We are doing this focus group as part of St. Jude Medical Center Community Health Needs Assessment. This is an every three years process in which non-profit hospitals such as St. Jude explore community needs with input from the local community to better respond to the unmet needs. My name is _____ and I'll be running the focus group along with my colleague _____. We do not work for the hospital as they wanted to have an outside partner to help run the process. This focus group is one of many that St. Jude Medical Center is holding to hear directly from its communities' residents.

A focus group is a great way to get information and to capture people's ideas, opinions, and experiences. It's a structured conversation where we have some scripted questions and look to you to respond and take the discussion where it needs to go.

We need your input and want you to share your honest and open thoughts with us. Your responses will be anonymous. While we will be reporting in broad terms what is said during this focus group, we will not be attributing it to any person or organization. And we ask the same of you—that if you discuss this focus group outside of this room, you do not connect anyone to anything specific that was said.

Ground Rules:

1. There are no right or wrong answers. It's ok to respectfully disagree with someone else's opinion as that leads to dialogue and a better understanding of everyone's position and thoughts. Every opinion counts, and it is perfectly fine to have a different opinion than others in the group, and you are encouraged to share your opinion even if it is different.

2. We have a list of questions to ask, but we want YOU to do the talking. We would like everyone to participate, so we may call on people who have been particularly quiet.
3. We would like to record our conversation. Our note taker will be taking notes so that we remember what people have to say, but we'd also like to record the conversation to ensure we have the most accurate information possible. Is that okay?

This session should take 90 minutes. If you need to get up to use the restroom or grab refreshments, feel free to do so.

Any questions before we begin?

Appendix 3d: Focus Group Protocols and Demographic Survey (continued)

OK, then a couple other things before we get into the questions. First of all, can we please go around the room and introduce ourselves and say where we live and say something you like about your community.

Focus Group Questions

1. What are the biggest health issues affecting you, your family and friends in the community?
    a. Prompt – health issues refers to specific health conditions like heart problems, diabetes, obesity, cancer, asthma, or depression, and health behaviors refers to exercising, smoking, unhealthy eating, and drug use

Now, I'd like to ask you to look at the graphic that we're handing out right now. This was made by the United States Center for Disease Control and Prevention, a federal agency whose mission it is to help our country be healthy. The visual shows the many things that contribute to community health. Note that this graphic, and your own introductions, show that there is a lot more to "health" than just medical concerns. Let's keep that in mind as we go to our next questions.

2. What are the things in your community that help you stay healthy?
    a. Prompt – if you were to tell a friend about some of the good things in this community that help people live a good life here, what would you tell them?
    b. Prompt – This could include safe places to walk, clean air, enough doctors, easy access to health care, caring community, affordable housing, good-paying jobs, etc.
3. What are some of the challenges to staying healthy in this community?
    a. Prompt – if you were to tell a friend about some of the things that make it difficult to live a good life here, what would you tell them?
    b. Prompt – This could include no nearby grocery stores with fresh produce, no place to get exercise, overcrowded housing, low incomes, no doctors that take your insurance, poor air quality, gangs, etc.
4. Thinking about all the concerns discussed today, which do you think are the biggest concerns needing the most immediate attention?
5. What would you like to see in the communities to address these top concerns? How can some of the positive aspects of your community help?

Closing:

I wanted to thank you on behalf of the hospital for spending your time with us and sharing your wisdom and experiences. I wanted to stress that this meeting has been one very important part of the Needs Assessment process for St. Jude Medical Center. I also wanted to be clear that everything that was said today will be recorded, reported, and considered. But some of what was said may not find its way into the final plan, because the hospital has to pull together everything they've learned in the process and make decisions about priorities. What I can say is that the final plan will be publicly available, and if you read it, you should see the key themes from today's meeting in there. Thank you again, and have a good evening.

Appendix 3d: Focus Group Protocols and Demographic Survey (continued)

Government/Non-Profit Stakeholders Focus Group

Hello everyone and thank you for agreeing to be part of this focus group. We appreciate your willingness to participate.

We are doing this focus group as part of St. Jude Medical Center Community Health Needs Assessment. This is an every three years process in which non-profit hospitals such as St. Jude study their communities' needs in order to become even better at serving those needs. My name is _____ and I'll be running the focus group along with my colleague _____. We do not work for the hospital as they wanted to have an outside partner to help run the process. This focus group is one of other focus groups that are being conducted with community residents.

A focus group is a great way to get information and to capture people's ideas, opinions, and experiences. It's a structured conversation where we have some scripted questions and look to you to respond and inform the discussion to where it needs to go.

We need your input and want you to share your honest and open thoughts with us. Your responses will be anonymous. While we will be reporting in broad terms what is said here today, we will not be attributing it to any person or organization. And we ask the same of you—that if you discuss this focus group outside of this room, you do not connect anyone to anything specific that was said.

Ground Rules:

1. We have a list of questions to ask, but we want YOU to do the talking. We would like everyone to participate, so we may call on people who have been particularly quiet. But answering any question is optional.
2. There are no right or wrong answers. It's ok to respectfully disagree with someone else's opinion. In fact, we encourage it because it leads to dialogue and a better understanding of everyone's position and thoughts.
3. _____ will be taking notes, but we also will be recording the group in order to capture everything you have to say. We are doing this for our own notes and reporting, but again, we won't share the recording or identify anyone by name in our report. You will remain anonymous.

Facilitator shows presentation focusing on high level findings from quantitative data. During the presentation, use the BARHII visual as an icebreaker to get people to talk about what factors influence a community's health, while answering the question "Please tell us your name, organization, and referring to the visual (provided in the PowerPoint), which area does your organization focus on or address in the upstream or downstream factors that influence community health?

Appendix 3d: Focus Group Protocols and Demographic Survey (continued)

After concluding the presentation, ask the following questions:

1. What are the biggest health issues facing our community?
    a. Prompt – health issues refers to specific health conditions like heart problems, diabetes, obesity, cancer, asthma, or depression, and health behaviors refers to exercising, smoking, unhealthy eating, and drug use
2. What helps our community stay healthy?
    a. Prompt – if you were to tell a friend or colleague about some of the good things in this community that help people live a good life here, what would you tell them?
    b. Prompt – This could include safe places to walk, clean air, enough doctors, easy access to health care, caring community, affordable housing, good-paying jobs, etc.

3. What are the challenges to staying healthy in our community?
    a. Prompt – if you were to tell a friend or colleague about some of the things that make it difficult for people to live a good life here, what would you tell them?
    b. Prompt – This could include no nearby grocery stores with fresh produce, no place to get exercise, overcrowded housing, low incomes, no doctors that take residents' insurance, poor air quality, gangs, etc.
4. What are the opportunities in our community to improve and maintain health?
5. What are the biggest health concerns needing immediate attention?

Closing: Thank the participants and talk about next steps.

Appendix 3d: Focus Group Protocols and Demographic Survey (continued)

Demographic Survey

Thank you for taking time to participate in our focus group today. Please take a few moments to complete the demographic survey below. Your identity will be kept confidential and anonymous. We'd like to gather some demographic data to reflect the individuals who participated in the focus groups. Please complete the survey and submit to the facilitator. Thank you for your time.

1. **Please check the box next to the description that best describes you:**

☐ Community Member who does not work for a local health or social services provider (skip to question 3)
☐ Community Member employed by:
- ☐ Community-based Org/Nonprofit
- ☐ County/Government Agency
- ☐ Foundation/Funder
- ☐ Health Care/Hospital/Clinic
- ☐ University
- ☐ Other (please provide): _____

2. **If applicable, please check the box next to the role that most closely matches your position/role within the organization:**

- ☐ Administrative Staff
- ☐ Board Member
- ☐ Executive Director
- ☐ Medical Professional
- ☐ Program Manager/Staff
- ☐ University/Faculty/Researcher
- ☐ Volunteer
- ☐ Other (please provide): _____

3. **Please check the box next to your current gender identity:**

- ☐ Female
- ☐ Male
- ☐ Other (please provide): _____
- ☐ Decline to answer

4. **What race/ethnicity do you identify as (Please select all that apply)**

- ☐ Black/African American
- ☐ Non-Latino White
- ☐ Asian or Pacific Islander:
  - ☐ Vietnamese
  - ☐ Filipino
  - ☐ Chinese
  - ☐ Japanese
  - ☐ Korean
  - ☐ Indian
- ☐ Hispanic/Latino
- ☐ Native American
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other: _____

5. **Do you identify as a person with chronic conditions, or a leader or representative of individuals with chronic conditions (such as diabetes, arthritis, or cancer)?**

- ☐ Yes
- ☐ No
- ☐ Decline to answer

6. **What is your age group?**

- ☐ 0 - 17 years
- ☐ 18 - 44 years
- ☐ 45 – 64 years
- ☐ 65 - 74 years
- ☐ 75 years or older

7. **How much total combined money did all members of your HOUSEHOLD earn last year before taxes?**

- ☐ Less than $20,000
- ☐ $20,000 to $34,999
- ☐ $35,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 or more
- ☐ Decline to answer

8. **How many people live in your household, including you?** Please enter a number **_____**

Appendix 4: Existing Health care Facilities in the Community

Name	Address	Description of Services Provided
St. Jude Neighborhood Health Centers	731 S. Highland Avenue Fullerton	Primary medical care services, dental, mental health, health education
VCC: The Gary Center	201 S. Harbor Blvd. La Habra	Primary medical care services, dental, mental health
Sierra Health Center	501 S. Brookhurst Fullerton	Primary medical care
North Orange County Regional Health Foundation	901 W. Orangethorpe Ave. Fullerton	Primary medical care
KCS Health Center	7212 Orangethorpe Ave. Buena Park	Primary medical care, mental health
Friends of Family Health Center	501 S. Idaho St. La Habra	Primary medical care, dental care
Central City Community Health Center	2237 Ball Rd. Anaheim	Primary medical care, dental care, mental health
Alta Med Medical Group	1820 W. Lincoln Ave. Anaheim 1814 W. Lincoln Ave. Anaheim	Primary medical care
UCI Family Health Center	300 W. Carl Karcher Way Anaheim	Primary medical care, mental health
Whittier First Day Health and Wellness Center	12426 Whittier Blvd Whittier	Primary care for the homeless
Presbyterian Intercommunity Hospital	12401 Washington Blvd. Whittier	Acute care services
Kaiser Hospital Anaheim	3460 E. La Palma Ave Anaheim	Acute care services
Placentia Linda Hospital	1301 N. Rose Dr. Placentia	Acute care services

Appendix 5: Prioritization Protocol Worksheets

Step 1 Criteria and Score Definitions

#	Criteria	Criteria Definition	Score Definitions				
Step 1			1	2	3	4	5
1	**Seriousness of the problem**	Degree to which the problem leads to death, disability, and impairs one's quality of life.	For most people with the problem, the consequences are mild and not life threatening		Most people with the problem have some impairment of their quality of life; only some people die from the problem		For most people with the problem, the consequences are lethal or extremely debilitating
2	**Scope of the problem - Part 1**	Number of persons affected	Affects very few people		Affects about half the population		Affects much of the population
3	**Scope of the problem - Part 2**	Take into account the variance between regional benchmark data and targets and/or statewide averages. (for example, the prevalence of the problem in the primary service area compared to Target 2020 goals and/or prevalence in the county or state.)	The region is doing much better than targets or county/statewide averages		The region is on par with targets or county/statewide averages		The region is doing much worse than targets or county/statewide averages
4	**Health disparities**	Degree to which specific groups are affected by the problem	There are no differences in prevalence or severity of the problem across demographic or socioeconomic groups		One or more demographic or socioeconomic groups are doing moderately worse than the average in the service area		One or more demographic or socioeconomic groups are doing much worse on the health problem than the average in the service area
5	**Importance to the community**	Community members recognize this as a problem; it is important to diverse community stakeholders	Community input did not identify this area as a problem		Community input showed a moderate amount of concern about this problem		Community input showed a high level of concern about this problem
6	**Potential to affect multiple health issues**	Affects residents' overall health status; addressing this issue would impact multiple health issues.	Addressing this issue would not affect any other health issue		Addressing this issue would affect a few other health issues		Addressing this issue would impact many health issues - it is a root problem
7	**Implications for not proceeding**	Risks associated with exacerbation of problem if not addressed at the earliest opportunity	There is no risk that this problem will get worse if we don't address it now		There is a moderate risk that the problem will get worse if we don't address it now		This problem will definitely get worse if we don't address it now

These criteria were applied by raters from The Olin Group Evaluation Team to all identified health needs.

Step 2 Criteria and Score Definitions

#	Criteria	Criteria Definition	Score Definitions				
Step 2			1	2	3	4	5
8	**Sustainability of impact**	The ministry's involvement over next 3 years would add significant momentum or impact that would remain even if funding or ministry emphasis were to cease	Ministry involvement would likely yield little to no momentum or impact that would remain after 3 years of funding		Ministry involvement would likely yield moderate momentum or impact that would remain after 3 years of funding		Ministry involvement would likely yield significant momentum or impact that would remain after 3 years of funding
9	**Opportunities for coordination/ partnership**	Ability to be part of collaborative efforts	There is not much opportunity for the ministry to be part of collaborative efforts		There is some opportunity for the ministry to be part of collaborative efforts		There are many opportunities for the ministry to be part of collaborative efforts
10	**Focus on prevention**	Effective and feasible primary and/or secondary prevention is possible	There are no or few effective and feasible prevention strategies with which the ministry could be involved		There are a moderate number of effective and feasible prevention strategies with which the ministry could be involved		There are many effective and feasible prevention strategies with which the ministry could be involved
11	**Existing efforts on the problem**	Ability to enhance existing efforts in the community	There is so much work being done on this problem that our contribution would be meaningless		The problem is already being addressed by others and our contribution would be only moderately meaningful		We could make a very meaningful contribution to enhance the work of others in addressing this problem
12	**Organizational competencies (only CB Staff complete)**	Ministry has or could develop the functional/technical, behavioral (relationship building) and leadership competency skills to address significant health need	The ministry does not have and could not develop the competencies to address the issue		The ministry has some of the competencies or could develop them to address the issue		The ministry has or could easily develop strong organizational competencies to address the issue

These criteria were applied by raters from the St. Jude Medical Center Health Needs Assessment Prioritization Working Group to all identified health needs.

Step 3 Criteria

Criteria	Criteria Definition	Responses		
Step 3		**Yes**		**No**
Relevance to Mission of St. Joseph Health	Is this area relevant or aligned with the Mission of St. Joseph Health?	Proceed to the next set of criteria		No further consideration of this health problem is necessary
Adheres to ERD's	Does this area adhere to the Catholic Ethical and Religious Directives?	Proceed to the next set of criteria		No further consideration of this health problem is necessary

These criteria were applied by the Community Benefit Staff of St. Jude Medical Center to all identified health needs.

Appendix 6: SJMC Community Benefit Committee

Name	Title	Affiliation or Organization
Ms. Sandi Baltes	Executive Director	La Habra Collaborative
Dr. Clayton Chau	Regional Medical Director, Mental Health	St. Joseph Hoag Health
Mr. Ron Di Luigi	Community Member	CalOptima Board
Dr. John Dymond	Retired Physician	St. Jude Medical Center
Ms. Rose Espinosa	Council Member	City of La Habra
Ms. Karin Freeman	Trustee	Cities of Placentia and Yorba Linda
Bishop Tim Freyer	Auxiliary Bishop	Diocese of Orange
Ms. Alison Garcia	Teacher	Fullerton School District
Ms. Sandra Gonzalez	Director of Community Services	City of Placentia
Mr. Rich Good	CEO	Anaheim YMCA
Mr. Miguel Hernandez	CEO	OC Congregation Community Organization
Mr. Duncan Johnson	Retired Superintendent	
Mr. Rusty Kennedy	CEO	Orange County Human Relations
Mr. Joe Lins	Realtor	
Dr. Donna Marino	Medical Director	St. Jude Neighborhood Health Center

Appendix 6: SJMC Community Benefit Committee (Continued)

Name	Title	Affiliation or Organization
Sr. Eileen McNerny	Sister of St. Joseph Board Member	Sisters of St. Joseph of Orange St. Jude Medical Center
Dr. Maria Minon	CMO Board Member	Children's Hospital of Orange County St. Jude Medical Center
Ms. Carol Morrison	Community Member	
Sr. Mary Rogers	Sister of St. Joseph Board Member	Sisters of St. Joseph of Orange St. Jude Medical Center
Ms. Hilda Sugarman	Board Member	Fullerton School District
Dr. Beth Swift	Mayor	City of Buena Park
Ms. Lynne Thies	Board Member	NAMI
Mr. Joseph Vargas	Supervisor	County of Orange HC Agency
Dr. Jeffery Winston	Ophthalmologist	St. Jude Heritage
Mr. Brian Helleland	Chief Executive	St. Jude Medical Center
Mr. Mark Jablonski	V.P. Mission Integration	St. Jude Medical Center
Ms. Susan Smith	V.P. Philanthropy	St. Jude Medical Center
Mr. Barry Ross	Vice President of Healthy Communities	St. Jude Medical Center