2024

COMMUNITY BENEFIT REPORT/

PROGRESS ON 2024-2026 COMMUNITY HEALTH IMPROVEMENT PLAN

Providence St. Jude Medical Center

To provide feedback on this CB Report or obtain a printed copy free of charge, please email Cecilia Bustamante-Pixa at Cecilia.Bustamante-Pixa@stjoe.org.

Providence

CONTENTS

EXECUTIVE SUMMARY

Providence continues its Mission of service in Orange County through Providence St. Jude Medical Center (SJMC). SJMC is an acute-care hospital founded in 1957 and located in Fullerton, California. The hospital's service area is the entirety of North Orange County, including 1,690,000 people.

Providence St. Jude Medical Center dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of people experiencing social inequities and health disparities. In FY24, the hospital provided $41,501,174 in Community Benefit in response to unmet needs. For FY24, Providence St. Jude Medical Center had an unpaid cost of Medicare of $63,328,792.

2024-2026 Providence St. Jude Medical Center Community Health Improvement Plan Priorities

As a result of the findings of our **2023 CHNA** and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, Providence St. Jude Medical Center focused on the following areas for its 2024-2026 Community Benefit efforts:

PRIORITY 1: ACCESS TO CARE

Ensure access to care that is financially sustainable for vulnerable, underserved, and low-income communities.

2024 Accomplishments

In FY24 the Avoidable Emergency Department (AED) Navigation program increased the number of primary care physician visits and specialty care visits by 21% among the Medi-Cal/ CalOptima patients. There was also a 171% increase in urgent care visits and a 46% reduction in avoidable ED visits. By our partners, CHIOC, 3,197 persons were enrolled into Medi-Cal and community outreach was expanded to 7,805 persons. 628 high school students from the Anaheim Union High School District (AUHSD) participated in health care workforce development programmatic efforts in collaboration with the TGR Foundation.

The Finamore Place clinic site of St. Jude Neighborhood Health Centers is scheduled to open during the fall 2024. It is in the process of final credentialing with CalOptima.

PRIORITY 2: BEHAVIORAL HEALTH (INCLUDING MENTAL HEALTH AND SUBSTANCE USE)

Creating awareness and providing services addressing mental health and substance use disorders.

2024 Accomplishments

Promise to Talk acquired over 2.09M impressions across all social media and web platforms during FY24. The year ended with 55,329 total encounters and 1,635 total promises made. 15,300 residents actively engaged on the social media platforms. 16 new lime green benches were installed at schools, churches, parks, and mental health rehabilitation centers. The Medication Assisted Treatment (MAT) program

continues to be implemented in the hospital emergency department since 2021. Emergency room implemented community naloxone distribution. 575 patients received MAT services in the ED. A total of 109 psychiatry visits to St. Jude Neighborhood Health Centers in Fullerton and Anaheim sites were provided.

PRIORITY 3: HOMELESSNESS AND AFFORDABLE HOUSING

Support effective advocacy efforts on state and local level.

2024 Accomplishments

In FY24, 884 housing champions were trained by our partners OC United Way and People for Housing OC/ YIMBY who engaged in housing element work to promote stronger policies and projects that will result in affordable housing and help prevent homelessness. In FY24 two new housing developments opened in Buena Park and in Santa Ana adding a total of 60 affordable housing units and 106 permanent supportive housing units in OC with the support of the Housing Champions. As a result of these efforts 1,089 people have been housed through WelcomeHomeOC and 157 property owners are in the network. The affordable housing navigation website has helped expand on these efforts.

Providence

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

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

Providence across five western states:

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

The Providence affiliate family includes:

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

As a comprehensive health care organization, we are serving more people, advancing best practices and continuing our more than 100-year tradition of serving the poor and vulnerable. Delivering services

across seven states, Providence is committed to touching millions of more lives and enhancing the health of the American West to transform care for the next generation and beyond.

INTRODUCTION

Who We Are

Our Mission	As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.
Our Vision	Health for a Better World.
Our Values	Compassion — Dignity — Justice — Excellence — Integrity

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

Our Commitment to Community

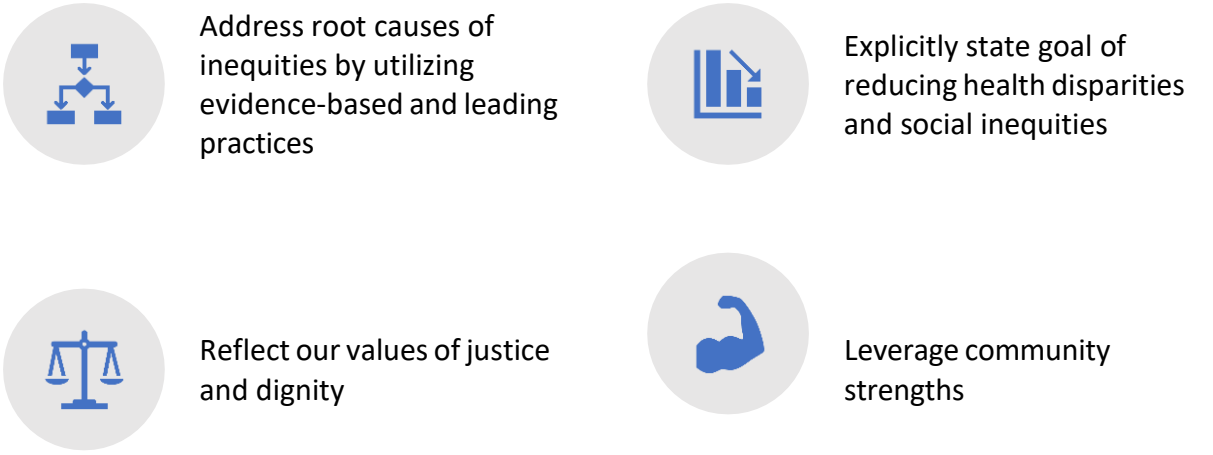
Providence St. Jude Medical Center dedicates resources to improve the health and quality of life for the communities we serve. During Fiscal Year 2024 (July 1, 2023 – June 30, 2024), Providence St. Jude Medical Center provided $41,501,174 in Community Benefit in response to unmet needs and to improve the health and quality of life for the communities we serve in North Orange County.

Health Equity

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

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

Figure 1. Best Practices for Centering Equity in the CHIP



Community Benefit Governance

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

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

The Community Health Committee has a minimum of twelve members, chaired by a member of the Medical Center Ministry Board. Current membership includes 17 community members. A majority of members have knowledge and experience with the populations most likely to have disproportionate unmet health needs. The Community Health Committee generally meets quarterly.

Roles and Responsibilities

Senior Leadership

• Chief Executive and senior leaders are directly accountable for CB performance.

Community Health Committee (CHC)

• CHC serves as an extension of trustees to provide direct oversight for all charitable program activities and ensure program alignment with "Advancing the State of the Art of Community Benefit" (ASACB) Five Core Principles. It includes diverse community stakeholders. Trustee members on CHC serve as 'board level champions.'

• The Committee provides recommendations to the Board of Trustees regarding budget, program targeting and program continuation or revision.

Community Health (CH) Department

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

• Manage data collection, program tracking tools and evaluation.

• Develops specific outreach strategies to access identified Disproportionate Unmet Health Needs (DUHN) populations.

• Coordinates with clinical departments to reduce inappropriate ER utilization.

• Advocates for CB to senior leadership and invests in programs to reduce health disparities.

Local Community

• Partnership to implement and sustain collaborative activities.

• Formal links with community partners.

• Provide community input to identify community health issues.

• Engagement of local government officials in strategic planning and advocacy on health-related issues on a city, county or regional level.

Planning for the Uninsured and Underinsured

Our Mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why Providence St. Jude Medical Center has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

One way Providence St. Jude Medical Center informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers

are offered an opportunity to complete the Patient Financial Assistance Application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible. For information on our Financial Assistance Program click https://www.providence.org/obp/ca. In FY24, Providence St. Jude Medical Center provided $3,697,271 free (charity care) and discounted care.

Medi-Cal (Medicaid)

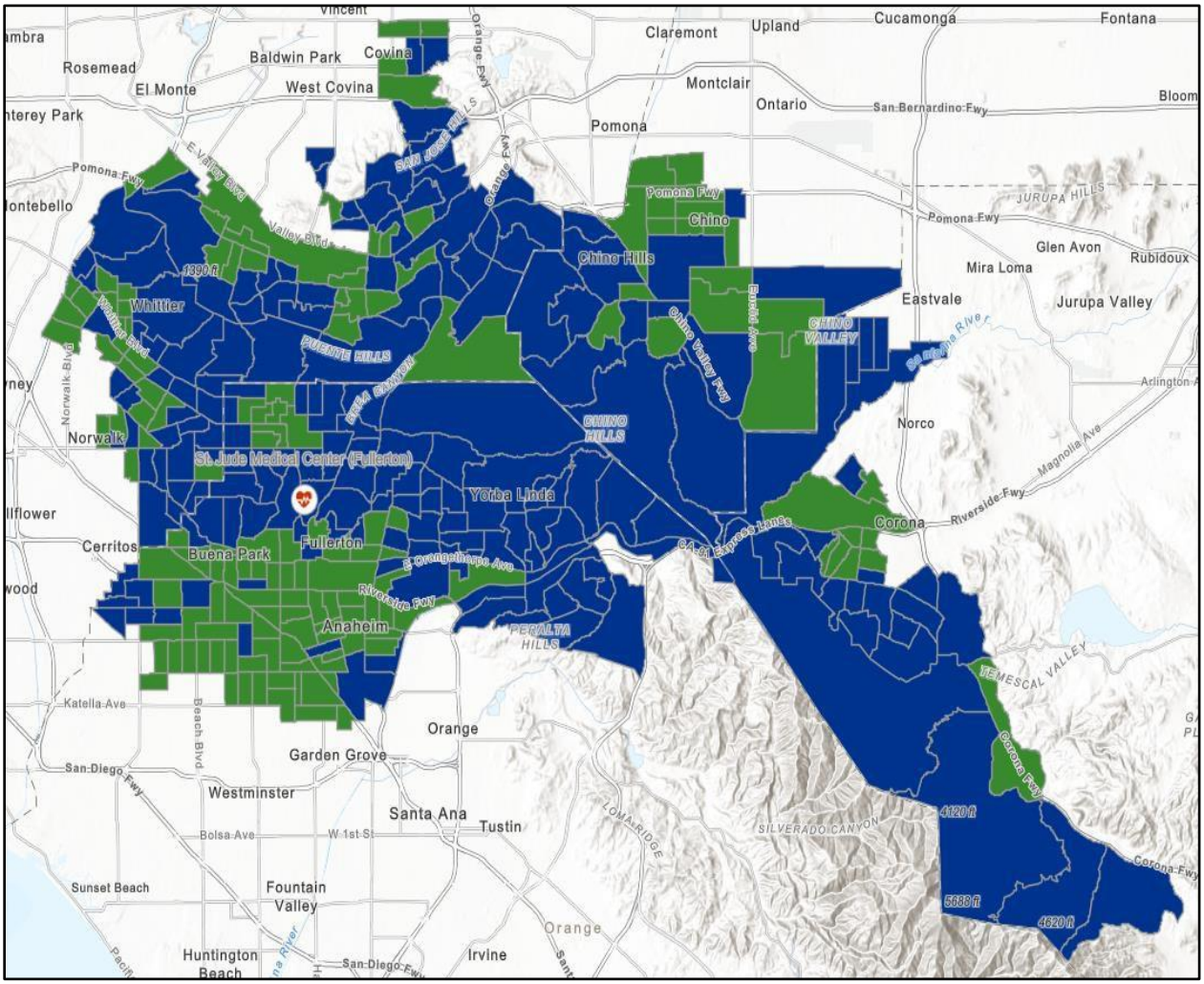
Providence St. Jude Medical Center provides access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California. In FY24, Providence St. Jude Medical Center provided $33,137,712 in Medicaid shortfall.

OUR COMMUNITY

Description of Community Served

Providence St. Jude Medical Center's service area is North Orange County and includes a population of approximately 1,690,000 million people.

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



To facilitate identifying health disparities and social inequities by place, we designated a "high need" service area and a "broader" service area, which together make up the North Orange County service area. Based on work done by the Public Health Alliance of Southern California and their Healthy Places Index (HPI) tool, we identified the high need service area based on income, education, English proficiency, and life expectancy.

Community Demographics

The following demographics are from the 2021 American Community Survey, 5-year estimate.

POPULATION AND AGE DEMOGRAPHICS

Of the over 1,690,000 permanent residents in the total service area, roughly 47% live in the high need area, defined by lower life expectancy at birth, lower high school graduation rates, and more households at or below 200% FPL compared to census tracts in the total service area. For reference, 200% FPL is equivalent to an annual household income of $53,000 or less for a family of 4. These households are more likely to regularly make spending tradeoffs regarding utilities, rent, groceries, medicine, and other basic expenses. The population in St. Jude Medical Center's total service area makes up 53% of Orange County.

The male-to-female distribution is roughly equal across geographies. Individuals under the age of 35 are more likely to live in high need census tracts.

Table 1. Population Demographics for St. Jude Medical Center Service Area and Orange County

Indicator	St. Jude Medical Center Service Area	Broader Service Area	High Need Service Area	Orange County
Total Population	1,690,479	901,553	788,926	3,182,923
Female Population	50.4%	50.8%	50.0%	50.4%
Male Population	49.6%	49.2%	50.0%	49.6%

Source: American Community Survey, 2021 5-Year Estimate

POPULATION BY RACE AND ETHNICITY

In comparison to the St. Jude service area overall, the people identifying as Hispanic, two or more races, some other race, and American Indian or Alaska Native are overrepresented in the high need service area. People identifying as white and Asian are overrepresented in the broader service area.

SOCIOECONOMIC INDICATORS

Table 2. Income Indicators for North Orange County Service Area

Indicator	Broader Service Area	High Need Service Area	Total Service Area	Orange County
Median Income Data Source: 2021 American Community Survey, 5-year estimate	$117,402	$74,335	$97,116	$100,429

The median income for the total service area for St. Jude Medical Center is slightly lower than Orange County overall. There is over a $43,000 difference in median income between St. Jude Medical Center Broader Service Area and the High Need Service Area.

Full demographic and socioeconomic information for the service area can be found in the 2023 CHNA for Providence St. Jude Medical Center.

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

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

Knowing where to focus our resources starts with our Community Health Needs Assessment (CHNA), an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets, and opportunities. The results of the CHNA are used to guide and inform efforts to better address the needs of the community. Through a mixed-methods approach, using quantitative and qualitative data, we collected information from the following sources: American Community Survey, Behavioral Risk Factor Surveillance System, local public health data, California Department of Public Health, California Office of Statewide Health Planning and Development, California Health Interview Survey, Orange County Health Care Agency's Data Portal, Orange County Equity Map, the National Cancer Institute, and local community health reports, and hospital utilization data. We also conducted listening sessions with community members and fielded a key informant survey to actively engage the community.

The 2023 CHNA was approved by the SJMC Community Health Committee on September 20, 2023.

Significant Community Health Needs Prioritized

On September 20, 2023, the primary and secondary data findings were reviewed with members of a cross-sector group Community Health Committee along with members of Providence staff. They asked questions and engaged with the data. One member requested that Health Education be added as a top significant need, which it was. At the end of the review, Committee members were invited to choose their top three priority needs based on the five criteria below.

The following criteria were used in the prioritization process:

- Worsening trend over time
- Disproportionate impact on low income and/or Black/African American, Brown, Indigenous, and People of Color (BBIPOC) communities
- Providence service area/high need service area rates worse than state average and/or national benchmarks
- Opportunity to impact: organizational commitment, partnership, severity, and/or scale of need
- Alignment with existing System priorities

PRIORITY 1: ACCESS TO CARE

Primary and secondary data shows that access to health care is challenging and inequitable, which can lead to inequitable health outcomes. There is race/ethnic/linguistic inequity. Black/African American and Hispanic or Latino individuals have the highest rate of AEDs and Behavioral Health ED visits in the St. Jude Medical Center service area. To reduce racial/ethnic disparities, outreach and services should be culturally and linguistically responsive. This includes a representative workforce and high-quality, widely available medical interpretation, and materials. People identifying as LGBTQIA+ and people with disabilities may experience inequities in health care access as well. For many individuals, culturally and linguistically responsive health education is important to their ability to access care (e.g., when to access preventive services, urgent care, ED, how to manage chronic conditions, etc.). Bringing health education and health services to the community where they are and partnering with trusted messenger community based organizations is critical to community health as well. Transportation is an ongoing barrier to access.

PRIORITY 2: BEHAVIORAL HEALTH (INCLUDING MENTAL HEALTH AND SUBSTANCE USE)

There is a need for more capacity (e.g., more facilities, providers, space, etc.) as well as mental health services that directly address the stigma of accessing mental health and substance use care, which varies by culture and community. Specific populations that were identified in listening sessions as needing additional mental health support include older adults in isolation and assisted living facilities, parents/caregivers of children identifying as LGBTQIA+, and people who have experienced trauma, violence, and displacement.

PRIORITY 3: AFFORDABLE HOUSING AND HOMELESSNESS

A lack of affordable housing can contribute to homelessness. Community members shared that affordable housing, especially for larger and multi-generational families is a need. Hospital leaders note the importance of meeting the needs of those who are housing insecure and/or unhoused.

Needs Beyond the Hospital's Service Program

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

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

The following community health needs identified in the ministry CHNA will not be addressed due to limited funds and capacity and to ensure a focused approach to the three CHIP priorities. Explanations are provided below:

1. **Culturally and linguistically concordant services:** While this was not selected as a priority issue, St. Jude Medical Center works to integrate culturally and linguistically concordant services in its community-based programming as well as provides interpreter services for multiple languages in its hospital-based settings.
2. **Access to safe, reliable transportation:** Although not identified as a top priority SJMC provides transportation support with taxi vouchers to vulnerable and low-income ED and inpatient population.
3. **Lack of community involvement and engagement:** Stakeholders and micro communities who participated in listening sessions identified a lack of involvement and engagement among some communities to address health disparities and inequities. Although this is not a priority identified, SJMC will prioritize community involvement and engagement in all key initiatives.
4. **Economic insecurity (lack of living wage jobs and unemployment):** While SJMC is not focusing on a specific initiative around economic insecurity, all strategies focus on the principles of health equity which can/will include issues around economic insecurity. In addition, our partnership with The Hub Family Resource Center in the Fullerton School District provides temporary financial support and access to social services that qualify families for financial assistance and job placement.
5. **Basic needs:** Although not identified as a selected priority, SJMC funds the pharmacy medication program by providing needed prescription medication to low-income and vulnerable patients upon discharge from the hospital. Additionally, St. Jude Medical Center provides access to clothing, shoes, and basic hygiene items to unhoused patients.
6. **Food insecurity:** Although not identified as a selected priority, SJMC will continue to address food insecurity through partnerships such as The Hub Family Resource Center in the Fullerton School District which provides food, temporary housing, and school attendance support.
7. **Access to dental care:** SJMC does not directly provide dental services, however we partner with local Federally Qualified Health Centers who offer this service.
8. **Racism and discrimination:** While SJMC is not focusing on a specific initiative around racism and discrimination all strategies focus on the principles of health equity which directly address racism and discrimination.
9. **Domestic violence, child abuse/neglect:** St. Jude Medical Center does not directly address domestic violence; however, we partner with community organizations who specialize in domestic violence and child abuse/neglect through our Federally Qualified Health Center (FQHC) partner.

In addition, Providence St. Jude Medical Center will collaborate with local organizations that address the aforementioned community needs to coordinate care and referrals to address these unmet needs.

COMMUNITY HEALTH IMPROVEMENT PLAN

Community Benefit Plan Report FY24

Providence St. Jude Medical Center approved its most recent Community Health Needs Assessment (CHNA) on November 15, 2023 and the Community Health Improvement plan in as required by state and federal law on February 14, 2024. The CHNA is a primary tool used by the hospital to determine its community benefit plan as required by California legislation, which outlines how we respond to community need. Because we are required to report a fiscal year July 1-June 30 time period for the state of California, and follow a January 1- December 31 time period, for federal reporting, we will report on 6 -months of the 2024-2026 CHIP/CB Plan where feasible, and close out our July 1-Dec.
2023 accomplishments, for the remaining 6 months of the 2021-2023 CHIP/CB Plan.

Summary of Community Health Improvement Planning Process

The local Community Health team worked with internal and external partners to develop strategies to respond to community needs.

The 2024-2026 CHIP was approved on February 14, 2024, and made publicly available no later than May 15,2024.

Addressing the Needs of the Community: 2024-2026 Key Community Benefit Initiatives and Evaluation Plan

2024 Accomplishments

COMMUNITY NEED ADDRESSED #1: ACCESS TO CARE

Initiative Name

Access to care

Population Served

Underserved, uninsured/underinsured communities in North Orange County

Long-Term Goal(s)/ Vision

1. To improve access to health care and preventive resources for people with low incomes and those uninsured by deploying programs to assist with navigating the health care system.
2. To ease the way for people to access appropriate and culturally responsive levels of care at the right time.

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

Strategy	Population Served	Strategy Measure	FY24 (6 month period) Accomplishments

Ensure seamless transition to Medi-Cal/CalOptima	Newly Medi-Cal eligible FQHC patient population.	# of patients enrolled	710 patients
Open new Finamore Place clinic site in Anaheim	Low Income uninsured and underinsured persons	# of patients served	Clinic opens September-December 2024
Support Avoidable ED Navigation Program to provide comprehensive intervention	Medi-Cal/CalOptima patients.	# of Avoidable ED visits # of PCP visits and Specialty Care visits	46% reduction in AED visits 21% increase in PCP visits and specialty care visits 171% increase in Urgent Care visits
Increase access to health care for North and Central Orange County providing Medi-Cal outreach, enrollment, retention, and utilization services.	Uninsured undocumented population age 26-49 who are newly eligible for Medi-Cal	# of persons enrolled # of persons receiving outreach and education	Enrolled 3,197 persons Provided outreach to 7,805 persons
Partner with TGR Foundation to promote health care workforce development	11th and 12th grade high school students in the Unified Anaheim School District	# of students participating in the healthcare career pathways program	628 total student participants

Evidence Based Sources

- Health insurance enrollment outreach and support: https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/health-insurance-enrollment-outreach-support
- Federally qualified health centers (FQHCs): https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/federally-qualified-health-centers-fqhcs
- Strategies for expanding health insurance coverage in vulnerable populations - Healthy People 2030 | health.gov

Resource Commitment

$1M per year in operating support for all access to care initiatives in 2024-2026

Key Community Partners

St. Jude Neighborhood Health Centers; Heritage Medical Group; CalOptima/CalAIM; Community Health Initiative of Orange County (CHIOC); TGR Foundation

2024 Accomplishments

710 people from the FQHC patient population that newly qualified for Medi-Cal coverage were enrolled, approximately 45% of the uninsured patient population. The opening of the St. Jude Neighborhood Health Center - Finamore Place clinic site in Anaheim is expected to take place in fall 2024 as they undergo final credentialing with CalOptima.

During FY24, 267 patients have enrolled in the Avoidable ED program. 1,451 encounters occurred and 828 unique patients were identified. The AED program's central team comprises of two Community Health Workers, a Social Work Case Manager and a Nurse Case Manager.

Partnered with CHIOC to enroll newly eligible Medi-Cal, uninsured, undocumented individuals between the ages of 26-49. For the duration of the grant period, CHIOC faced several challenges and opportunities with education and enrollment of the new eligible population for Medi-Cal. CHIOC was represented at different community events targeting this population. Digital marketing continues to be utilized to bring awareness about Medi-Cal expansion. The foundation of contacts CHIOC possesses have supported the organization to further expand outreach through existing contacts, referrals, social media, phone banking, outreach events and activities. 2 barriers that persist is the fear of Public Charge and many working individuals who are undocumented and do not qualify for Medi-Cal because they are over income. CHIOC is working on coordinating "Know Your Benefits" workshops to further empower the target audience on programs, utilization, and coverage.

Collaborated with the TGR Foundation to promote health care workforce development among high school students in the AUHSD and North Orange County Regional Occupational Program. A "Community Health Academy" was hosted on October 14 at TGR Foundation's Learning Lab in Anaheim where teens had the opportunity to learn about healthcare careers. The event was the official launch to the new Career-Connected Learning programs. 31 students participated in the Career Academy Day. 243 students participated in the health careers panel session. 310 students from AUHSD participated in the career explorer program. 44 students participated in the career explorer presentation on CHNA. In total there was 628 participants.

COMMUNITY NEED ADDRESSED #2: BEHAVIORAL HEALTH (INCLUDING MENTAL HEALTH AND SUBSTANCE USE)

Initiative Name

Behavioral Health (Including Mental Health and Substance Use)

Population Served

Underserved communities living in North Orange County

Long-Term Goal(s)/ Vision

1. To ensure equitable access to high-quality, culturally responsive, and linguistically appropriate mental/behavioral health services, especially for populations who are on the margins and are low income.
2. Reduce mental health stigma in the community.

Table 4. Strategies and Strategy Measures for Addressing Behavioral Health (Including Mental Health and Substance Use)

Strategy	**Population Served**	**Strategy Measure**	**FY 2024 (6 month period) Accomplishments**
Promote Each Mind Matters Campaign/ Green Bench OC among community partners	Low-income communities with an emphasis in Latino and Vietnamese households.	# of residents active on the EMM & Green Bench OC social media sites. \# of new green benches installed in key/high traffic locations.	15,835 active residents on social media sites. 16 new green benches installed.
Expand MAT Program in Emergency Department by promoting free Naloxone Program.	Patients with opioid use disorder	# of patients and/or community at large who receive naloxone prescription in the ED.	575 patients received MAT services in the ED.
Collaborate with partner FQHCs to provide free psychiatry services	FQHC patients	# of patients who receive psychiatric evaluation and medication management.	109 unique patients; individuals have been provided access to psychiatric services.

Evidence Based Sources

- Behavioral health primary care integration: https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/behavioral-health-primary-care-integration

Resource Commitment

$150,000-$200,000 per year for Each Mind Matters and other mental health strategies.

Key Community Partners

St. Joseph Hospital Orange, Mission Hospital, Westbound Communications, St. Jude Neighborhood Health Centers (FQHC).

2024 Accomplishments

Promise to Talk acquired over 2.09M impressions across all social media and web platforms during FY24. The year ended with 55,329 total encounters and 1,635 total promises. During FY24 GreenBenchOC.org and PromiseToTalk.org garnered 15,300 total website visits. The websites encourage open conversations to reduce the stigma surrounding mental health along with resources that can empower members of the community to take action and prioritize their mental health. PromiseToTalk.org received 7,782 visitors. GreenBenchOC.org received 7,518 visitors. 16 new lime green benches were installed at schools, churches, parks and mental health rehabilitation centers to encourage conversations about mental health in north and south Orange County. Building lasting partnerships with local organizations is key for making strong connections and a positive impact within the community. In FY24, Promise To Talk partnered with the Diocese of Orange, El Sol Academy, and Be Well OC through the Green Bench OC initiative, as a result, partners installed green benches on their locations. Promise To Talk's participation in events such as the Cinco De Mayo celebration hosted by Bower's Museum and Día Del Niño hosted by UNIDOS South OC helps develop meaningful conversations with community members who share about their own struggles with mental health and helps facilitate the process with community members committing to a promise to talk about these issues with a trusted friend or family member. Promise to Talk also created and shared a Back-To-School toolkit with the purpose of supporting parents in helping their children navigate their emotions during the upcoming school year. Dissemination of the toolkit resulted in 845,585 social media impressions and was shared with 75 partner organizations and 33 schools. Community event participation also provide media coverage opportunities and help spread awareness among our target audiences. This campaign allows us to continue having important conversations with members of the community and create interest around the stigma reduction movement using in-person and digital connections.

The MAT Program continues to be fully implemented in the hospital emergency department since 2021/ It also conducted community naloxone distribution. 575 patients received MAT services in the ED.

Partner FQHCs provided a total of 109 psychiatry visits to St. Jude Neighborhood Health Centers' patients in Fullerton and Anaheim sites.

COMMUNITY NEED ADDRESSED #3: HOMELESSNESS AND AFFORDABLE HOUSING

Initiative Name

Homelessness and Affordable Housing

Population Served

Unhoused people/communities and low-income residents in North Orange County

Long-Term Goal(s)/ Vision

Providence is a dedicated member of local coalitions to ensure coordination of homeless support services, including recuperative care, and that there are increased connections to supportive services for individuals experiencing homelessness.

Table 5. Strategies and Strategy Measures for Addressing Homelessness and Affordable Housing

Strategy	**Population Served**	**Strategy Measure**	**FY 2024 (6 month period) Accomplishments**
Support Homeless Navigation Program	Patients experiencing homelessness	Decrease the number of days patients experiencing homelessness are in the hospital beyond what is medically necessary without an appropriate place to discharge	503 days in the hospital
Partner with Illumination Foundation to provide Recuperative Care.	Patients experiencing homelessness	# of patients that are referred to recuperative care post discharge and obtain access to primary care, behavioral health services, case management, and supportive housing services.	103 unique clients served

Support United Way Eviction Diversion & Prevention Program	Families at risk for eviction	# of households that are assessed and receive an ecosystem of eviction prevention services.	600 clients referred to the program 347 clients utilized eviction prevention assessment tool 165 clients served with eviction diversion services
Support Homes for All, an advocacy training program to build community leaders' capacity in north and central OC to address immediate housing needs and advocate for increased production of affordable housing.	Persons living in rent-burdened census tracts	# of Community-based Organizations trained	3 community based organizations trained 30 community members trained using the curriculum 20 residents actively participate and attend meetings
Support development of OC's first Affordable Housing Access website to empower residents and Housing Navigators in social service agencies seeking affordable housing opportunities.	Low-income residents trying to secure stable affordable housing	Website developed and deployed in English and Spanish.	Affordable Housing website was developed and has been associated with 1,089 people accessing housing and 157 property owners joining the network.
Create access point for the Fullerton School District's Hub Family Resource Center at Valencia Park Elementary School	Title 1 school-age children and their families experiencing housing insecurity	# of families that access McKinney-Vento Act resources including assistance with housing, food, health care, and	144 families (406 individuals) accessed services

		mental health services	

Evidence Based Sources

- Best practices for community responses to unsheltered homelessness: http://www.evidenceonhomelessness.com/recent_highlights/series-of-briefs-offer-evidence-based-guidance-and-best-practices-for-community-responses-to-unsheltered-homelessness/

Resource Commitment

$800,000 is budgeted for 2024-2026 to support Homeless Navigation Program

Key Community Partners

Orange County Health Care Agency; Illumination Foundation; The Kennedy Commission; United Way OC; People For Housing; Fullerton School District

2024 Accomplishments

The Homeless Care Navigation program continued with two care navigators who provided services to 375 unique homeless clients with a total of 2,134 encounters.

Partnered with Illumination Foundation to provide 103 unique clients experiencing homelessness with recuperative care services. Between April 2023 – March 2024, there was a total of 282 visits. The average length of stay (LOS) was 51.2 days; the shortest LOS was 1 day and the longest was 176 days. There were 17 unique cases where patients were housed and left the program. During this time 42 patients were connected to therapy (144 visits) and 37 patients were connected to psychiatry. 57 unique cases were connected to specialty care and 56 unique cases were connected to outside services. 20 instances occurred where ED visits were prevented. 18 instances for wound care were provided. 7 cases required transfer to higher level of care. 70 instances of hospital follow ups. 10 patients received vaccinations and 158 instances of medication being refilled.

Client Success Story: Jane had been homeless since 2016 and had been unable to access services for her broken leg after being told she needed a complete knee replacement after a fall. Upon arriving to Unity House on September 1, 2023, Jane immediately felt cared for. Recuperative care staff dispensed her medication, checked her vitals, and provided daily assistance with all her medical issues. Staff helped her get Medi-Cal, set up IFMG as her PCP, and within the first two weeks Jane was referred to an orthopedic surgeon. 10 days later she had her first appointment. On February 21, 2024, Jane had successful knee surgery. Post-surgery, Jane received support and services throughout the entire process and recovery. She is in the process of finding housing using supporting housing services.

In FY24, OC United Way recruited 226 new Housing Champions for a cumulative total of 884 community members in the network, which has increased the breadth of community members supporting housing solutions in their neighborhoods. The Eviction Diversion and Prevention program had 600 total clients referred to the program. 347 utilized eviction prevention assessment tool, designed by the Eviction Diversion Collaborative, and were referred to partner organizations. 165 persons have been served with eviction diversion services. A key accomplishment in FY24 was the development of a shared tenant assessment tool that focuses on vulnerability to ensure residents with the most barriers to stability are

prioritized with services. The “Stay Housed OC” website was also launched in March 2024 to provide a resource hub for tenants, offer training workshops, toolkits, and timely, relevant information for tenants at risk of eviction.

OC United Way hosted and organized 12 online community chats, two “Housing Policy Made Simple” webinars, a “Summit” of community organizing groups, and a Homelessness 101 specifically for elected officials and city staff in August 2023. United to End Homelessness' affordable housing navigation and landlord incentive program, WelcomeHomeOC, and affordable housing website has helped house over 1,000 people in Orange County and has a network of 157 property owners. The website **https://unitedtoendhomelessness.org/** offers an opportunity to empower individuals from the community to find stable affordable housing.

During FY24, the Fullerton School District has helped support 611 families with resources towards accessing food assistance, housing, healthcare, mental health, and other social services programs. Chronic absenteeism among foster youth decreased by 10.5% and 7.6% among students experiencing homelessness. “The Hub” resource was established at Valencia Park Elementary School and provided services to 144 families, 406 individuals after its grand opening in October 2023.

Other Community Benefit Programs

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

Initiative (Community Need Addressed)	Program Name	Description	Population Served (Low Income, Vulnerable or Broader Community)	FY24 (6 month period) Accomplishments
Engaging community partners to address health disparities	Healthy Communities: Move More Eat Healthy	Technical assistance to support community collaboratives	Low-income	5 community collaboratives are addressing disparities
Lack of public transportation	Transportation Program	Provide non-emergency medical transportation	Low-income	3,865 encounters
Lack of access to medical services	Post Hospital Transition Care for Indigent Patients	Hospital costs incurred to take care of indigent patients, both the uninsured and underinsured – including long-	Low-income	16 encounters

		term facility, homecare, hospice, mental health, ambulance fees and taxicab vouchers among others		
Lack of support services for frail elderly	Senior Services	Information and referrals, support groups, classes, Caring Neighbors Volunteer Program	Low-income	10,871 encounters
Access to Care	Rehab Community Reintegration	Provides recreational, exercise, communication, and other groups for individuals with a disability to assist in their re-entry into the community	Broader community; people with disabilities	1,424 encounters
Support for family caregivers overwhelmed with needs of person they are caring	Family Caregiver Support Program/Orange Caregiver Resource Center	Partnership to provide family caregivers with assessment, advice for developing a respite program, referrals, education, legal and support services that assist them in their role as a caregiver	Broader Community	22,914 encounters
Coordination of services for traumatic brain injury patient population	St. Jude Brain Injury Network	Provide case management, support services to assist adult survivors of traumatic brain	Low-income	6,331 encounters

		injury with assistance in vocational, housing, health and financial needs		
Food Insecurity	Meals on Wheels Food Finders	Special diets for home delivery and food donation	Broader Community	5,532 meals
Neuro Rehab	Neuro Rehab Continuum	Inpatient and Outpatient rehab	Broader Community	16,030 encounters

FY24 COMMUNITY BENEFIT INVESTMENT

In FY24 Providence St. Jude Medical Center invested a total of $41,501,174 in key community benefit programs. Invested $1,793,094 in community health programs and grants for the poor and vulnerable. Provided $3,697,271 in charity care, $33,137,712 in unpaid cost of Medi-Cal. Providence St. Jude Medical Center applies a ratio of cost to charge to quantify financial assistance at cost, unreimbursed Medicaid, other means-tested government programs. The cost to charge ratio is aligned with the IRS Form 990, Schedule H Worksheet 2. Our community benefit program expenses are reported in alignment with the total cost incurred to run our programs, and we offset any restricted revenue received to arrive at our net community benefit expense.

FY2024 PROVIDENCE ST. JUDE MEDICAL CENTER
(July 1, 2023-June 30, 2024)

CA Senate Bill (SB) 697 Categories	Community Benefit Program Categories	Net Benefit
Medical Care for Vulnerable Populations	Financial Assistance at cost	$3,697,271
	Unpaid cost of Medicaid	$33,137,712
	Unpaid other govt. programs	-
Other Benefits for Vulnerable Populations	Community Health Improvement Services	$1,793,094
	Subsidized Health Services	-
	Cash and In-Kind Contributions	$1,375,345
	Community Building	-
	Community Benefit Operations	$141,752
	Total Benefits for Vulnerable Populations	$40,145,174
Other Benefits for the Broader Community Populations	Community Health Improvement Services	$682,339
	Subsidized Health Services	$607,069
	Cash and In-Kind Contributions	-
	Community Building	-
	Community Benefit Operations	$21,592
Health Profession Education, Training and Research	Health Professions Education and Research	$45,000
	Total Benefits for the Broader Community	$1,356,000
	Total Community Benefit	$41,501,174
Medical Care Services for the Broader Community	**Total Medicare shortfall**	$63,328,792

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

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

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

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

2024 CB REPORT GOVERNANCE APPROVAL

This 2024 Community Benefit Report was adopted by the Providence St. Jude Medical Center Community Health Committee of the hospital on August 14, 2024. The final report will be made widely available by December 1, 2024.

Sr. Mary Rogers, CSJ — Date: 8/14/2024
Chair, Providence St. Jude Medical Center Community Health Committee

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LAURA RAMOS
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8/28/2024
Laura Ramos — Date

Chief Executive, St. Jude Medical

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8/23/2024
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Providence

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

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

Providence across five western states:

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

The Providence affiliate family includes:

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

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