

**St. Jude Medical Center  
St. Jude Heritage Health**

**FY 05 Community Benefit Report**

**And**

**FY 06 – 08 Community Benefit Plan**

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St. Jude Heritage Health**

**FY 05 Community Benefit Report and  
FY 06 – 08 Community Benefit Plan**

**TABLE OF CONTENTS**

**I. Community Benefit Report - FY 2005**

A.	Executive Summary	Page 3
B.	FY 03-05 Plan: FY 05 Progress on Programs	Page 5
C.	Quantified Progress	Page 10
D.	Non-Quantified Progress	Page 13
E.	Public Process	Page 14

**II. Community Benefit Report – FY 2006-2008**

A.	Community Needs: Assets and Demographic Assessment	Page 15
B.	Organizational Structure/Community Involvement	Page 18
C.	FY 06 – 08 Community Benefit Plan	Page 19

## I. Community Benefit Report - FY 2005

### A. EXECUTIVE SUMMARY

St. Jude Medical Center (SJMC) is a 359- bed hospital serving North Orange County with Centers of Excellence in Cardiac, Oncology, Women and Children's, Orthopedic and Rehabilitation Services. The Medical Center has 2,338 employees. St. Jude Heritage Health (SJHH) is a medical practice foundation providing ambulatory services for over 200,000 people and consists of 14 offices with 110 physicians and 716 employees. Together, the Medical Center and Foundation form the largest integrated health care delivery system in North Orange County.

St. Jude Medical Center and St. Jude Heritage Health have a fundamental commitment to serve the community, with a special focus on vulnerable and at-risk populations. The mission of SJMC/SJHH is to extend the Catholic Healthcare ministry of the Sisters of St. Joseph by improving the health and quality of life of people in communities we serve.

St. Jude Medical Center provided **\$33,702,000** in community benefit activities in FY 05 representing 12.0% of operating expenses and providing over 537,000 encounters. This represents an 81% increase in expenses over FY 04. St. Jude Heritage Health provided **\$3,434,000** in community benefit dollars in FY05 serving 101,379 persons. This represents a 297% increase in community benefit expenses over FY 04.

Major community benefit activities focus on increasing access to care, disease prevention/ management and community building. The key activities provided over this past year include:

- ◆ Supported the expansion of the CaliforniaKids Program in Orange County by obtaining a Measure H grant for \$57,460 funding an additional 160 children and by contributing \$95,000 funding 264 children.
- ◆ Children's Mobile Health Clinic – 3,061 visits were provided in FY05, a 33% decrease over FY 04, which correlates to the significant decrease in uninsured children.
- ◆ Adult Mobile Health Services – 4,845 adult medical and prenatal visits were provided in FY 05, a 16% decrease from FY04. Higher risk prenatal patients were transferred to UCI for care because of a lack of available OB/GYN for certain cases.
- ◆ Implemented a Well Woman Initiative with funding from the St. Joseph Health System Foundation which increased the number of women receiving well woman exams, a 44% increase from when the program began in 2003.
- ◆ Clinics participated in quality initiatives on diabetes with the ABCD Collaborative, PAP smears with the Coalition of Orange County Community Clinics and dental care with the Oral Health Collaborative.
- ◆ The Medical Center's Project Fit America program was expanded to the Orangethorpe Elementary School in Fullerton.
- ◆ St. Jude Dental Clinic- provided 6,115 procedures for children, a 30.6% increase over FY04, primarily as a result of additional dentist hours added.
- ◆ Psycho-educational support group for Spanish speaking women – 102 encounters were provided in the first quarter and then the program was temporarily discontinued due to the leave of the social worker.

- ◆ Provided the Open Airways program for asthma education to 227 children at 18 schools.
- ◆ Began implementation of a \$499,500 grant from the California Endowment as the lead agency in a Collaborative to impact system change around sub-standard housing conditions that trigger asthma in children.
- ◆ Continued to provide a sick-child day care center at the TAPP high school as part of a Children and Families Commission grant with the Fullerton High School District.
- ◆ Collaborated for the final year with the Orange County Human Relations Council and the City of Fullerton on a Community Building Initiative grant from the St. Joseph Health System Foundation to develop community leadership in Fullerton.
- ◆ Collaborated for the second year with The Gary Center and the City of La Habra in the La Habra Works project, to create jobs for low-income residents in La Habra.
- ◆ Provided continued leadership to the West Fullerton Improvement Committee, which focused in FY 05 on services for low-income youth.
- ◆ Dedicated staff time and provided technical assistance to the following collaboratives and organizations: Fullerton Collaborative, Anaheim/Fullerton Family Resource Center, Brea Family Resource Center, Placentia Families First Collaborative, Gary Center, Boys and Girls Club of Buena Park, YMCA of North Orange County, Boys and Girls Club of Fullerton, Feedback Foundation, Orange County Coalition of Community Clinics, Crittenton Services and Women's Transitional Living Center.
- ◆ Continued the Senior Connection Caring Neighbors Program to provide volunteer support services to frail homebound elderly.
- ◆ Provided mentors for medical, nurse practitioner, medical assistant and high school students in the SJHH medical offices and the community clinics.
- ◆ Continued to provide disease management programs, screenings and education for the broader community in the areas of asthma; cardiac wellness; pulmonary wellness; wound care; safety; women's health, cancer and brain attack.
- ◆ Served as the sponsoring agency for the Orange Caregiver Resource Center and the St. Jude Brain Injury Network, county-wide programs that support the needs of caregivers (OCRC) and persons with traumatic brain injury (BIN). In FY05, OCRC became the lead agency for the Federal Caregiver Support Program contract.
- ◆ Expanded non-emergency medical transportation services for seniors with the expansion of the grant funded North Orange County Senior Connections Program. This program provided 25,556 trips in FY 05. In addition, St. Jude Medical Center's own transportation program provided additional 8,591 trips.
- ◆ Working with the Fullerton Collaborative maintained the number of after-school program slots with funding from 21<sup>st</sup> Century grants.
- ◆ Obtained approval from the City of Fullerton to partner with them on a new medical and dental clinic in Richman Park.
- ◆ Committed \$500,000 over three years to the MediKids collaborative program with a goal of providing health insurance for all children in Orange County.
- ◆ Began Phase II implementation of Advancing the State of the Art of Community Benefit project.

Community Benefit priorities for FY 06-08 are:

- ◆ Increase access to health care for the uninsured and underinsured.
- ◆ Prevention and chronic disease management with a targeted effort to decrease diabetes mortality and incidence of late/no prenatal care in zip code 92832

- ◆ Community capacity building through collaborative partnerships with a focus on education.

### **B. FY 03-05Plan: FY 05 Progress on Programs**

Increasing access to healthcare services has been the cornerstone of all community benefit activities. The Orange County Health Needs Assessment for 2005 showed that in the St. Jude service area the percentage of uninsured children decreased from 7.7% to 5% since 2002, with 6,550 uninsured children, while the percentage of uninsured adults has decreased from 11.7% to 10%, with 37,500 uninsured adults. This fiscal year through hospital funds and grants 424 children were insured in the CaliforniaKids program. These positive gains may be correlated to the decrease in adult and pediatric clinic services. People with insurance prefer to go to a provider who is in their community every day rather than a mobile clinic. Dental Clinic procedures increased over 30% as dentist hours were increased at the clinic. A major effort to expand access to care was the development of the MediKids project whose goal is to insure every child in Orange County. The Medical Center has committed \$500,000 over three years to support this county-wide collaborative effort.

Prevention and wellness programs were another major community benefit initiative in FY05. The Project Fit America program designed to promote healthy lifestyles in children was expanded in FY05 to include Orangethorpe Elementary School in Fullerton, which is the ninth school that now operates this program with our support in North Orange County.

The Open Airways Program is designed to teach self-management skills to children with asthma who are 8-11 year old. In FY 2005, Open Airways was offered at 18 schools in North Orange County with 227 graduates. The Fullerton Asthma Collaborative Treatment Services began its first year as a collaborative of agencies seeking to support a culturally appropriate advocacy and education program to reduce the incidence of asthma among low income Latino children and their families living in low income housing.

The Medical Center completed a strategic plan in FY 05 to better meet the needs of seniors in North Orange County. Priority areas of focus include working to keep seniors healthy through wellness and prevention programs and to provide supportive services to frail seniors to assist them to remain in their homes. The Medical Center continued to fund the Caring Neighbors Program, a wellness and support program for frail elderly after its initial funding from UniHealth Foundation was completed.

The Psycho-educational Support Group for Spanish Women was limited this year due to the leave of absence of the clinic social worker. Clients reported improved understanding of community resources, laws related to protection from domestic violence, positive parenting skills and conflict resolution/communication techniques.

The Congestive Heart Failure program has been expanded and is successful in preventing hospitalization and improving quality of life in 196 patients with CHF.

Community capacity building has continued in West Fullerton with a focus on services for youth. The Medical Center helped sustain a summer youth program and through its collaborative is introducing new programs for low income youth in the area.

Goal/Outcome/ Aim for end of FY 05	Major strategies /initiatives	FY 05 Measures	Baseline FY 02	FY05 Progress from FY 04
Increase the number of uninsured adults in North Orange County who have a medical home.	<p>Sustain the expanded services for adults that were initiated in FY02 with Measure H funding.</p> <p>Explore the feasibility of opening a fixed site medical clinic in Fullerton.</p>	<i>Provide adult medical services to 400 new patients annually through the Adult Mobile Clinic</i>	In FY 02, 577 new adults were seen in the Adult Mobile Health Clinic	<p><b>FY05 Progress</b> In FY05 there were 727 new adult medical patients seen..</p> <p>A site for the new clinic has been approved by the City of Fullerton.</p>
Increase the number of low income children who have access to dental services in North Orange County	Sustain the expanded services for children initiated in FY 02 with Measure H and Prop 10 funding.	<p><b>FY05 Measure</b> <i>Provide dental services to 150 new patients.</i></p> <p><i>Provide 6 community dental screenings.</i></p>	In FY02, there were 178 new patients seen in the Dental Clinic.	<p><b>FY05 Progress</b> In FY05 there were 199 new patients seen in the Dental Clinic.</p> <p>Provided 14 dental screenings where 543 children were screened. 25% had visible tooth decay.</p>
Improve the self management of congestive heart failure in members of the St. Jude integrated delivery system	<p>Continue Cardiac Wellness Program</p> <p>Develop strategies to reach CHF patients who are not in the Cardiac Wellness Program,</p>	<p><b>FY 04/05</b> # of Emergency Department visits for CHF Improvement in Quality of Life Measure</p>	<p>National rate is 12% - 20%</p> <p>Baseline is initial assessment SF36 score. (Quality of Life Index)</p>	<p><b>FY 05 Progress</b> There were 4 patients out of 196 (2%) in the CHF program that were admitted to the Emergency Department, as</p>

Goal/Outcome/ Aim for end of FY 05	Major strategies /initiatives	FY 05 Measures	Baseline FY 02	FY05 Progress from FY 04
	including referrals from community clinic			<p>compared to a readmission rate of 17% for CHF patients who are not in the program.</p> <p>There was an improvement in SF-36 scores in all categories at the 6 month follow-up as compared to baseline scores.</p>
Increase the availability of behavioral counseling services available for low income clients in North Orange County	Facilitate meetings with major providers of counseling services to determine opportunities for synergies. Support efforts of Fullerton Collaborative to increase counseling services.	<b>FY05 Measure</b> <i>Facilitation of expanded hours or new counseling access sites</i>	Currently there are five major counseling programs in North Orange County	<b>FY 05 Progress</b> The Anaheim-Fullerton Family Resource Center added a full-time counselor in addition to the existing services in the community.

Goal/Outcome/ Aim for end of FY 05	Major strategies /initiatives	FY 05 Measures	Baseline FY 02	FY05 Progress from FY 04
<p>Increase the number of elementary students who know how to self manage asthma tests and medications</p>	<p>Continue to support the Open Airways Programs in local schools.</p> <p>Continue to provide Asthma Control Today classes.</p>	<p><b><i>FY 05 Measure</i></b> <i># of ED visits for asthma for children 8-11. Goal is to reduce visits by 5%.</i></p> <p><i>Provide Open Airways Program in a minimum of 20 schools.</i></p>	<p>In FY 02 there were 61 Emergency Department visits for children 8-11 with an asthma diagnosis</p>	<p><b>FY 05 Progress</b></p> <p>In FY05 there were 51 ED admissions of children 0-5 with asthma, as compared to 66 in FY 04, representing a decrease of 22.7%.</p> <p>In FY 05, the Open Airways program was provided to 18 schools.</p>

Goal/Outcome/ Aim for end of FY 05	Major strategies /initiatives	FY 05 Measures	Baseline FY 02	FY05 Progress from FY 04
Services more readily available in West Fullerton with facilitation of resident self-sufficiency	Provide leadership in the planning and development for a community center in West Fullerton	<b>FY05 Measure</b> HUD application for community center completed and if funded implemented	There is no full-service community center in West Fullerton	<b>FY05 Progress:</b> St. Jude Medical Center facilitated a partnership with Cal State University Fullerton who agreed to be the lead agency on a HUD grant to build a modular community center in West Fullerton. The grant was not funded. However, additional youth services have been brought into this community in FY 05..
Improve education scores at South Fullerton schools	Provide leadership in the Fullerton Collaborative in order to move its strategic plan forward.	<b>FY05 Measure</b> <i>Sustain Coordinator role to bring in \$1 million in grant funds</i>	Strategic plan in place. Healthy Start grant at 1 school and after school grant at 7 schools	<b>FY 05 Progress</b> The Coordinator role was sustained in FY 05. Over \$1 million in grant funds have been brought into the community through the Fullerton Collaborative to assist the schools with after school programs and other supportive services.

### **C. Quantified Progress**

The leadership of the Medical Center is represented on the Healthy Communities Committee of the Board of Trustees, which provides oversight to all community benefit programs. The leadership received a presentation this year from Kevin Barnett, Dr. P.H. regarding the guiding principles of the Advancing the State of the Art of Community Benefit project. The Medical Center is one of two pilot sites of the St. Joseph Health System for this national demonstration project. Community benefit activities are addressed in the separate orientations of senior leadership, managers and supervisors, staff and physicians, where opportunities to participate in community benefit programs are outlined. All staff received a flyer with opportunities to support community benefit activities and over 60 staff responded with interest.

The Medical Center budgets 10% of its net income for its Care for the Poor programs, which are specifically, directed at low income vulnerable populations. In addition, through the budget philosophy process, at least 1.5% of budgeted expenses is targeted to community health/healthy communities programs. In FY 05, \$3.7 million was budgeted for Care for the Poor programs and over \$5.5 million was budgeted for community health and healthy community programs. These investments represent a significant commitment to community benefit. Each year, community benefit priorities are identified by hospital departments for consideration in the budget philosophy process. In FY 05, the Caring Neighbors Senior Wellness program designed to support frail elderly to remain in their homes was funded through this process, as was support to the Fullerton Collaborative infrastructure which assisted the group to obtain its 501 ( c ) (3) status

There has been a significant increase in expenses in Unpaid cost of state and local programs and Unpaid cost of Medicare. This is a result of rising costs and severity of illness without a corresponding increase in revenue. At the Medical Center, there was a 23% decrease in community services for the broader community. This does not reflect a decrease in programs but a more stringent review of community benefit programs based on the criteria of the Advancing the State of the Art of Community Benefit project.

**St. Jude Medical Center**  
**QUANTIFIABLE COMMUNITY BENEFIT TREND**  
**As of 6/30/05**

	FY 2004	FY 2005	FY 05 % of Net Patient Revenue	FY 05 % of Total Operating Expenses
<b>BENEFITS FOR THE POOR<sup>1</sup></b>				
Charity Care (Financial Assistance)	\$ 958,000	\$ 1,162,000	0.4%	0.4%
Community Services <sup>2**</sup>	\$ 1,094,000	\$ 1,272,000	0.4%	0.4%
Unpaid costs of state and local programs	\$ 7,801,000	\$11,155,000	3.9%	4.0%
<b>Total Quantifiable Benefits for the Poor</b>	<b>\$ 9,853,000</b>	<b>\$13,589,000</b>	<b>4.7%</b>	<b>4.8%</b>
<b>BENEFITS FOR THE BROADER COMMUNITY</b>				
Community Services	\$ 4,679,000	\$ 3,645,000	1.3%	1.3%
<b>Total Quantifiable Benefits for the Broader Community</b>	<b>\$ 4,679,000</b>	<b>\$ 3,645,000</b>	<b>1.3%</b>	<b>1.3%</b>
<b>Total Quantified Community Benefit</b> (Excluding Medicare shortfalls.)	<b>\$14,532,000</b>	<b>\$17,234,000</b>	<b>6.0%</b>	<b>6.1%</b>
<b>Unpaid Cost of Medicare</b>	<b>\$ 4,050,000</b>	<b>\$16,468,000</b>	<b>5.7%</b>	<b>5.9%</b>
<b>Total Quantified Community Benefit</b> (Including Medicare shortfalls.)	<b>\$18,582,000</b>	<b>\$33,702,000</b>	<b>11.8%</b>	<b>12.0%</b>

*\*\*Foundation Funds included in Community Services for the Poor –FY 04 \$618,440  
Foundation Funds included in Community Services for the Poor –FY 05 \$1,085,012*

<sup>1</sup> Households earning less than 50% of Median Income.

<sup>2</sup> Including Foundation funds distributed in the local community through the hospital's Care for the Poor Committee.

**Heritage-North**  
**QUANTIFIABLE COMMUNITY BENEFIT TREND**  
**As of 6/30/05**

	<b>FY 2004</b>	<b>FY 2005</b>	<b>FY 05 % of Net Patient Revenue</b>	<b>FY 05 % of Total Operating Expenses</b>
<b>BENEFITS FOR THE POOR<sup>3</sup></b>				
Charity Care (Financial Assistance)	\$ 62,000	\$941,000	0.7%	0.7%
Community Services <sup>4**</sup>	\$0	\$0	0%	0%
Unpaid costs of state and local programs	\$269,000	\$796,000	0.6%	0.6%
<b>Total Quantifiable Benefits for the Poor</b>	<b>\$331,000</b>	<b>\$1,737,000</b>	<b>1.3%</b>	<b>1.3%</b>
<b>BENEFITS FOR THE BROADER COMMUNITY</b>				
Community Services	\$37,000	\$173,000	0.1%	0.1%
<b>Total Quantifiable Benefits for the Broader Community</b>	<b>\$37,000</b>	<b>\$173,000</b>	<b>0.1%</b>	<b>0.1%</b>
<b>Total Quantified Community Benefit (Excluding Medicare shortfalls.)</b>	<b>\$368,000</b>	<b>\$1,910,000</b>	<b>1.4%</b>	<b>1.4%</b>
<b>Unpaid Cost of Medicare</b>	<b>\$0</b>	<b>\$1,524,000</b>	<b>1.2%</b>	<b>1.2%</b>
<b>Total Quantified Community Benefit (Including Medicare shortfalls.)</b>	<b>\$368,000</b>	<b>\$3,434,000</b>	<b>2.6%</b>	<b>2.6%</b>

<sup>3</sup> Households earning less than 50% of Median Income.

<sup>4</sup> Including Foundation funds distributed in the local community through the hospital's Care for the Poor Committee.

## **D. NON-QUANTIFIED PROGRESS**

St. Jude Medical Center and St. Jude Heritage Health staffs are actively involved in community organizations in order to promote collaboration and a healthy community. All new physicians and staff are informed of community benefit volunteer opportunities on orientation. All employees this year received a flyer identifying 6 different opportunities for volunteer work, including serving at the food distribution program, mentoring youth, visiting seniors and working at the thrift shop which supports our community clinics. Employees at SJMC have provided over one thousand hours of volunteer work in the community. SJHH employees provided volunteer support to the food distribution programs, as well supported holiday food drives, providing \$14,601 in donations and serving 247 persons. Many of these activities were designed to help build capacity of smaller not-for-profit community organizations. Executive Management Team members are on the Boards of local not-for-profit organizations. In addition, a number of organizations have been supported through endorsement of grant applications, such as the Women's Transitional Living Center, Gary Center and the Orange County Human Relations Council. Staff participates on the Steering Committee for the OCHNA to insure that input is given about the implementation of the data and the design of the community survey.

The volunteer programs of SJMC and SJHH have also focused beyond the hospital or medical office walls. This year the Medical Center continued its Food Distribution Program in West Fullerton with hospital and foundation employees volunteering to distribute the food to hundreds of families. Both hospital and foundation employees participated in the Uninsured Angels project raising over \$2,400 to insure children in the CaliforniaKids program. SJHH has a mentoring program that exposes people to health careers. The Medical Center serves as a site for internships for the Latino Health Professions Program, Cal State Long Beach to expand the number of minority's in health care.

Collaboration to improve the quality of life in low-income communities continued to be a key initiative this year. Efforts are focused on South and West Fullerton, two of the most dense and low-income areas of Orange County. The Medical Center continues to work with the Valencia Task Force, a group of low-income residents who have advocated with the city of Fullerton to have our fixed site health clinic in a local park. Medical Center staff have provided leadership to the Fullerton Collaborative which this year sponsored Faces of Fullerton, a community-wide event that brought 5,000 people from all Fullerton communities together for a day of interaction and celebration. Leadership has also been provided to the West Fullerton Improvement Committee, which has successfully obtained funding for the Fullerton Asthma Collaborative, and for a youth recreation program. In addition, the Medical Center is a key partner in La Habra Works, a collaborative project designed to create new businesses for low income residents of La Habra. These efforts are designed to have long-term impact on the community by building on their assets and engaging local residents in issues that are of critical importance to them. Other Collaborative projects include the Senior Connections program providing non-emergency medical transportation to seniors throughout north and central Orange County, the TAPP program providing a mildly ill child care center for children of students at La Sierra High School and the Healthy Smiles/Oral Health Collaboratives.

## **E. Public Process**

This year the Medical Center has placed its Community Benefit Report on its web site and highlighted programs in its publications. Updates on the Medical Center's activities have been provided at various community meetings, including the Fullerton Collaborative, Brea Rotary Club, La Habra Rotary Club, Valencia Task Force and with elected officials. The Medical Center Report to the Community continues to be distributed to internal and external publics. Medical Center staff also have used data from the Community Benefit report in meetings with policy makers to address efforts to improve the health and quality of life in the communities we serve.

## II. Community Benefit Report FY 2006 - 2008

### A. Community Needs/Assets and Demographic Assessment

The North Orange County cities of Fullerton, La Habra, Placentia, Buena Park, Brea, Yorba Linda and parts of Anaheim are the cities of focus for this community benefit plan. This area represents an extremely diverse population based on ethnic and socio-economic characteristics. Demographic information from 2003 shows that this area has a population of 795,472. The population, ethnic, age and income characteristics of this area are outlined below.

**TABLE 1.1 BREAKDOWN OF SJMC CITIES OF FOCUS**

Communities	Population	Zip Codes
Buena Park	81,193	90620, 90621
La Habra	70,177	90631
Anaheim	363,391	92801, 92804, 92805, 92806, 92807, 92808
Brea	35,538	92821, 92823
Fullerton	129,196	92831, 92832, 92833, 92835
Placentia	50,466	92870
Yorba Linda	65,511	92886, 92887
<b>TOTAL</b>	<b>795,472</b>	

\* Source for tables 1.1-1.4: U.S. Bureau of the Census, 2000 Census of Population and Housing, ESRI BIS forecasts for 2003 and 2008.

**TABLE 1.2 ETHNICITY OF SJMC CITIES OF FOCUS**

Ethnic Group	Percent
Caucasian	41%
Latino/Hispanic	39%
Asian/Pacific Islander	14%
Black	2%
All other ethnicities	4%

**TABLE 1.3 AGE DISTRIBUTION FOR CITIES OF FOCUS**

Children (0-4)	8%
Children (5-14)	16%
Children (15-19)	7%
Adults (35-44)	16%
Adults (45-64)	20%
Adults (65-74)	6%
Adults (75+)	5%

**TABLE 1.4 INCOME CATEGORIES FOR CITIES OF FOCUS**

Income Categories	Percent
< \$24,999	9%
\$25,000-\$49,999	28%
\$ 50,000-\$74,999	22%
>\$75,000	41%

There are pockets of poverty in almost every city. Approximately 10,000 households have an annual income of under \$19,999. The percentage of children below poverty level goes from 3.01 % in Yorba Linda to 12.9% in Placentia, 14.14% in Fullerton, 14.35% in Buena Park, 16.8% in La Habra and 18.77% in parts of Anaheim.

The Medical Center worked with the St. Joseph Health System Planning Department to identify specific neighborhoods in our community with disproportionate unmet health needs or populations (DUHN). Key demographic /socioeconomic variables associated with community need were identified, ranked as positive or negative and a composite rating made to rank each block based on need in 5 categories from high need to least need. The DUHN communities that were identified in the Medical Center service area

include South Fullerton, east Buena Park, Southwest Placentia, north Anaheim and central La Habra. Profiles of these DUHN neighborhoods are outlined in Table 1.5. These neighborhoods have an unemployment rate that is 50-100% higher than the County average unemployment rate, household income that is 36-45% less than the County average income, and childhood poverty rates more than twice the County average. These areas are largely Hispanic, who represent between 56.2 - 78.4% of the population. A key indicator that impacts poverty in these neighborhoods is that the percentage of people over 25 without a high school diploma is more than twice the County average. The poverty level in these neighborhoods is reflected in the lower expenditures on health care, about one-half the average household expenditure on health care in the County.

**Table 1.5: Disproportionate Unmet Health Need Neighborhoods  
Key Indicators**

Indicator	South Fullerton	East Buena Park	SW Placentia	North Anaheim	Central La Habra	Orange County
Population	40,544	32,163	6,861	50,670	26,122	2,968,111
% Hispanic	56.2%	58.2%	78.4%	69.3%	71.3%	25.6%
Unemployment Rate	12.1%	9.3%	9.5%	9.2%	7.2%	6.0%
Median Household Income	\$36,969	\$41,922	\$40,674	\$42,505	\$45,115	\$70,786
% 25+ with no high school diploma	31%	38%	53.4%	42.7%	39.2%	19.7%
% children below FPL	28.6%	22.7%	26.7%	26.5%	24.9%	12.6%
Avg. \$ on health care	\$1,994	\$2,198	\$2,164	2,217	\$2,361	\$4,134

The objective health care data reported by the Orange County Health Care Agency reflects the DUHN status of these neighborhoods. South Fullerton and North Anaheim are among the highest areas with percent of live births with no or late prenatal care in the County. Eastern Buena Park, South Fullerton and North Anaheim are among the areas with the highest percentage of inadequate prenatal care in the County. South Fullerton, central La Habra, north Anaheim and eastern Buena Park are among the neighborhoods in the County with the highest diabetes mortality rate. This data is usually associated with higher rates of poverty.

The Medical Center is involved with each of these pockets of poverty in a variety of ways. While our Community Clinics serve all these neighborhoods, we have focused involvement with community capacity building in Fullerton, Placentia and La Habra. Since there is another not-for-profit hospital and community clinic located in north Anaheim, we have not focused our efforts in that neighborhood, although we are involved in the Anaheim-Fullerton Family Resource Center which is located and serves North Anaheim. While our Dental Clinic is in Buena Park, we have not yet focused broader attention on this neighborhood. Our work in these areas indicated that the needs we have identified in Fullerton, Placentia and La Habra are similar to the needs in Anaheim and Buena Park.

Table 1.6 below highlights the major needs and assets of the three target neighborhoods where St. Jude Medical Center is most engaged.

**Table 1.6: Needs and Assets of Target Neighborhoods**

Target Neighborhood	Key Needs	Assets
South Fullerton	<ul style="list-style-type: none"> <li>• Lack of access to health care</li> <li>• Drug and alcohol use</li> <li>• Public safety/crime</li> <li>• Affordable housing</li> </ul>	<ul style="list-style-type: none"> <li>• Valencia Task Force</li> <li>• West Fullerton Improvement Committee</li> <li>• Fullerton Collaborative</li> <li>• St. Jude Medical Center</li> <li>• Churches</li> <li>• CBO's</li> <li>• Community Center</li> </ul>
Southwest Placentia	<ul style="list-style-type: none"> <li>• Affordable housing</li> <li>• Public safety/crime</li> <li>• Civic Engagement</li> </ul>	<ul style="list-style-type: none"> <li>• Families First Collaborative</li> <li>• CBO's</li> <li>• Schools</li> <li>• Community Centers</li> </ul>
Central La Habra	<ul style="list-style-type: none"> <li>• Jobs</li> <li>• Affordable Housing</li> <li>• Public safety/crime</li> </ul>	<ul style="list-style-type: none"> <li>• La Habra Works</li> <li>• CBO's</li> <li>• City Council representing community</li> </ul>

The needs assessment process used to develop the FY06-08 Community Benefit Action Plan involved: participation in the Orange County Health Care Needs Assessment; as well as the review of objective data from the Orange County Health Care Agency, data from the St. Joseph Health System Planning and Research Department and review of targeted local focus groups and interviews as reported above. This data was summarized and presented to community groups for input and prioritization.

The Orange County Health Care Needs Assessment, a community-based collaborative effort created to collect and make available accurate and useful health data for Orange County was the primary data source for the needs assessment. Data for St. Jude Medical Center's service area was provided through random phone interviews with adults and families with children using a structured interview guide. The key findings of the OCHNA survey in North Orange County are:

- ◆ Number of uninsured adults has slightly decreased to 37,500, representing 10% of the adults.
- ◆ Number of uninsured children has decreased from over 10,000 to 6,550, representing 5% of the children in the area
- ◆ 19.5% of children have no dental insurance.
- ◆ 40.6% of the population perceive themselves as overweight
- ◆ Preventive services are not fully accessed or discussed by providers with patients.
- ◆ The greatest concerns of parents are the quality of education and the emotional well-being of their children.

The Medical Center Healthy Communities Committee of the Board of Trustees used the following criteria to select priority program areas of focus: relevancy to mission; size of the problem; seriousness of the problem; effectiveness of interventions; economic feasibility; acceptability to community; legality; time commitment; degree of controversy; existing efforts; implications for not proceeding with priority and sustainability.

## **B. Organizational Structure/Community Involvement**

The Healthy Communities Board, which is a sub-committee of the Board of Trustees has oversight for the Medical Center's and SJHH's healthy community programs and community benefit planning. This Committee, with twenty-nine members is made up of Board members, community members and executive and management staff of St. Jude Medical Center and St. Jude Heritage Healthcare Foundation. This committee approves the Community Benefit Plan and changes in programs and services. The Committee has defined its responsibility more specifically in the last year to include recommendation of the Care for the Poor budget, community benefit program content and design, program targeting, program continuation or termination and program monitoring. All budget and program termination decisions must be approved by the Board of Trustees. The Medical Center's Vice President of Healthy Communities is responsible for the implementation and monitoring of the plan. He actively participates on the Steering Committee of the Orange County Health Needs Assessment which designs the basic health needs assessment and on the community collaboratives from which input is solicited on priorities.

The Strategic Planning process of the Medical Center and the Foundation is based on the vision, mission and goals of the St. Joseph Health System. Each ministry then develops its own strategic plan taking into account the parts of the continuum their services address. One of the key strategic priority areas in the plan is Community Outreach and Social Change. Community Benefit activities around prevention and wellness, care for the underserved, healthy communities, advocacy, environmental consciousness and systemic health care reform are key elements in this area. The Community Benefit activities are integrated into this part of the strategic plan. The Strategic Plan is refined and prioritized by the Executive Management Team, then approved by the Hospital, Foundation and Health System Boards of Trustees.

There is extensive support of Board and Executive Management Team members for community benefit programs. Over the past few years, extensive efforts have been made to diversify membership on the Board of Trustees and the Healthy Communities Committee to represent the DUHN communities. The Board of Trustees recruited a Hispanic councilwoman from La Habra who has founded programs for low income immigrant families and a professor from California State University Fullerton who has done extensive research on the health care needs of the DUHN population. The Healthy Communities Committee has added a Hispanic pastor who serves a low-income immigrant community in South Fullerton and a Hispanic manager of a local Family Resource Center. Board members have assisted the Medical Center move forward on programs and potential grant opportunities. EMT members serve on the Boards of Directors of not-for-profit community organizations. These relationships have assisted the Medical Center to build new collaborations and obtain funding for community benefit programs.

Community benefit activities can only be successful with the involvement of outside community stakeholders who collaborate with the Medical Center to achieve a common vision and mutual goals. The Medical Center is involved with several key community

collaboratives from which it has received input into its community benefit activities and to which it looks for support. The Valencia Task Force is a group of low-income Hispanic residents who have participated in leadership training and community building over the past three years as a result of a grant from the St. Joseph Health System Foundation. This group has identified two health related priority areas: access to medical and dental services and drug/alcohol use in the community. The Task Force has worked with the Medical Center to identify a Valencia Community Health Committee whose role will be to work with the Medical Center on these issues. A key element of this will be their involvement in the development of the new St. Jude Neighborhood Health Center in their community. They will also be involved in a new primary prevention program regarding alcohol use that the Medical Center is partnering with CSP Project Path through a grant from the St. Joseph Health System Foundation. The new Health Committee will monitor progress on key elements of this community benefit plan. The West Fullerton Improvement Committee is a group of faith based and not-for-profit organizations in West Fullerton that is focusing on bringing services for youth in that community. A project related to childhood asthma and the sub-standard housing conditions that trigger asthma symptoms has been initiated as a result of the Committee. Residents are receiving leadership training and community organizing from Orange County Human Relations Council and Orange County Congregation of Community Organization. These residents will be in a position soon to provide input and leadership into our community benefit activities. In Placentia, the Medical Center is working with the Families First Collaborative, a group of agencies who are seeking to develop existing immigrant parent groups into a leadership group to address the physical environment. In La Habra, the Medical Center is a partner in La Habra Works, a community building initiative that seeks to create jobs for low-income immigrants. It is hoped that these latter two groups, as they are trained and organized, will be able to be important partners with the Medical Center in collaborating on community benefit activities.

### **C. FY 06-08 Community Benefits Plan**

The Medical Center, in collaboration with the Healthy Communities Committee of the Board of Trustees and external stakeholders has identified the following priority areas to address in its FY 06-08 Community Benefit Plan:

- Health Care Access
- Promoting Health Improvement/Disease Management
- Healthy Communities

#### **Health Care Access**

While significant progress has been made in reducing the number of children who are uninsured in the Medical Center's service area, there are still over 44,000 uninsured persons whose needs must be addressed. Data from the Orange County Health Needs Assessment (2005) showed the following: 73.3% of the uninsured did not see a physician in the past year because of cost; 39.5% of the uninsured were not taking a prescribed drug because of cost; none of the uninsured had a mammogram in the past year; and 15% of the uninsured in our area use the Emergency Department as their primary place for medical care. Existing community clinics in North Orange County have capacity to serve only 27% of the uninsured. The Medical Center will address the Health Care Access issue through the following strategies:

- 1) Increase capacity of community clinics by opening the St. Jude Neighborhood Health Center in Richman Park, Fullerton. It is anticipated that this new clinic will serve over 5,000 people each year.
- 2) Provide leadership and financial support to the Orange County Children's Health Initiative and the CaliforniaKids Collaborative. The goal of the Children's Health Initiative is to insure every child in Orange County. The Medical Center, as part of a St. Joseph Health System collaborative project, has committed to an investment of \$500,000 over three years to increase the number of Care Coordinators to enroll eligible children in MediCal and Healthy Families and to pay for insurance premiums for those children who are not eligible for government programs. The Children's Health Initiative will leverage these funds and bring in key stakeholders who have the capacity to see that every child has health insurance. The CaliforniaKids Collaborative funds premiums in the CaliforniaKids program.
- 3) Advocate for universal children's health insurance through community education and legislative advocacy.

### **Promoting Health Improvement/Disease Management**

The Medical Center provides a wide variety of health improvement and disease management programs. This plan will address the following specific health indicators in the low-income community of South Fullerton (zip code 92832): Inadequate/Late prenatal care and Diabetes. This zip code was identified by the Orange County Health Care Agency in the highest need quartile in the county for these indicators. 15.38% of births in this neighborhood did not have prenatal care in the first trimester. The Diabetes mortality rate was over twice the county mortality rate in this neighborhood. This is the neighborhood where the new St. Jude Neighborhood Health Center will be located and where there is an engaged resident group and other community resources to provide support.

### **Healthy Communities**

The Medical Center's healthy communities initiative is Education. Over the past three years the Medical Center has focused its efforts on the Title I schools in Fullerton through its support of the Fullerton Collaborative. Significant progress was achieved by increasing after school program slots and providing support services to the target schools. A key factor in poverty is lack of a high school diploma. Over the next three years as part of this plan, the Medical Center will work with local community groups to identify strategies to improve the percentage of youth in targeted neighborhoods of Fullerton with a high school diploma.

<b>LYON #</b>	<b>Title:</b> <b>St. Jude Neighborhood Health Center</b>	<b>Focus Area:</b> Healthcare Access
<b>3 Year Outcome Desired:</b> Increase the percentage of the DUHN population in North Orange County who have access to a community clinic by 30%.		

<b>Strategy 1: Open the St. Jude Neighborhood Health Center</b>	
<b>FY '06 Baseline: Currently community clinics in North Orange County reach 27% of the uninsured. There is no community clinic in the Valencia community. The City of Fullerton has agreed to partner with SJMC to provide land in Richman Park for the clinic. The Fullerton School District has agreed to work with SJMC on land for parking.</b>	
<b>FY '06 Measure</b>	<b>Outcomes/Progress based on Measures</b>
1. Community Clinic licensed and operating.	1.
2. 600 Medical/dental visits in FY06.	2.
3. Contract with St. Jude Heritage for an FTE Physician.	3.

<b>Strategy 2: Form a Valencia Community Health Committee to advise the development and implementation of the new clinic and to address community health issues.</b>	
<b>FY '06 Baseline: Committee of residents has met once.</b>	
<b>FY '06 Measure</b>	<b>Outcomes/Progress based on Measures</b>
1. # of active residents participating in committee	1.
2. Establish a resident Chair or Co-Chair	2.
3. 4 Committee member meetings are held to solicit input on clinic operations.	3.

<b>LYON #</b>	<b>Title:</b> <b>MediKids – Orange County Children’s Health Initiative</b>	<b>Focus Area:</b> Healthcare Access/Reform
<b>3 Year Outcome Desired:</b> Every child in Orange County has health insurance and a medical home.		

<b>Strategy 1: Provide leadership to insure a strong Orange County Children’s Health Initiative</b>	
<b>FY '06 Baseline: Coalition has been formed and is in process of hiring an Executive Director. Leveraged funding is very short of need.</b>	
<b>FY '06 Measure</b>	<b>Outcomes/Progress based on Measures</b>
1. Five key partners are providing active leadership and significant funding to project.	1.
2. Fund development plan has been developed and is being implemented.	2.

<b>Strategy 2: Increase enrollment of eligible children in Medi-Cal and Healthy Families</b>	
<b>FY '06 Baseline: Efforts to enroll children are fragmented. Number of Certified Application Assistants has declined in county.</b>	
<b>FY '06 Measure</b>	<b>Outcomes/Progress based on Measures</b>
1. 4,700 applications completed for Healthy Families, Medi-Cal.	1.
2. 80% of enrolled children tracked to a medical home.	2.
3. As a collaborative partner in the MediKids Project, increase the # of CAA’s by 6.	3.
4. Pilot 100% Campaign at one Elementary School in Placentia.	4.

<b>Strategy 3: Increase premium support for uninsured children not eligible for Medi-Cal/Healthy Families</b>	
<b>FY '06 Baseline: Five hospitals are helping to fund CaliforniaKids premiums. Currently, 5,400 children covered.</b>	
<b>FY '06 Measure</b>	<b>Outcomes/Progress based on Measures</b>
1. \$500,000 raised in additional premium support for either CaliforniaKids or alternative product.	1.
2. Common countywide structure to receive coalition funding established.	2.
3. 6,300 children covered under CaliforniaKids or alternate product.	3.

<b>LYON #</b>	<b>Title:</b> <b>Valencia Community Diabetes Program at new SJMC Neighborhood Center.</b>	<b>Focus Area:</b> Promoting Health Improvement/Disease Management
<b>3 Year Outcome Desired:</b> Implement strategies to improve diabetes morbidity and mortality in the Valencia Community Zip Code 92832.		

<b>Strategy 1: Establish a baseline of residents who are at risk for diabetes in the Valencia community and increase their access to a medical home for care.</b>	
<b>FY '06 Baseline: Currently no baseline data exists and there is no community clinic available in the area. Diabetes Mortality rate is 29.19 per 100,000.</b>	
<b>FY '06 Measure</b>	<b>Outcomes/Progress based on Measures</b>
1. Using census data establish an estimated baseline of residents who are at risk for Diabetes or have Diabetes and other demographic factors (e.g., age, gender, ethnicity).	1.
2. Design and strategically focus outreach and screenings using a population based approach.	2.
3. Baseline established and # Diabetic patients enrolled in new St. Jude Neighborhood Health Center tracked.	3.

<b>Strategy 2: Initiate planning for a diabetic clinic at the St. Jude Neighborhood Health Center</b>	
<b>FY '06 Baseline: Currently there is no diabetic clinic in the community.</b>	
<b>FY '06 Measure</b>	<b>Outcomes/Progress based on Measures</b>
1. Clinic model for diabetic care developed in collaboration with St. Jude Heritage endocrinologist and SJMC diabetic educator.	1.
2. Collaboration with Coalition of Orange County Community Clinic HCAP grant regarding diabetes achieved if grant funded (County-wide, \$1Million)	2.

<b>Strategy 3: Develop a Wellness Center at the St. Jude Neighborhood Health Center to offer lifestyle change interventions to pre-diabetics and diabetics.</b>	
<b>FY '06 Baseline: No Wellness Center available in the community. Lack of fitness facilities in the community. Is a CDBG census tract.</b>	
<b>FY '06 Measure</b>	<b>Outcomes/Progress based on Measures</b>
1. Program plan for Wellness Center completed in collaboration with Valencia Community Health Committee and California State University Fullerton.	1.
2. Completed (operations/facility) plan for equipping and staffing Wellness Center fitness facility in collaboration with California State University Fullerton.	2.

<b>LYON #</b>	<b>Title:</b> Fullerton Healthy Beginnings Program	<b>Focus Area:</b> Promoting Health Improvement/Disease Management
<b>3 Year Outcome Desired:</b> Reduction in percentage of pregnant women in Valencia zip code 92832 who have inadequate prenatal care.		

<b>Strategy 1: Identify barriers to women seeking early prenatal care.</b>	
<b>FY '06 Baseline: Currently, 15.9% of pregnant women in zip code 92832 have inadequate prenatal care. There is no organized effort to address this issue.</b>	
<b>FY '06 Measure</b>	<b>Outcomes/Progress based on Measures</b>
1. Identify key demographic factors of population impacted.	1.
2. # and type of barriers identified.	2.
3. One focus group with residents held to identify barriers.	3.

<b>Strategy 2: Provide prenatal care at St. Jude Neighborhood Health Clinic</b>	
<b>FY '06 Baseline: Currently no prenatal services offered in the neighborhood.</b>	
<b>FY '06 Measure</b>	<b>Outcomes/Progress based on Measures</b>
1. Clinic licensed and opened.	1.
2. Baseline established and # Women provided prenatal care in first trimester tracked.	2.

<b>Strategy 3: Increase # of OB/GYN and Family Physicians who will accept Medi-Cal women for deliveries.</b>	
<b>FY '06 Baseline: Currently few OB/GYN's at SJMC will provide care for Medi-Cal patients. Discussion on reducing role of Family Practitioners in deliveries.</b>	
<b>FY '06 Measure</b>	<b>Outcomes/Progress based on Measures</b>
1. Add one OB/GYN on SJMC staff who will accept Medi-Cal patients from our Clinic for deliveries.	1.
2. Identify at least one strategy to increase availability of physician coverage for prenatal patient deliveries.	2.

<b>LYON #</b>	<b>Title: Healthy Communities Initiative: Education</b>	<b>Focus Area: Healthy Communities</b>
<b>3 Year Outcome Desired:</b> Increase community focus on strategies that will increase the percentage of low-income youth from targeted N. OC Communities who are likely to have a high school diploma.		

<b>Strategy 1: Develop baseline data on the percentage of low income youth from Fullerton Title One Schools who do not graduate high school.</b>	
<b>FY '06 Baseline: Currently no community specific baseline exists.</b>	
<b>FY '06 Measure</b>	<b>Outcomes/Progress based on Measures</b>
1. Baseline developed with school district.	1.
2. Focus group held with community residents (parents and kids) to identify barriers to high school graduation.	2.

<b>Strategy 2: Work with Fullerton Collaborative and other community groups to identify and implement best practices that insure a higher percentage of students receive a high school diploma.</b>	
<b>FY '06 Baseline: Limited efforts have been made to start a mentor program for students.</b>	
<b>FY '06 Measure</b>	<b>Outcomes/Progress based on Measures</b>
1. Best practices identified.	1.
2. Collaborative adopts issue as a priority.	2.

### Summary of Other Community Benefit Programs

<b>Program/Activity Name</b>	<b>FY 06 Baseline</b>	<b>FY 06 Measure</b>	<b>Outcome/Progress</b>
<b>Nurse Advice Line</b>	N/A	Avoidance of ER visits	
<b>CHF Clinic</b>	2% admitted to ED in FY 05	% admitted to ED	
<b>St. Jude Adult Mobile Health Clinic</b>	727 new adult patients seen in the clinic in FY 05	# of new adult patients seen in the clinic	
<b>St. Jude Dental Clinic</b>	199 new patients seen in the clinic in FY 05	# of new patients seen in the clinic	
<b>St. Jude Children's Mobile Health Clinic</b>	1,306 children with a medical home in FY 05	# of children who have a medical home because of the clinic	
<b>Caring Neighbors</b>	157 new clients and 27 volunteers in FY 05	# of clients and volunteers	
<b>Open Airways</b>	Provided at 18 schools in FY 05; 51 ED visits for asthma in children 8 - 11 in FY 05	# of ED visits for asthma in children 8 - 11	
<b>Senior Transportation Program</b>	Over 10,000 trips	# of trips	
<b>Meals on Wheels</b>	4,770 meals	# meals	
<b>Rehab Integration Programs</b>	Over 7,500 encounters	# persons served	
<b>Caring Neighbors</b>	157 clients enrolled	# clients served	
<b>Women's Health</b>	Over 1,500 clients in Bridges	# low income clients served	
<b>Community Education and Screenings</b>	4,680 clients served in FY 05	# clients served	

## ASACB Preliminary Review Template

### ASACB Program Activity Preliminary Review Template

Program Activity  (Use ASACB Content Category)	Vuln. Pop. or Gen. Pop.  (GP or VP)	If Vuln. Pop., meets ASACB criteria (Y or N)	If Gen. Pop., meets DUHN criteria (Y or N)	Primary Prev. emphasis  (Y or N)	CCB emphasis  (Y or N)	Evidence based links to clin. svcs (Y or N)	Collab. Gov. with Comm. Ptrs. (Y or N)	Meets ASACB criteria as a priority (Y or N)	Part of CB budget or dept. budget (CB or D)	Hospital Net Contrib.  (in \$\$\$)
Nurse Advice Line	GP		N	Y	N	N	N	Y	D	\$1,260,000
Healthy Communities	VP	Y		Y	Y	N	Y	Y	CB budget	\$822,000
Community Education	GP		N	Y	N	N	N	Y	D	\$467,000
Cancer Center Comm Programs	GP		N	N	N	N	N	N	D	\$402,000
Membership Affiliations	GP	N	N	N	N	N	Y	N	N	\$380,000
Children's Mobile Health Clinic	VP	Y		Y	N	Y	Y	Y	CB budget	\$331,000
Women;s Health Education	GP		N	Y	N	N	N	Y	D	\$382,000
Adult Mobile Health Clinic	VP	Y		Y	N	Y	Y	Y	CB budget	\$290,000
ED Social Workers	GP		Y	Y	N	N	N	Y	D	\$238,000
Community Transportation	GP		N	Y	N	N	Y	Y	D	\$204,000
CHF Clinic	GP		N	Y	N	Y	N	Y	D	\$167,000
Paramedic Service	GP		N	N	N	Y	Y	N	D	\$150,000
Mother Baby Assessment	GP		N	Y	N	N	N	Y	D	\$124,000
Senior Services	GP		N	Y	Y	N	Y	Y	D	\$100,000
Orange Caregiver Resource	GP		N	Y	Y	Y	Y	Y	D	\$169,000
Appearance Center	GP		N	Y	N	Y	N	Y	D	\$97,000
Dental Clinic	VP		N	N	N	N	N	N	CB budget	\$89,000
Health Educ and Wellness	GP	Y	Y	Y	N	Y	Y	Y	D	\$87,000
Asthma Management	GP		N	Y	N	Y	Y	Y	D	\$57,000
Caring Neighbors Program	GP		N	Y	N	N	N	N	D	\$50,000
Meals on Wheels	GP		Y	Y	N	Y	N	Y	D	\$22,000
Brain Injury Network	VP	Y		Y	Y	N	Y	Y	D	\$30,000
Falls Risk Reduction	GP		Y	Y	N	N	Y	Y	D	\$45,000
TAPP	VP	Y		Y	Y	N	Y	Y	D	\$14,000
Bridges for Newborn	VP	Y		Y	N	N	Y	Y	D	\$47,000
Rehab Comm Integration	GP		Y	Y	N	N	Y	Y	D	\$36,000
Rehab Comm F/U	GP		Y	Y	N	N	Y	Y	D	\$21,000
Patient Facilitation	VP	Y		Y	N	N	N	Y	D	\$23,000
West Fullerton Asthma Prev	VP	Y		Y	Y	N	Y	Y	D	\$17,000
Comm Benefit Support	VP	Y		N	N	N	N	Y	CB budget	\$13,000