FY25

COMMUNITY BENEFIT REPORT/

PROGRESS ON 2024-2026 COMMUNITY HEALTH IMPROVEMENT PLAN

Providence St. Jude Medical Center

Fullerton, California

Reporting Period: July 1, 2024 – June 30, 2025

HCAI ID: 106301342

To provide feedback on this CB Report or obtain a printed copy free of charge, please email Peter Hernandez at pedro.hernandez@providence.org

Providence

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EXECUTIVE SUMMARY

Providence continues its Mission of service in Orange County through Providence St. Jude Medical Center (SJMC). SJMC is an acute-care hospital 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 FY25, the hospital provided **$56,144,038** in Community Benefit in response to unmet needs. For FY25, Providence St. Jude Medical Center had an unpaid cost of Medicare of $166,753,414. FY25 CB Report can be located online at: https://www.providence.org/locations/socal/st-jude-medical-center/about-us/community-benefit

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.

2025 Accomplishments

In FY25, the Avoidable ED Navigation program increased the number of primary care physician visits by 99%. Specialty care visits increased by 171%. There was also a 13% decrease in avoidable ED visits. By our partners, CHIOC, 1,851 persons were enrolled into Medi-Cal and community outreach was expanded to 1,055 residents who received outreach and education. 115,148 persons were also reached using a multimodal approach that included participation in community engagement events, newsletters, and social media platforms. 483 high school students participated in the health care workforce development programmatic efforts in collaboration with the TGR Foundation, which included a career panel event, student showcase, industry visit to St. Jude Medical Center, and the micro internship program.

The Finamore Place clinic site of St. Jude Neighborhood Health Centers opened in 2025 and had 2,102 visits that included medical and behavioral health visits.

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

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

2025 Accomplishments

Promise to Talk acquired 3,029,050 digital impressions across all social media and web platforms during FY25. There were 24,684 encounters, which includes residents active on social media sites and in person and 806 total promises made. 29 new lime green benches installed at schools, churches, parks, and

mental health rehabilitation centers. The MAT Program continues to be implemented in the hospital Emergency Department since 2021. 431 patients received MAT services in the ED. The St. Jude Neighborhood Health Centers in Fullerton and Anaheim sites provided 231 psychiatry visits.

PRIORITY 3: HOMELESSNESS AND AFFORDABLE HOUSING

Support effective advocacy efforts on state and local level.

2025 Accomplishments

In FY25, the Homes for All partnership, a five-part training series on affordable housing advocacy, expanded to include the Multi-Ethnic Collaborative of Community Agencies (MECCA) and a Latino Youth-service organization. 25 “systems change advocates” from MECCA were trained representing 10 community-based organizations. 60 total Housing Navigators have been trained in the Homes for All advocacy curriculum. 362 patients were referred to recuperative care post discharge and obtained access to primary care, behavioral health services, case management, or supportive housing services. 291 clients were matched for housing using the United Way Homelessness Prevention and Stabilization program. 1,385 individuals experiencing housing insecurity accessed services using the Fullerton School District’s Hub Family Resource Center at Valencia Park Elementary.

About Providence

For nearly 170 years, Providence has been dedicated to supporting communities across the seven states we serve. We have always believed in the power of collaboration, recognizing that strong partnerships are essential to our vision of health for a better world.

As we focus on our core operations of delivering high-quality, compassionate care, we rely on partners in local communities to help us get upstream so we can address the social factors that affect health, especially in communities experiencing high levels of health disparities.

At the heart of this collaboration is our community benefit programs. Every year, our family of organizations identifies unmet community needs and responds with strategic contributions and partnerships. Through this work, we aim to meet basic health needs, remove barriers to health, build resilient communities and find innovative ways to serve those who are most vulnerable.

Together, our 125,000 caregivers (all employees) serve in 51 hospitals, 1,014 clinics and a comprehensive range of health and social services across Alaska, California, Montana, New Mexico, Oregon, Texas and Washington.

For more information go to: https://www.providence.org/about/annual-report

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

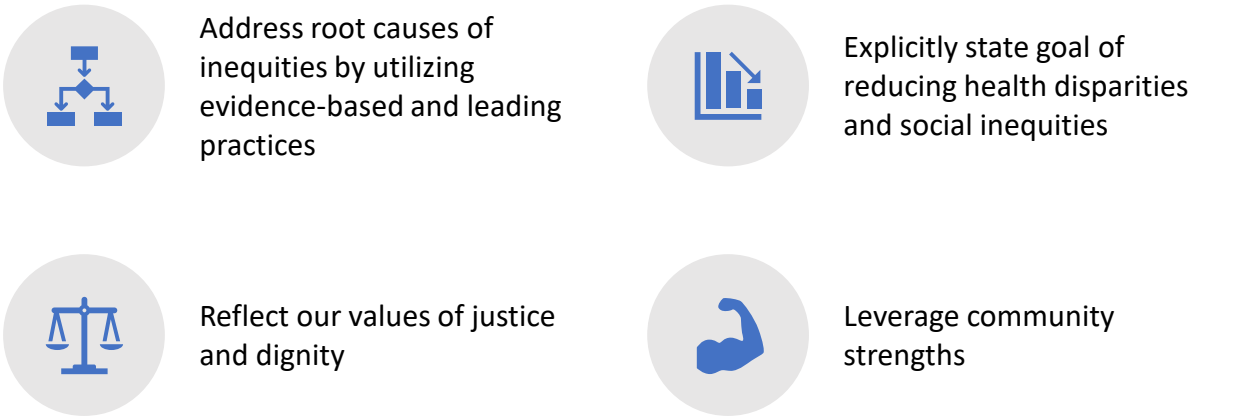
Providence St. Jude Medical Center dedicates resources to improve the health and quality of life for the communities we serve. During Fiscal Year 2025 (July 1, 2024 – June 30, 2025), Providence St. Jude Medical Center provided $56,144,038 Community Benefit in response to unmet needs and to improve the 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 the 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 meets quarterly.

Roles and Responsibilities

Senior Leadership

• Chief Executive and senior leaders including the hospital's Chief Mission Integration Officer, 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 and 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 FY25, Providence St. Jude Medical Center provided $7,767,190 free (charity care) and discounted care.

Medi-Cal (Medicaid)

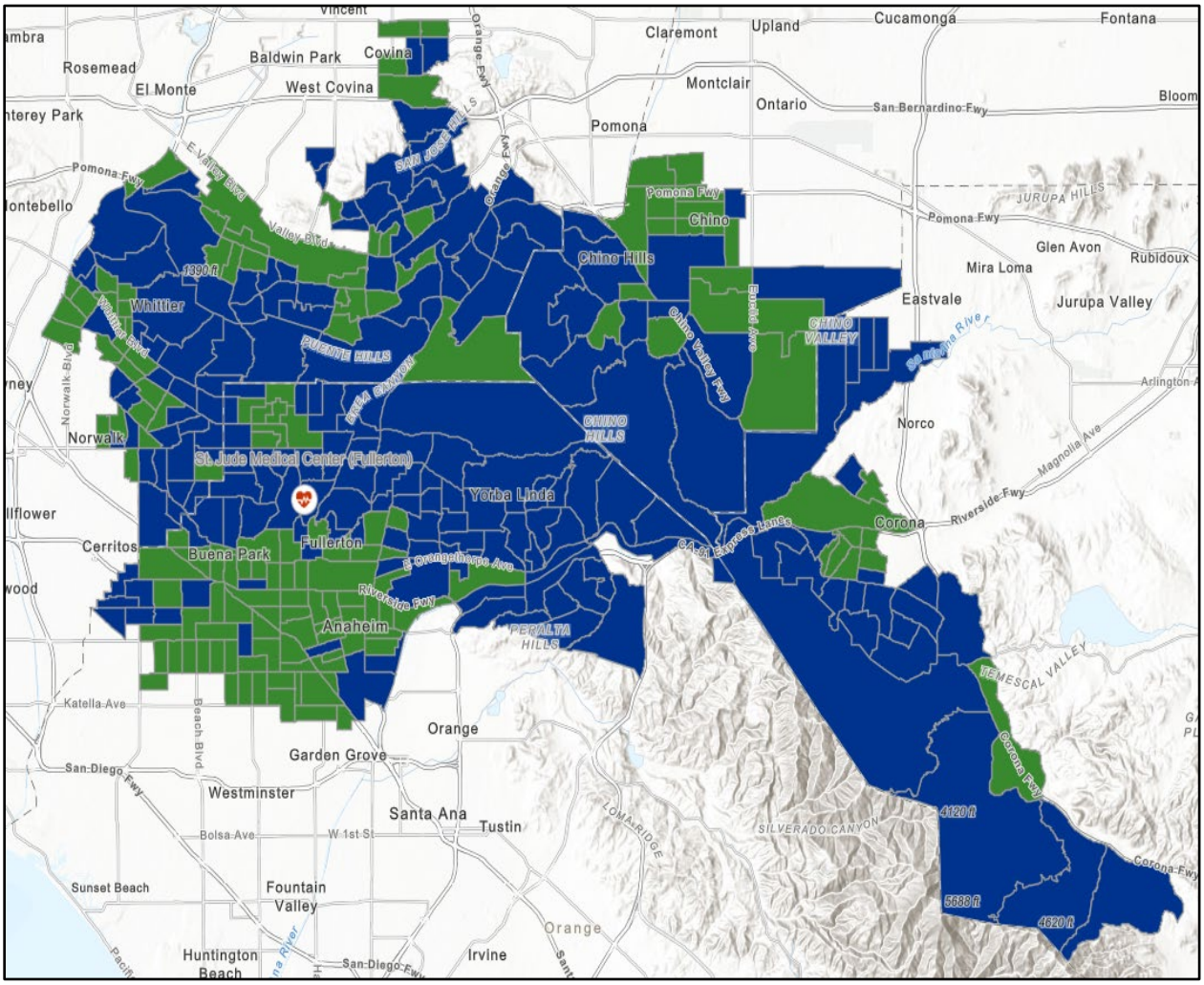
Providence St. Jude Medical Center provides access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California. In FY25, Providence St. Jude Medical Center provided $42,647,593 in Medicaid shortfall.

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, 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 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 CHNA results guide and inform efforts to better address the community's needs. 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.

Eight (8) listening sessions with people who have chronic conditions, are from diverse communities, have low-incomes, and/or are medically underserved, focusing on historically underserved and underrepresented "micro communities." We also received 70 responses to a key informant survey from organizations that serve these and other underserved populations to gain deeper understanding of community strengths and opportunities.

The CHNA would not have been possible without the engagement and participation of crucial community partners, including leadership from various Community Based Organizations (CBOs), school districts and educational institutions, Federally Qualified Health Centers (FQHC), medical centers, faith-based and community- based organizations, law enforcement, cities, and government agencies. Additionally, several partners were critical in their outreach and facilitation of resident listening sessions. Those include: The Cambodian Family, the Illumination Institute, Korean Community Services (KCS), the LGBTQ Center Orange County, the Orange County Aging Services Collaborative, HEAL Collective, UNIDOS South Orange County, and Vital Access Care Foundation (VACF).

The 2023 CHNA was approved by the SJMC Community Health Committee on September 20, 2023. Our 2023 CHNA is posted on our public website at: https://www.providence.org/about/annual-report/reports/chna-and-chip-reports under Southern California-> Fullerton

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 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 community needs to coordinate care and referrals to address these unmet needs.

COMMUNITY HEALTH IMPROVEMENT 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 by May 15, 2024.

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

2025 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	FY25 Accomplishments
Ensure seamless transition to Medi-Cal/CalOptima	Newly Medi-Cal eligible FQHC patient population.	# of patients enrolled	120 patients
Open new Finamore Place clinic site in Anaheim	Low Income uninsured and underinsured persons	# of patients served	2,102 visits

Support Avoidable ED Navigation Program to provide comprehensive intervention	Medi-Cal/CalOptima patients.	# of Avoidable ED visits # of PCP visits and Specialty Care visits	497 total AED visits Pre engagement ER visits 1,538 Post engagement ER visits 1,342 Total of 13% decrease in ER visits Pre engagement PCP visits 607 Post engagement PCP visits 1,212 Total of 99% increase in PCP visits Pre engagement Specialty Care visits 1,229 Post engagement Specialty Care visits 3,335 Total of 171% increase in Specialty 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 1,851 persons 1,055 residents received outreach and education; 115,148 persons were reached using multi-modal approach that included in person, social media, and newsletters
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	483 high school students served. This includes the career panel event, student showcase, industry visit to St. Jude Medical center, and the micro-internship program.

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

2025 Accomplishments

An additional 120 FQHC patient population that newly qualified for Medi-Cal coverage were enrolled who had not applied during the initial expansion period. The opening of the St. Jude Neighborhood Health Center - Finamore Place clinic site in Anaheim was approved after undergoing final credentialing with CalOptima. There have been 2,102 visits from low income uninsured and underinsured persons. Of those 2,077 were medical visits and 25 behavioral health visits.

During FY25, 497 patients enrolled in the Avoidable ED program. During that time 1,972 encounters occurred, and 1,580 unique patients were identified. The AED program central team comprises of two Community Health Workers, a Social Work Case Manager and a Nurse Case Manager.

Partnered with Community Health Initiative of Orange County (CHIOC) to enroll newly eligible Medi-Cal, uninsured, undocumented individuals ages 26-49. For the duration of the grant period, CHIOC supported 1,487 undocumented individuals in enrolling into Medi-Cal. CHIOC's culturally competent and personalized support helped remove barriers and facilitated enrollment for the individuals. To enroll individuals from the target audience, CHIOC implemented a multi-modal outreach strategy that included participation in community events, regularly utilizing social media platforms, and disseminating informative newsletters using email. The multi-modal approach reached 115,148 individuals and expanded awareness about health care resources and enrollment opportunities. In addition, 57 "Know Your Benefits" presentations were provided where a total of 1,055 community members participated and had an opportunity to learn about healthcare programs available, eligibility requirements, and how to effectively use their coverage. Major barriers that impacted enrollment goals included concerns about public charge rule and fear of deportation. As a result, undocumented individuals and mixed-status families avoided applying for Medi-Cal, even when eligible.

Collaborated with the TGR Foundation to promote health care workforce development among high school students in Orange County. Teens learned about healthcare careers as a component of the Career-Connected Learning programs. In FY25, 31 students participated in the Career Academy Day. On November 22, 2024, 217 students participated in the health careers panel event where students had exposure to different hospital professions to network and engage; designed with the purpose of contributing to a pipeline of the future health care workforce. 91% of students surveyed demonstrated they planned to apply what they learned during the event in the future. 456 students from AUHSD participated in the career explorer program. 65 students participated in the career explorer presentation on the Community Health Needs Assessment and Student Showcase presentation. On February 28, 2025, students from four local high schools had an opportunity to compete in a Student Showcase and present their solutions to challenges outlined in the hospital's Community Health Needs Assessment. During the Student Showcase presentation, students offered innovative health care solutions on

homelessness, elderly care, substance use and many other topics. 17 teams presented their solutions with a winning team being announced for each high school. Another accomplishment from the presentations resulted in several students being selected to serve on a community advisory council as the first student participants. 40 students also participated in the micro-internship opportunity where they learned about addressing gaps within Community Health Needs Assessment by enhancing youth voice in public health. And 15 students attended the industry visit to St. Jude Medical Center. In total there were 780 encounters with 483 high school students served.

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	FY25 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.	11,640 active residents on social media sites. 29 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.	431 patients received naloxone prescription in the ED.

Collaborate with partner FQHCs to provide free psychiatry services	FQHC patients	# of patients who receive psychiatric evaluation and medication management.	231 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).

2025 Accomplishments

Promise to Talk acquired 3,029,050 impressions across all social media and web platforms during FY25. There were 24,684 encounters, which includes residents active on social media sites and in person and 806 total promises made. During FY25 GreenBenchOC.org and PromiseToTalk.org garnered 11,640 active resident visitors. The websites continue to encourage open conversations to reduce the stigma surrounding mental health along with resources that can empower members of the community to act and prioritize their mental health. 29 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 FY25, Promise to Talk participated in five outreach events where 4.3K meaningful interactions with community members took place. Community members shared about their own struggles with mental health and Promise to Talk helped facilitate the process for community members to commit to talking about these issues with a trusted friend or family member. Promise to Talk also re-created and shared a Back-To-School toolkit to support parents and children on how to navigate the stressful and challenging time. Promise to Talk also introduced the first-ever holiday toolkit, with resources to support the community during the holidays. 1,472,049 social media impressions occurred during the back to school and holiday seasons. During this time, the toolkits were shared with 261 partner organizations and 33 schools. Community event participation also provided media coverage opportunities and helped spread awareness among our target audiences. The campaign continues to initiate important conversations with members of the community and create interest around mental health by using in-person and digital connections and was reflected in an increase in positive sentiment scores from previous years.

In addition, the MAT Program continues to be fully implemented in the hospital's Emergency Department since 2021. 431 patients received naloxone prescription through the MAT program in the ED in FY25. And partner FQHC's provided 231 individuals access to psychiatric services.

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	FY25 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	510 days in the hospital
Partner with Illumination Foundation to provide Recuperative Care; Year 2: Included all recuperative care patient referrals	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.	362 unique clients served
Support United Way Eviction Diversion & Prevention Program; new program name in Year 2: Homeless Prevention and	Families at risk for eviction	# of households that are assessed and receive an ecosystem of eviction prevention services.	A total of 2,433 client calls seeking rental assistance. 296 clients passed eligibility pre-screening and were eligible for referral.

Stabilization Program			
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	10 community-based organizations represented in training 25 community members trained using the curriculum Provided 4 workshops
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.	The AHAP (Affordable Housing Access Platform), has formed an official partnership with 211 OC to leverage their Get Help OC platform to connect residents seeking affordable housing with those opportunities. We are still working to get buy in from cities and housing providers. We set a goal to have 20 interested cities before we begin the build out, so far, we have 14.
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 mental health services	1,385 individuals accessed 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

2025 Accomplishments

The Homeless Care Navigation program continued with two care navigators who provided services to 571 unique homeless clients with 3,694 encounters. 362 patients experiencing homelessness were referred to recuperative care post discharge and obtained access to primary, behavioral health services, case management, and supportive housing services. During FY25, 144 patients stayed beyond medically necessary for 510 days.

In FY25, the Homelessness Prevention and Stabilization program had 2,433 client calls seeking rental assistance. 296 clients passed eligibility pre-screening and were eligible for referral; 291 clients were matched for housing.

The Homes for All partnership expanded by training 25 "systems change advocates" from Arabic, Korean, Cambodian, Chinese, Vietnamese, and other South Asian and Southeast Asian communities for a total of 60 Housing Navigators. By working with MECCA, 10 organizations were represented during the training. The training occurred over a six-month period with five in person training sessions and "deeper dive" webinars on topics like zoning and housing typologies. Housing Navigator training was also developed in response to requests from community-based organizations of support needed in navigating resources for residents experiencing housing insecurity. In addition, in November 2024, data from interviewing 29 out of 34 Orange County cities about their policies around affordable housing production and connecting residents to the units was presented to a group of county officials, city staff, affordable housing developers, and social service agencies. The AHAP formed an official partnership with 211 OC to leverage their Get Help OC platform to connect residents seeking affordable housing with those opportunities and is still working to get buy in from cities and housing providers. 14 cities have expressed interest in the AHAP with the goal of reaching 20.

During FY25, the Fullerton School District helped support 1,385 individuals with resources to access food assistance, housing, healthcare, mental health, and other social services programs, 131% above the target. Chronic absenteeism among students reduced by 2.7% because of the support provided by case management for students and families. 1,241 students received comprehensive case management services throughout the year. "The Hub" resource established at Valencia Park Elementary School provided services to 1,114 students, exceeding the target goal by 59.1%. This was a result of using a centralized approach to connect students to critical resources while streamlining service delivery and coordination among support staff.

Providence Government Affairs update efforts

Local- Providence continues to keep our community and elected stakeholders informed about recent changes to the local healthcare landscape. To strengthen collaboration, we hosted hospital tours and community events, providing updates on recently passed HR1 (One Big Beautiful Bill Act of 2025), state budget, and local challenges impacting our Orange County ministries. These events provide opportunities for local elected leaders, community members, and area health care partners to engage

with Providence leadership and find ways to work together to strengthen Orange County's care continuum.

State- Providence collaborated with other health care organizations to advocate for the passage of legislation strengthening behavioral health treatment, ethical implementation of AI in health care, and sensible reforms to California's hospital seismic regulations. Providence also actively advocated for the passage of California's Proposition 35 to permanently extend the state's MCO tax and provide critical funding for Medi-Cal and graduate medical education.

Federal - On July 4, H.R. 1, officially known as the One Big Beautiful Bill Act of 2025, was signed into law by President Trump. H.R. 1 includes significant policy changes affecting Medicaid, the Affordable Care Act, Medicare, and an expansion of health savings accounts. Providence and our partners advocated strongly against cuts to health care funding and harmful provisions contained in H.R. 1 but faced a challenging advocacy landscape. Providence held more than 100 meetings and events with federal lawmakers, participated in four nationwide coalitions to amplify our message, and ran our "Many Faces of Medicaid" advocacy campaign that resulted in 7,000 messages being sent to federal lawmakers from our caregivers and patients.

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)	FY25 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	4,074 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-term facility, homecare, hospice, mental health, ambulance fees, and taxicab vouchers among others	Low-income	14 encounters

Lack of support services for frail elderly	Senior Services	Information and referrals, support groups, classes, Caring Neighbors Volunteer Program	Low-income	20,608 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	1,384 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	28,397 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 injury with assistance in vocational, housing, health, and financial needs	Low-income	1,031 encounters
Food Insecurity	Meals on Wheels Food Finders	Special diets for home delivery and food donation	Broader Community	5,757 meals
Neuro Rehab	Neuro Rehab Continuum	Inpatient and Outpatient rehab	Broader Community	20,843 encounters

FY25 COMMUNITY BENEFIT FINANCIALS

In FY25 Providence St. Jude Medical Center invested a total of $56,144,038 in key community benefit programs. St. Jude Medical Center invested $54,140,130 in community benefit programs for the poor and vulnerable and $2,003,908 in broader community. Provided $7,767,190 in charity care, $42,647,593 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.

FY2025 PROVIDENCE ST. JUDE MEDICAL CENTER
(July 1, 2024 - June 30, 2025)

Financial Assistance and Means-Tested Government Program	Vulnerable Population	Broader Community	Total
Traditional Charity Care	$7,767,190	$0	**$7,767,190**
Medi-Cal	$42,647,593	$0	**$42,647,593**
Other Means-Tested Government (Indigent Care)	$0	$0	**$0**
Sum Financial Assistance and Means-Tested Government Program	**$50,414,783**	**$0**	**$50,414,783**
Other Benefits			
Community Health Improvement Services	$1,940,303	$1,585,884	**$3,526,187**
Community Benefit Operations	$622,727	$0	**$622,727**
Health Professions Education	$0	$30,000	**$30,000**
Subsidized Health Services	$0	$338,874	**$338,874**
Research	$0	$0	**$0**
Cash and in-kind Contributions for Community Benefits	$1,162,317	$49,150	**$1,211,467**
Other Community Benefits	$0	$0	**$0**
Total Other Benefits	**$3,725,347**	**$2,003,908**	**$5,729,255**
Community Benefits Spending			
Total Community Benefits	$54,140,130	$2,003,908	**$56,144,038**
Medicare (non-IRS)	$166,753,414	$0	**$166,753,414**
Total Community Benefits with Medicare	**$220,893,544**	**$2,003,908**	**$222,897,452**

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 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.

Our Community Services Manager supported in the development of a safety committee for the Valencia Park Elementary community in the city of Fullerton. The committee formed as a follow up after the Community Services Manager, along with other community partners, attended a presentation on a youth led Safe Routes to School walking assessment who presented their findings and identified local needs in their community. In the presentation they highlighted the need for more safety, more code enforcement, more walkable crosswalks and street crossings, and activities in their community. The committee was able to support the students by sharing their findings to different stakeholders throughout the city, which included the Fullerton Collaborative. As a result, several of their concerns were addressed by implementing new LED lights at the local park for additional safety and visibility, more code enforcement, renovating parts of the park, offering sports league opportunities, trainings, more lines of communication, and other support.

In addition, Medical Center leaders serve on the Boards of Directors of many non-profit organizations, including 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.

2025 CB REPORT GOVERNANCE APPROVAL

This 2025 Community Benefit Report was adopted by the Providence St. Jude Medical Center Community Health Committee of the hospital on Wednesday, August 20, 2025. The final report will be made widely available by November 20, 2025.

Signed by:
Fidencio Mares
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11/6/2025

Fidencio Mares — Date

Chair, Providence St. Jude Medical Center Community Health Committee

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LAURA RAMOS
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11/4/2025

Laura Ramos — Date

Chief Executive, Providence St. Jude Medical Center

Signed by:
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11/4/2025

Michael Robinson — Date

Chief Community Health Officer, South Division Providence

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Providence