ST. JUDE MEDICAL CENTER
ST. JUDE HERITAGE HEALTH CARE

COMMUNITY BENEFIT PLAN

2006 - 2008

St. Jude Medical Center/St. Jude Heritage Healthcare
Community Benefits Plan 2006-2008

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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
TOTAL	795,472	

* 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%
Unemploy-ment 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	• Lack of access to health care • Drug and alcohol use • Public safety/crime • Affordable housing	• Valencia Task Force • West Fullerton Improvement Committee • Fullerton Collaborative • St. Jude Medical Center • Churches • CBO's • Community Center
Southwest Placentia	• Affordable housing • Public safety/crime • Civic Engagement	• Families First Collaborative • CBO's • Schools • Community Centers
Central La Habra	• Jobs • Affordable Housing • Public safety/crime	• La Habra Works • CBO's • City Council representing community

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.

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.

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

Strategy 1: Open the St. Jude Neighborhood Health Center	
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.	
FY '06 Measure	Outcomes/Progress based on Measures
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.

Strategy 2: Form a Valencia Community Health Committee to advise the development and implementation of the new clinic and to address community health issues.	
FY '06 Baseline: Committee of residents has met once.	
FY '06 Measure	**Outcomes/Progress based on Measures**
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.

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

Strategy 1: Provide leadership to insure a strong Orange County Children's Health Initiative	
FY '06 Baseline: Coalition has been formed and is in process of hiring an Executive Director. Leveraged funding is very short of need.	
FY '06 Measure	Outcomes/Progress based on Measures
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.

Strategy 2: Increase enrollment of eligible children in Medi-Cal and Healthy Families	
FY '06 Baseline: Efforts to enroll children are fragmented. Number of Certified Application Assistants has declined in county.	
FY '06 Measure	**Outcomes/Progress based on Measures**
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.

Strategy 3: Increase premium support for uninsured children not eligible for Medi-Cal/Healthy Families	
FY '06 Baseline: Five hospitals are helping to fund CaliforniaKids premiums. Currently, 5,400 children covered.	
FY '06 Measure	**Outcomes/Progress based on Measures**
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.

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

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.	
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.	
FY ’06 Measure	Outcomes/Progress based on Measures
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.

Strategy 2: **Initiate planning for a diabetic clinic at the St. Jude Neighborhood Health Center**	
FY ’06 Baseline: Currently there is no diabetic clinic in the community.	
FY ’06 Measure	**Outcomes/Progress based on Measures**
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.

Strategy 3: Develop a Wellness Center at the St. Jude Neighborhood Health Center to offer lifestyle change interventions to pre-diabetics and diabetics.	
FY '06 Baseline: No Wellness Center available in the community. Lack of fitness facilities in the community. Is a CDBG census tract.	
FY '06 Measure	**Outcomes/Progress based on Measures**
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.

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

Strategy 1: Identify barriers to women seeking early prenatal care.	
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.	
FY '06 Measure	Outcomes/Progress based on Measures
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.

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

Strategy 3: Increase # of OB/GYN and Family Physicians who will accept Medi-Cal women for deliveries.	
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.	
FY '06 Measure	**Outcomes/Progress based on Measures**
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.

LYON #	Title: **Healthy Communities Initiative: Education**	Focus Area: Healthy Communities

3 Year Outcome Desired:
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.

Strategy 1: Develop baseline data on the percentage of low income youth from Fullerton Title One Schools who do not graduate high school.	
FY ’06 Baseline: Currently no community specific baseline exists.	
FY ’06 Measure	Outcomes/Progress based on Measures
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.

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.	
FY ’06 Baseline: Limited efforts have been made to start a mentor program for students.	
FY ’06 Measure	**Outcomes/Progress based on Measures**
1. Best practices identified.	1.
2. Collaborative adopts issue as a priority.	2.

Summary of Other Community Benefit Programs

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