St. Joseph's Medical Center

Community Benefit 2021 Report and 2022 Plan

Adopted October 2021

Dignity Health.
St. Joseph's Medical Center

A message from

Don Wiley, president and CEO of St. Joseph's Medical Center, and Debra Cunningham, Chair Port City Operating Company, LLC Board of Managers.

Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our initiatives to deliver community benefit include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital with community partners, and investing in efforts that address social determinants of health.

St. Joseph's Medical Center shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The 2021 Community Benefit Report and 2022 Plan describes much of this work. This report meets requirements for the California state law (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health hospitals in Arizona and Nevada voluntarily produce these reports and plans, as well. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2021 (FY21), St. Joseph's Medical Center provided $46,012,788 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $19,719,103 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Board of Managers reviewed, approved and adopted the 2021 Community Benefit Report and 2022 Plan at its October 25, 2021 meeting.

Thank you for taking the time to review our report and plan. We welcome any questions or ideas for collaborating that you may have, by reaching out to Tammy Shaff, Director of Community Health, at Tammy.Shaff@DignityHealth.org.

Donald Wiley, President/CEO

Debra Cunningham, Chair Port City Operating Company, LLC Board of Managers

Table of Contents

At-a-Glance Summary

Community Served

St. Joseph's Medical Center lies in one of the fastest growing counties in California, containing both rural and urban areas, with individual cities separated by agriculture and open space lands. The county is celebrated for its diverse communities of Latinos and African Americans as well as Asian immigrants; but there is also a big gap in health outcomes between ethnic groups. It is a county of contrasts, holding on one hand growth opportunities and a variety of assets and resources to support health, and on the other hand significant challenges in terms of economic security, health and health disparities.

Economic Value of Community Benefit

$46,012,788 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits

$19,719,703 in unreimbursed costs of caring for patients covered by Medicare

Significant Community Health Needs Being Addressed

The significant community health needs the hospital is helping to address and that forms the basis of this document was identified in the hospital's most recent Community Health Needs Assessment (CHNA). The need being addressed by strategies and programs are:

- Mental Health
- Economic Security
- Obesity/Healthy Eating Active Living (HEAL)/Diabetes
- Violence/Injury Prevention
- Access to Care
- Substance Abuse/Tobacco
- Oral Health

FY21 Programs and Services

The hospital delivered several programs and services to help address identified significant community health needs. These included:

- Mental Health: Friends of Seniors, Mental Health First Aid Training, San Joaquin County Transforming Communities for Healing, Youth Overcoming Life's Obstacles (YOLO) Group, Social Needs Support through our diabetes programming, and by supporting Boys & Girls Club at Sierra Vista and Delta Health Care & Management Services Corporation through the Community Benefit Grants Program
- Economic Security: Continued involvement in San Joaquin County Whole Person Care and San Joaquin County Continuum of Care, and by supporting Visionary Home Builders of California, Inc. and Lutheran Social Services through the Community Benefit Grants Program
- Obesity/Diabetes: Diabetes Navigator and Diabetes Education programs and by supporting Boys & Girls Club at Sierra Vista through the Community Benefit Grants Program

	• Violence and Injury: Human Trafficking Awareness and Education and development of programming around trauma informed care. • Access to Care: St Mary's Free Medical Clinic, Graduate Medical Education (GME) program, and Recuperative Care which also increase housing access along with linkages to mental health and substance use treatment, and by supporting Dentists Organized for Veterans and Delta Health Care & Management Services Corporation through the Community Benefit Grants Program • Substance Use: Bridge Program to expand medication assisted treatment with Buprenorphine • Oral Health: Support of St Mary's Free Dental Clinic and by supporting Dentists Organized for Veterans through the Community Benefit Grants Program
FY22 Planned Programs and Services	The hospital intends to continue many of the FY21 programs and plans to further develop interventions to respond to priority needs found in the 2019 CHNA. The following is a brief summary of the strategies to address needs, and program level detail can be found in the Program Digest section of this report. • Community benefit program expenditures provide financial support to various community programs that are often essential safety net services for the most vulnerable of populations. The primary needs addressed through reinvestments in the community include, but are not limited to: Economic Security, Access to Care and Oral Health. • Community grants program annually assesses and funds programs and services dedicated to significantly impacting CHNA findings. This strategy encompasses the potential to help address all identified needs. • Community benefit operations and programs deliver direct services as well as in-kind support through a variety of approaches to address health disparities and improve on health outcomes either directly or indirectly. • Completing the new CHNA that will identify the community needs and priorities for the next 3 years. • Initiatives to address Social Determinants of Health and other prevention related activities including Community Health Improvement Plan (CHIP) work around park activation and beautification, CHA, Pathways Community Hub.

This document is publicly available online at https://www.dignityhealth.org/central-california/locations/stjosephs-stockton/about-us/community-programs/community-health-needs-assesment.

Written comments on this report can be submitted to the St. Joseph's Medical Center Community Health Department, 1800 North California Street, Stockton, CA 95204 or by e-mail to Tammy.Shaff@dignityhealth.org.

Our Hospital and the Community Served

About St. Joseph's Medical Center

St. Joseph's Medical Center is a member of Dignity Health, which is a part of CommonSpirit Health.

The facility has been delivering quality, compassionate care for residents of the greater San Joaquin County since 1899.

- Centrally located in the City of Stockton and San Joaquin County.
- Founded by Father William B. O'Connor and the Dominican Sisters of San Rafael, St. Joseph's Medical Center continues the legacy of caring for the poor and disenfranchised.
- 355 beds, 2,700 employees, 700 physicians, 20,000 patient admissions, 94,000 emergency visits, 3,400 babies delivered annually.
- Recipient of an "A" Grade for Patient Safety by the Leapfrog Group.
- Accredited by the National Accreditation Program for Breast Centers.
- "Best of San Joaquin" – Voted best hospital in San Joaquin County by The Record's readers and by San Joaquin Magazine.
- Recipient of the Consumer Choice Award by the National Research Foundation.
- Accredited by the American College of Surgeon's Commission on Cancer.
- Certified Primary Stroke Center by the Joint Commission.
- Designated as a Blue Distinction Center® by Blue Shield of California for Cardiac Care and Maternity Care.
- Designated Baby-Friendly™ hospital by the World Health Organization and UNICEF.
- Designated STEMI and Stroke Receiving Center by County EMS.
- American College of Cardiology's NCDR Chest Pain − MI Registry Platinum Performance Achievement Award.
- Recipient of the American Heart Association's Get With The Guidelines®-Gold Plus Quality Achievement Award and the Mission: Lifeline® Gold Receiving Quality Achievement Award.

Our Mission

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Our Vision

A healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

Financial Assistance for Medically Necessary Care

St. Joseph's Medical Center is dedicated to creating healthier communities by providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay. Advocating for the poor and vulnerable is both our mission and our passion. The hospital has financial assistance available to help pay for medically necessary services provided to those patients who meet certain income requirements. The financial assistance policy, a plain language summary of the policy, and a financial assistance application are on the hospital's website.

Description of the Community Served

St. Joseph's Medical Center serves residents of Stockton along with members of neighboring communities within San Joaquin County. The overall service area consists of 24 ZIP codes. The population of San Joaquin County is approximately 762,000, while the City of Stockton is home to roughly 387,000 residents. A summary description of the community is below. Additional details can be found in the CHNA report online.

St. Joseph's Medical Center lies in one of the fastest growing counties in California, containing both rural and urban areas, with individual cities separated by agriculture and open space lands. The county is celebrated for its diverse communities of Latinos and African Americans as well as Asian immigrants; but there is also a big gap in health outcomes between ethnic groups. It is a county of contrasts, holding in one hand growth opportunities and a variety of assets and resources to support health, and on the other hand significant challenges in terms of economic security, health and health disparities.

St. Joseph's Medical Center Service Area Demographics
(based on ZIP codes of residence for the top 75% of patient visits)

Total Population	321,404
Race	
White - Non-Hispanic	18.7%
Black/African American - Non-Hispanic	9.4%
Hispanic or Latino	51.5%
Asian/Pacific Islander	16.4%
All Others	4.0%
Total Hispanic & Race	
% Below Poverty	17.0%
Unemployment	8.5%
No High School Diploma	25.7%
Medicaid (household)	12.7%
Uninsured (household)	6.6%

Source: Claritas Pop-Facts® 2021; *SG2 Market Demographic Module*

SG2 Analytics Platform Reports:

Demographics Market Snapshot

Population Age 16+ by Employment Status

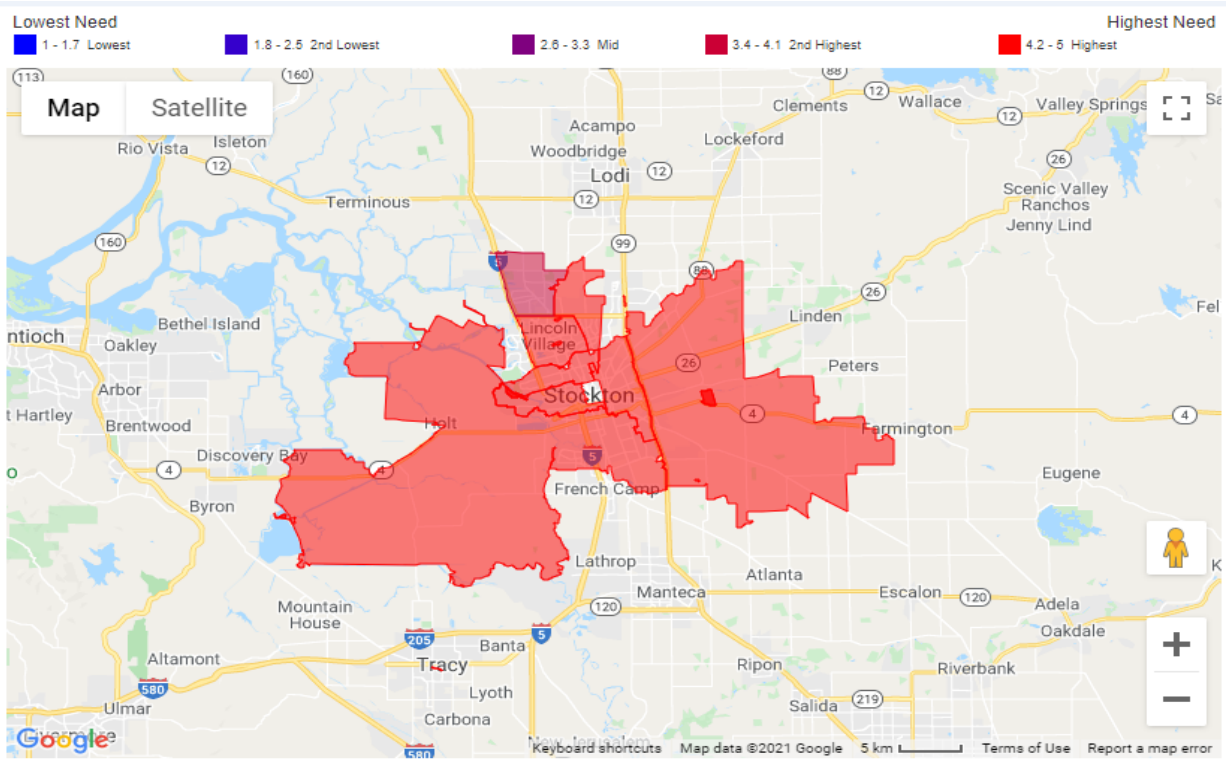
Families by Poverty Status, Marital Status and Children Age

Insurance Covereage Estimates; map data export

Community Need Index

One tool used to assess health needs is the Community Need Index (CNI) created and made publicly available by Dignity Health and IBM Watson Health. The CNI analyzes data at the zip code level on five factors known to contribute or be barriers to healthcare access: income, culture/language, education, housing status, and insurance coverage.

Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.



Mean(zipcode): 4.6 / Mean(person): 4.6 CNI Score Median: 4.7 CNI Score Mode: 4.6,4.8

Zip Code	CNI Score	Population	City	County	State
95203	5	17130	Stockton	San Joaquin	California
95204	4.4	29172	Stockton	San Joaquin	California
95205	5	41133	Stockton	San Joaquin	California
95206	4.8	71869	Stockton	San Joaquin	California
95207	4.6	50390	Stockton	San Joaquin	California
95209	3.6	44269	Stockton	San Joaquin	California
95210	4.8	42547	Stockton	San Joaquin	California
95215	4.6	24894	Stockton	San Joaquin	California

Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its community health improvement planning process. These include, but are not limited, to conducting a Community Health Needs Assessment with community input at least every three years, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospital's community benefit plan and programs were identified in the most recent CHNA report, which was adopted in

The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at https://www.dignityhealth.org/central-california/locations/stjosephs-stockton/about-us/community-programs/community-health-needs-assesment or upon request at the hospital's Community Health office

Significant Health Needs

The most recent community health needs assessment identified the following significant community health needs:

Highest Priority

- Mental Health
- Economic Security
- Obesity/Healthy Eating and Active Living (HEAL)/Diabetes

Medium Priority

- Violence/Injury Prevention
- Access to Care
- Substance Abuse/Tobacco

Lower Priority

- Asthma
- Oral Health
- Climate and Health

Significant Needs the Hospital Does Not Intend to Address

Asthma: The hospital has chosen to not address this identified need at this time so that resources can be directed towards higher priority needs. In addition, the University of the Pacific's School of Pharmacy offers

personalized education for both pediatric and adult patients via their Asthma clinic which is open to all members of the San Joaquin community and Little Manilla Rising has Community Health Workers engaged directly with vulnerable community members to support asthma education and home modifications to prevent or reduce asthma related causes.

Climate and Health: Air quality is of significant importance in the overall health and quality of life of residents, however the topic is not the hospital's area of expertise. St. Joseph's Medical Center will not be addressing this identified need and will defer to the San Joaquin Valley Air Pollution Control District to develop the needed strategies to address the community's concerns.

2021 Report and 2022 Plan

This section presents strategies and program activities the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It summarizes actions taken in FY21 and planned activities for FY22, with statements on anticipated impacts, planned collaboration, and patient financial assistance for medically necessary care. Program Digests provide detail on select programs' goals, measurable objectives, expenses and other information.

This report specifies planned activities consistent with the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

The anticipated impacts of the hospital's activities on significant health needs are summarized below, and for select program initiatives are stated in Program Digests. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospital works to evaluate impact and sets priorities for its community health programs in triennial Community Health Needs Assessments.

Creating the Community Benefit Plan

St. Joseph's Medical Center is dedicated to improving community health and delivering community benefits with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

The process used to identify and design the programs, initiatives, and collaborative efforts in this report has been based on the thoughtful evaluation of the CHNA findings, the San Joaquin County Public Health's Community Health Improvement Plan (CHIP) priorities, and the existing community benefit investments with proven success.

Participants in the strategic planning process included community health department leadership and staff, as well as an advisory team composed of representatives from hospital administration, county public health services, CHNA and CHIP stakeholders, and community members.

Community input was obtained throughout the CHNA and CHIP processes and all feedback was considered in the development of this report. Additionally, local residents participated in the advisory team and were key contributors to the strategy developed.

Programs and initiatives selected to address identified needs were based on the following criteria:

- Existing programs resulting in impactful outcomes.
- Evidence-based or promising practice.
- Possibility in addressing health disparities and the social determinants of health.
- Probability of impacting health equity and cultural disparities.
- Alignment with current county-wide collaborative efforts.

Impact of the Coronavirus Pandemic

Within the San Joaquin County (SJC) area, the pandemic elevated the expertise of every layer of leadership throughout our organization and expanded collaboration opportunities among multi sector service providers throughout the county. Many of the needs and challenges already experienced by SJC residents were greatly exacerbated by the pandemic. Below is a summary of St. Joseph's Medical Center's response to the pandemic as a collaborative community health partner.

- Housing the Homeless: The Community Health Department team provided technical assistance in the planning and implementation of Project RoomKey, as well as support the care coordination and placement of high risk and COVID positive patients through ongoing collaboration with all partners.
- Personal Protective Equipment (PPE) for the community: In partnership with Public Health and the United Way of San Joaquin County, Dignity Health led the organization of volunteers to assemble nearly 120,000 mask kits, as well as coordinate county-wide distribution of the kits which included a reusable mask, hand sanitizer, COVID education and 211 information and resources. In addition, Dignity Health coordinated the distribution of over 86,000 cloth masks and 4,000 bottles of hand sanitizer to support various service providers The approach with dissemination included partnering with community based organizations to provide culturally appropriate education along with the supplies, and ensured that those most at risk, including; migrant farm workers, the unsheltered, and low income communities, were well informed and had the resources to best protect themselves and their family members.
- Community Benefit Nursing Staff were allocated to the Screening Stations at the hospital entrances to screen employees, patients and visitors for fever as well as other symptoms associated with COVID-19.
- Community Health management were assigned to assist in the leadership of the Mass COVID Vaccination clinics. SJMC partnered with Adventist Health and Kaiser Permanente to operate a mass vaccination clinic at the Stockton Arena. 15,664 people were vaccinated over 10 weeks. SJMC leaders, nurses and community health team coordinated and worked on these efforts on behalf of all of SJMC.

In FY22, the hospital plans to continue promoting healthy lifestyles through virtual health education programming to encourage the prevention and management of chronic diseases. Preventative screenings

and general health maintenance volumes declined during the pandemic, so campaigns to encourage ongoing wellness and healthy living will continue to be an area of focus. Additionally, implementing a Health Related Social Needs Screening for all Emergency Department patients will help to ensure that the hospital is proactive in helping to address the needs of the whole person.

Also, to further protect our community, as well as being positive examples for them, the CEO of CommonSpirit Health, Lloyd H. Dean released a statement on August 12, 2021 requiring all employees to be vaccinated.

Report and Plan by Health Need

The tables below present strategies and program activities the hospital has delivered or intends to deliver to help address significant health needs identified in the community health needs assessment.

They are organized by health need and include statements of strategy and program impact, and any collaboration with other organizations in our community.

Health Need: Mental Health

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Community Grants Program	Through a formal process, grants are administered annually to non-profit organizations that best demonstrate their ability to impact community health needs as they pertain to the most recent needs assessment. The following programs awarded funding in 2020 for November 1, 2020 through December 31, 2021 and are addressing mental health: ● Boys & Girls Club at Sierra Vista – By teaching sculling, this program will work with youth on social emotional health ensuring that participants make the connection that physical activity is a stress reliever. ● Delta Health Care and Management Services Corporation – Mental health support for high school aged youth in SUSD. The formal grant process for calendar year 2022 will conclude at the end of 2021 and all projects will include one or more of the 2019 CHNA health needs.	☒	☒
Community Benefit Operations and Programs	In partnership with St. Joseph's Behavioral Health Center and in collaboration with other mental health experts and service providers, the hospital's Community Health department will deploy several programs to address community needs	☒	☒
Community Health Social Worker	This person is responsible for providing outreach and education regarding the following activities. • Anxiety and Depression Workshops: These sessions, targeting youth, will be provided to the community at no cost and in collaboration with school districts throughout the county. The goal of the workshops will be to provide strength based programming that empowers resiliency and introduces essential coping skills to reduce symptoms of anxiety and	☒	☒

	depression. • Mental Health First Aid Training: This course teaches how to help someone who may be experiencing a mental health or substance use challenge. The training helps to identify, understand and respond to signs of addictions and mental illnesses.		
SJC Trauma Initiative	A collaborative group of over 70 members, representing 41 organizations throughout the county focusing on addressing trauma and promoting equity through the development of a Trauma Informed Care train-the-trainer training model for sustainability. This initiative focuses on addressing diversity, inclusion and cultural humility for both medical staff and providers, as well as social service providers.	☒	☒
Friends of Seniors Links Program	This program supports the reduction of isolation and depression in older adults.	☒	☒
San Joaquin Mental Health Consortium	Membership in this consortium supports sharing mental health resources and best practices.	☒	☒
Connected Community Network (CNN)	This network was created to provide the general population with access to resources and programs offered through various community based organizations (CBOs). Many of these CBOs provide vital services that help people address a variety of needs, including but not limited to: affordable housing; maternal, infant, and child health; chronic disease management programs, healthy food, and mental health and substance abuse counseling.	☒	☒

Impact: Overall, these strategies will focus on prevention and early intervention of identifying and responding to mental health issues. There are additional programs and strategies listed in other areas of this report that are also anticipated to impact mental and behavioral health needs.

Collaboration: Cross-sector collaboration is planned for all of the programs listed in order to ensure efficiency of services, leveraging of resources, avoidance of duplication, and to ensure sustainability. The short list of key partners include: Community Partnership for Families of San Joaquin, El Concilio, United Way, Catholic Charities, Housing Authority County of San Joaquin, Delta Sculling Center, Aspire Public Schools, Aspire Stockton Secondary Academy, STAND, Stockton Unified School District, Brian Huff, LMFT, United Way of SJC, the growing number of CCN and SJC Trauma Initiative partners.

Health Need: Economic Security

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Connected Community Network (CCN)	This county-wide network of stakeholders, navigation and convening partners, along with community based organizations will create a fully integrated referral system. The system will increase community member connections to various medical and social services.	☒	☒
San Joaquin County Continuum of Care (SJCoC)	Community Health staff participate actively in the SJCoC in the following capacities; general membership, Education and Membership Committee, the Strategic Planning Committee, as well as the Coordinated Entry System Committee to develop solutions to end homelessness.	☒	☒
San Joaquin County Whole Person Care (WPC)	As a partner in this countywide collaborative project, the hospital identifies and refers homeless patients to WPC in an effort to secure stable housing and income for individuals experiencing or at-risk of homelessness.	☒	☒
Gospel Center Rescue Mission Recuperative Care (GCRM)	Safe hospital discharge for those experiencing homelessness with medical conditions that could worsen if returned to the streets. Case management services help to ensure compliance with discharge plans and link individuals to resources for housing, employment, and other services to help them become self-sufficient. GCRM also converted some of their housing to specifically take homeless COVID positive patients that were able to be discharged from the hospital.	☒	☒
Community Grants Program	Through a formal process, grants are administered annually to non-profit organizations that best demonstrate their ability to impact community health needs as they pertain to the most recent needs assessment. The following programs awarded funding in 2020 for November 1, 2020 through December 31, 2021 and are addressing economic security: ● Lutheran Social Services – Life and job skills for youth exiting the foster care program to minimize homelessness among youth. ● Visionary Home Builders of California, Inc. – Job skills for 240 residents along with digital training and support. The formal grant process for calendar year 2022 will conclude at the end of 2021 and all projects will include one or more of the 2019 CHNA health needs.	☒	☒
Impact: Outcomes will include referrals and connections to a multitude of community based programs such as; shelter/housing assistance, residential substance abuse treatment programs, life skills and work			

readiness programs. Programs funded through community grants are anticipated to prevent economic insecurities for low income families and increase youth academic performance.
Collaboration: San Joaquin County 211, United Way of San Joaquin County, along with several other stakeholders are instrumental partners for the CCN, as well as in the SJCoC and the SJC WPC program. Partners in the Community Grants Program include; Community Partnership for Families of San Joaquin, El Concilio, United Way, Catholic Charities, San Joaquin Delta College, Guardian Scholars Program; Aspiranet and the TAY Program.

Health Need: Obesity/Health Eating Active Living (HEAL)/Diabetes

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
St. Joseph's Community Health Department Education Programs	● Certified Diabetes Educator Consultations: Free one-on-one, personalized diabetes education for populations who face significant barriers to better health. ● Diabetes Education and Empowerment Program (DEEP): 2 hour/week, 6 week program focusing on healthy living and diabetes prevention and management. ● Diabetes Navigator: Resource and referral service for patients and community members seeking health education and support. ● Matters of Balance: This nine week workshop offers older adults 2 hour weekly sessions that provide practical tips to overcome fears of falling. ● Sugar Fix Support Group: Monthly diabetes support group offering multi-disciplinary professional presentations along with peer support.	☒	☒
San Joaquin Community Health Improvement Plan (CHIP)	As a core team and steering committee member, hospital staff will play a supportive and active role in advancing the CHIP goal of helping people of all ages and abilities get more physically active through programs that meet their language and culture needs. The goal of the CHIP is to increase physical activity in residents through the utilization of community parks. More information regarding the CHIP can be found at www.healthiersanjoaquin.org.	☒	☒

Community Grants Program	Through a formal process, grants are administered annually to non-profit organizations that best demonstrate their ability to impact community health needs as they pertain to the most recent needs assessment. The following programs awarded funding in 2020 for November 1, 2020 through December 31, 2021 and are addressing obesity and healthy eating active living: ● Boys & Girls Club at Sierra Vista – This program promotes physical activity and community support for underprivileged youth through sculling, a lifelong sport that has proven physical and emotional benefits. The formal grant process for calendar year 2022 will conclude at the end of 2021 and all projects will include one or more of the 2019 CHNA health needs.	☒	☒

Impact: Community members are expected to increase knowledge of diabetes, decrease A1C levels, increase consumption of fruits and vegetables, and increase physical activity. Youth are anticipated to increase their knowledge of living a healthy lifestyle.

Collaboration: All community health programs can be, and often are, delivered in collaboration with various community based organizations. San Joaquin County Public Health Services supports the Matter of Balance program and the CHIP strategy will be deployed alongside various stakeholders, including city Parks and Recreation and other healthcare systems. Partners include: Housing Authority County of San Joaquin, Delta Sculling Center, Aspire Public Schools, Aspire Stockton Secondary Academy, and STAND.

Health Need: Violence/Injury Prevention

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Human Trafficking Education and Outreach	Through involvement in both the Human Trafficking Healthcare Workgroup and the San Joaquin County Human Trafficking Taskforce, the hospital seeks to increase awareness, response, and care and support of trafficked victims beyond its internal protocols and staff training.	☒	☒
Outreach & Education - Community Health Social Worker	Please see the description in the Mental Health section. Through a comprehensive strategy, the social worker is implementing programs to reduce cycles of violence within families and vulnerable communities.	☒	☒
San Joaquin Community Health	Please see the description in the above section. Through the increased utilization of parks in priority	☒	☒

Improvement Plan (CHIP)	neighborhoods, a reduction in neighborhood crime is an anticipated outcome.		

Impact: The above strategies are a multipronged approach to reducing violence and injury, and the anticipated impact for each are included in the respective summary description.

Collaboration: The full list of collaborative partners for each program is described in the program digest section of this report.

Health Need: Access to Care

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Certified Diabetes Educator (CDE) Consultations	CDE consultations are provided at no cost to individuals who would otherwise not have access to this specialty service. One on one consultations evaluate and address barriers to diabetes care and management.	☒	☒
San Joaquin County Whole Person Care (WPC)	In addition to increasing economic security, the WPC program helps to ensure medical compliance. The primary lead entities in this work are health care providers and mental health professionals who provide comprehensive care management for homeless individuals.	☒	☒
Graduate Medical Education (GME)	Dignity Health is committed to increasing access to care through workforce development and SJMC is a leader in growing future medical providers in San Joaquin County. The GME program started in 2018 with 15 residents and is set to expand to approximately 200 residents by 2025.	☒	☒
Free Medical and Dental Clinics	This community benefit investment provides financial support of St. Mary's Dining Room's health and dental clinics that provides free medical and dental services for the uninsured.	☒	☒
Frontlines of Communities in the United States (FOCUS)	Supports CDC recommendations for screening and linkage to care. Works with partners to develop and share replicable model programs that embody best practices in HIV and HCV screening and linkage to care. As of FY22 Syphilis screening is being added in.	☒	☒

Community Grants Program	Through a formal process, grants are administered annually to non-profit organizations that best demonstrate their ability to impact community health needs as they pertain to the most recent needs assessment. The following programs awarded funding in 2020 for November 1, 2020 through December 31, 2021 and are addressing access to care: ● Delta Health Care and Management Services Corporation – Mental health support for high school aged youth in SUSD. ● Dentists Organized for Veterans (DOV) – Dental care for veterans who do not qualify for the VA. The formal grant process for calendar year 2022 will conclude at the end of 2021 and all projects will include one or more of the 2019 CHNA health needs.	☒	☒
Financial Assistance Program	High-quality, affordable services are provided regardless of an individual's ability to pay, and the hospital's financial assistance offers discounted, interest free payments, or free services depending on the patient's financial circumstances.	☒	☒
Impact: Overall, these programs will increase referrals and linkages to medical appointments and deliver equitable and culturally sensitive health care services for at risk individuals.			
Collaboration: All community health programs can be, and often are, delivered in collaboration with various community based organizations. Partners include: San Joaquin County Veterans Service Office, VA Palo Alto Health Care System, VA Northern California Health Care System, Stockton Unified School District, and Brian Huff, LMFT.			

Health Need: Substance Abuse/Tobacco

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
CA Bridge Program Opioid Grant	Provide medication assisted treatment with Buprenorphine to those struggling with opioid use disorder. Provide education to both the community and other healthcare providers regarding opioid use disorder and treatment options such as buprenorphine. Participate in the San Joaquin County Opioid Safety Coalition.	☒	☒
Impact: Decrease in opioid overdose deaths, increase prescriptions of Buprenorphine.			

Collaboration: Emergency department physicians, Substance Use Navigator, Public Health Institute, first responders, and members of the San Joaquin County Opioid Safety Coalition.

Health Need: Oral Health

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Free Dental Clinic	Financial Support for St. Mary's Dining Room Dental Clinic. Provides free oral care for the uninsured.	☒	☒
Community Grants Program	Through a formal process, grants are administered annually to non-profit organizations that best demonstrate their ability to impact community health needs as they pertain to the most recent needs assessment. The following programs awarded funding in 2020 for November 1, 2020 through December 31, 2021 and are addressing oral health: ● Dentists Organized for Veterans (DOV) - Dental care for veterans who do not qualify for the VA. The formal grant process for calendar year 2022 will conclude at the end of 2021 and all projects will include one or more of the 2019 CHNA health needs.	☒	☒

Impact: Direct oral health services for uninsured individuals and veterans in need.

Collaboration: This community benefit investment provides the necessary safety net of services to ensure equitable care for the most vulnerable in the community. Partners assisting in this include: San Joaquin County Veterans Service Office, VA Palo Alto Health Care System, and VA Northern California Health Care System.

Community Grants Program

One important way the hospital helps to address community health needs is by awarding financial grants to non-profit organizations working together to improve health status and quality of life. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations.

In FY21, the hospital awarded the grants below totaling $283,392 in conjunction with St. Joseph's Behavioral Health Center which contributed $9,757 of the total. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Visionary Home Builders of CA	Community Link Digital Literacy Program	$20,000
Boys & Girls Club	Row & Rise Together!	$67,537
Lutheran Social Services	A Clean Start	$75,000
Dentists Organized For Veterans	The DOV Project	$20,855
Delta Health Care	Action in Mentoring (AIM) Project	$100,000

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs. The digests include program descriptions and intervention actions, statements of which health needs are being addressed, any planned collaboration, and program goals and measurable objectives.

	**Friends of Seniors & Links Project**
Significant Health Needs Addressed	➢ Mental Health ➢ Economic Security ➢ Access to Care
Program Description	This volunteer based program provides friendly visiting, transportation assistance, and resource and referral services to address basic needs for homebound seniors. The Links Project, piloted in Fall 2019, encourages seniors to utilize technology tools and social media to increase their independent living and reduce their feelings of stress, isolation, and depression.
Community Benefit Category	A3 Health Care Support Services
FY 2021 Report	
Program Goal / Anticipated Impact	Increase volunteer recruitment and retention in order to meet the growing needs of older adults experiencing limited social support. Improve access to care via transportation assistance, improve on feelings of stress and loneliness, and assist with level of safety and independence.
Measurable Objective(s) with Indicator(s)	Establish a minimum of one new referral partnership to increase volunteer recruitment. Ensure that a minimum of 75% of community resource referrals are accepted and resolved.
Intervention Actions for Achieving Goal	Regular meetings with volunteers, along with surveys, help to ensure program quality and impact.
Collaboration	This program relies greatly on a strong partnership with dedicated and compassionate community volunteers. Outreach for volunteer recruitment occurs regularly with the support of San Joaquin Delta College, University of the Pacific, VolunteerMatch.com, and community centers, just to name a few.
Performance / Impact	In FY21, the pandemic ceased volunteer recruitment efforts, and the existing volunteers increased their telephonic friendly visiting and

	social service support referrals. 354 total volunteer service hours, representing: 47% Phone Reassurance 24% Friendly Visiting 13% Shopping 10% Medical Transport 4% Other activities (such as social events) 2% Other transportation
Hospital's Contribution / Program Expense	Total program expense was $46,841, which is 100% supported by St. Joseph's Medical Center's Operational Budget.
FY 2022 Plan	
Program Goal / Anticipated Impact	Increase program volunteers in order to serve more seniors. Increase telephonic and in-person support. Increase access to care and food security. Increase independence and safety in place of residence and reduce feelings of isolation, loneliness, and depression.
Measurable Objective(s) with Indicator(s)	Outputs will include; number and type of rides provided, hours of friendly visiting, number of seniors using technology to meet their basic needs. Achieve a minimum score of 8 out of a 1 to 10 rating scale on all survey questions. Outcomes collected via annual survey include; rating of volunteer qualities along with client rating of perceived levels of stress, loneliness/isolation, safety/well-being, confidence and independence. Increase volunteers by 10%, decrease % of volunteer rides and increase the usage of other transportation assistance options, and increase % of friendly visiting. A minimum of 75% of community referrals will be accepted and resolved.
Intervention Actions for Achieving Goal	Increase program outreach and volunteer recruitment efforts. Establish comprehensive volunteer orientation to ensure program quality and ideal volunteer/senior matching. Update the annual survey to include an assessment of depression, and use completed surveys to evaluate if the program is meeting intended goals, as well as provide regular program oversight and interaction with program volunteers to ensure program effectiveness. Train and provide volunteers with access to the Unite Us platform for resource and referrals.
Planned Collaboration	Continued partnership with local colleges and additional community based organizations will be essential for both volunteer and senior recruitment. Explore partnership expansion with UOP to include both interns and undergrad students.

Diabetes Navigation and Education

Significant Health Needs Addressed	➢ Obesity/Healthy Eating Active Living (HEAL)/Diabetes ➢ Access to Care
Program Description	The following diabetes education programs will continue to be available to the community at no cost and in order to deliver these programs a significant amount of outreach is associated to ensure program participation and success: • Certified Diabetes Care Education Specialist (CDCES) Consultations: Free one-on- one, personalized diabetes education for populations who face significant barriers to better health. • Diabetes Education Empowerment Program (DEEP): Comprehensive series of classes targeting individuals with diabetes and pre-diabetes. - 2 hours per week, 6 weeks program. • Diabetes Navigator: Resource and referral service for patients and community members seeking health education and support. • Sugar Fix: Led by a RN, Certified Diabetes Educator, this monthly diabetes support group offers multi-disciplinary professional presentations along with peer support.
Community Benefit Category	A1 Community Health Education
FY 2021 Report	
Program Goal / Anticipated Impact	CDE Consultations – Increase knowledge of how to take medications, increase confidence in managing diabetes, reduce consumption of sugary beverages, and reduce A1C levels. DEEP – Increase knowledge of ways to handle stress, increase confidence with goal setting and asking for support, increase physical activity. Diabetes Navigator – Provide resource/referral services to individuals with diabetes regarding health education/support in order to better manage conditions. Sugar Fix Support Group – Increase knowledge of important health topics.
Measurable Objective(s) with Indicator(s)	Each program has set metrics and they are outlined below under Performance/Impact.
Intervention Actions for Achieving Goal	Continued and expanded outreach in both community and clinical settings to ensure that community residents take advantage of the no fee services.
Collaboration	CDE consultations are delivered in the community in partnership with clinics who serve high-risk populations; St. Mary's Dining Room, Asian Pacific Self-development & Residential Association (APSARA), and Fremont Clinic. All other classes/workshops are open to be delivered in the community and often are provided in community centers, libraries, and community based organizations upon request.

Performance / Impact	In FY21 SJMC had the following participation: **Diabetes Navigator:** 167 Total referrals, 163 unduplicated persons and 40 (25%) of those persons interested or scheduled for 1:1 counseling. Mailed out information packets to 35 (21%) persons **DEEP:** 22 Total Participants ● 55% Male; 45% Female ● 45% Hispanic; 14% Asian; 14% White; 9% Black; 18% Other/Unknown ● 10% Under 40 years old; 36% 40-49 years old; 18% 50-59 years old; 36% 60+ years old **CDE Consultations:** 23 Total Participants ● 57% Male; 43% Female ● 65% Hispanic; 13% Black; 13% White; 9% Asian ● 17% Under 40 years old; 13% 40-49 years old; 27% 50-59 years old; 43% 60+ years old **Sugar Fix:** 57 Total Participants
Hospital's Contribution / Program Expense	Total expense for all programs was $86,203, which is 100% supported by St. Joseph's Medical Center's Operational Budget.
FY 2022 Plan	
Program Goal / Anticipated Impact	Same as noted in the FY 2021 Report section of this digest.
Measurable Objective(s) with Indicator(s)	Continue current data collection as noted in the 2021 section of this digest.
Intervention Actions for Achieving Goal	Develop a targeted outreach and engagement approach to continue to reach underserved and/or at risk populations that have not yet been served. Explore ways of delivering services virtually.
Planned Collaboration	Continued collaboration with organizations listed above, as well as with faith-based community leaders. Partnering with the University of the Pacific (UOP) will support diabetes navigation and education by creating a multidisciplinary team approach for patients. UOP social work, pharmacy and nutrition interns rotting through the community health department, will enhance the patient care plan by contributing in their area of expertise. A new partnership with Abbott will provide patients with access to health food and a community health worker through their Future Well Communities program.

Recuperative Care at Gospel Center Rescue Mission	
Significant Health Needs Addressed	➢ Mental Health ➢ Economic Security ➢ Obesity/Healthy Eating Active Living (HEAL)/Diabetes ➢ Violence/Injury Prevention ➢ Access to Care ➢ Substance Abuse/Tobacco ➢ Oral Health
Program Description	Safe hospital discharge for those experiencing homelessness with medical conditions that could worsen if returned to the streets. Case management services help to ensure compliance with discharge plans and connection to housing and other social services.
Community Benefit Category	E2 Grants
FY 2021 Report	
Program Goal / Anticipated Impact	Provide shelter for post-hospital recovery and connect homeless individuals to housing, continued access to care, and substance use treatment post recuperative care.
Measurable Objective(s) with Indicator(s)	# of individuals served, # of recuperative care days, # of post-program connections.
Intervention Actions for Achieving Goal	Continued communication/training with care coordination staff to ensure appropriate referrals to the program.
Collaboration	Hospital Care Coordination and Social Work staff partner closely with Gospel Center Rescue Mission (GCRM) to ensure appropriate program referrals. GCRM and SJMC also partner with the San Joaquin Continuum of Care and the San Joaquin County Whole Person Care program.
Performance / Impact	In 2020 there were 82 total enrollments into Recuperative Care 2,232 total Recuperative Care days. Average length of stay in Recuperative Care 34 days. Over 44% were placed at home, assisted living, treatment programs, or other shelters.
Hospital's Contribution / Program Expense	$100,000
FY 2022 Plan	

Program Goal / Anticipated Impact	Same as noted in the FY 2021 Report section of this digest.
Measurable Objective(s) with Indicator(s)	Same as noted in the FY 2021 Report section of this digest.
Intervention Actions for Achieving Goal	Hospital Care Coordination and Social Work staff will need to work closely with GCRM staff to identify areas for improvement to further improve the outcomes for this vulnerable population.
Planned Collaboration	Same as noted in the FY 2021 Report section of this digest.

Homecoming Project

Significant Health Needs Addressed	➢ Mental Health ➢ Economic Security ➢ Obesity/Healthy Eating Active Living (HEAL)/Diabetes ➢ Violence/Injury Prevention ➢ Access to Care
Program Description	Safe hospital discharge for high risk individuals lacking family support. Case management services help to ensure compliance with discharge plans and a safe recovery in their place of residence. St. Joseph's Medical Center provides grant funding to Catholic Charities for this program.
Community Benefit Category	E2 Grants

FY 2021 Report

Program Goal / Anticipated Impact	Assist with safe hospital recovery and ensure individuals are wrapped with necessary resources to support needs. Maintain a hospital readmission rate of 15% or less. This population is very high risk for readmissions and without intervention may otherwise have a 20-30% readmission rate.
Measurable Objective(s) with Indicator(s)	# of individuals served, # of referrals by type, % of 30-day hospital readmissions.
Intervention Actions for Achieving Goal	Continued communication/training with community health and care coordination staff to ensure appropriate referrals to the program. Continued evaluation of workflows to ensure efficiencies.

Collaboration	Hospital Care Coordination and Social Work staff partner closely with Community Health staff to ensure appropriate referrals. Community Health staff then refers patients to Catholic Charities for services.
Performance / Impact	407 referrals, 385 unduplicated persons, 210 referred to Catholic Charities, 150 enrolled in the program, 30 declined enrollment, and 30 individuals were unable to be reached. Of the 150 persons enrolled, 22 were readmitted within 30 days. Met goal of maintaining readmission rate under 15%. FY 2020-2021 readmissions were at 14.7%.
Hospital's Contribution / Program Expense	$94,576

Service Type for 221 Enrolled Clients	Total Services Utilized	% of Services
House-making	114	51.6%
Mental Health	17	7.7%
Transportation	48	21.7%
Rx Express	6	2.7%
DME	13	5.9%
CC Food Pantry	22	9.9%
Incontinence Supplies	1	0.5%

FY 2022 Plan

Program Goal / Anticipated Impact	Same as noted in the FY 2021 Report section of this digest.
Measurable Objective(s) with Indicator(s)	Same as noted in the FY 2021 Report section of this digest.
Intervention Actions for Achieving Goal	Continued evaluation of program workflows, and expanded partnership with extended care facilities to help ensure program linkages post their discharges.

Planned Collaboration	Same as above, and to include local skilled nursing and extended care facilities.

Cancer Awareness Screenings

Significant Health Needs Addressed	➢ Obesity/Healthy Eating Active Living (HEAL)/Diabetes ➢ Access to Care
Program Description	Community outreach and screening events targeted for low income and vulnerable populations with low health literacy and limited access to care.
Community Benefit Category	A1 Community Health Education
FY 2021 Report	
Program Goal / Anticipated Impact	Increase understanding of the importance of regular cancer screenings for members of the Hmong and Cambodian community.
Measurable Objective(s) with Indicator(s)	# of participants, # of screenings, % increase in knowledge.
Intervention Actions for Achieving Goal	Continued rapport building and support for Hmong and Cambodian residents through established community partnerships and door-to-door outreach in South East Asian neighborhoods.
Collaboration	This program is in collaboration with St. Joseph's Cancer Institute, American Cancer Society, APSARA, St. Joseph's Imaging Center, Community Medical Centers, as well as with medical providers who primarily serve the South East Asian Community.
Performance / Impact	Due to the pandemic, cancer outreach and screening events were cancelled in FY 2021. Moreover, due to the challenges with computer knowledge and access within this subset of the community, virtual outreach was not considered to be an effective alternative strategy.
Hospital's Contribution / Program Expense	Total expense for all programs was $4,195 which is 100% supported by St. Joseph's Medical Center's Operational Budget.
FY 2022 Plan	
Program Goal / Anticipated Impact	Expand cancer awareness outreach and screenings to additional at risk populations, such as Latino and African American residents.

Measurable Objective(s) with Indicator(s)	Same as above.
Intervention Actions for Achieving Goal	Assess other current initiatives from health systems pertaining to cancer screening efforts to explore potential partnership and avoid duplication.
Planned Collaboration	In addition to the collaboration referenced above, existing partnerships in the faith community as well as with St. Joseph's Graduate Medical Education program will be strengthened. A partnership with Health Plan of San Joaquin to expand mobile mammography efforts is also in development.

Graduate Medical Education (GME)

Significant Health Needs Addressed	➢ Mental Health ➢ Obesity/Healthy Eating Active Living (HEAL)/Diabetes ➢ Violence/Injury Prevention ➢ Access to Care ➢ Substance Abuse/Tobacco
Program Description	Dignity Health is committed to workforce development, and SJMC is a leader in growing future medical providers in San Joaquin County. The GME program started in 2018 and below is a summary of the implemented and planned expansion of the program: ● Family Medicine: 6 new residents each year x3 years (started 6/2018) ● Emergency Medicine: 9 new residents each year x3 years (started 6/2018) ● Internal Medicine: 10 new residents each year x3 years (started 6/2020) ● Transitional Year: 10 new residents each year 1 year (started 6/2020) ● Anesthesia: 6 new residents each year x4 years (started 06/2021) ● Psychiatry: 7 new residents each year x4 years (started 06/2021) ● Urology: 4 new residents each year x5 years (to start 06/2022) ● Neurology: 4 new residents each year x4 years (to start 06/2022) ● Interventional Radiology: 2 new residents each year x5 years (to start 06/2022) ● Orthopedic Surgery: 2 new residents each year x5 years (to start 06/2022)

Community Benefit Category	B1 – Physicians/Medical Students
FY 2021 Report	
Program Goal / Anticipated Impact	Train residents to safely and competently provide the highest quality care for the medically underserved, underinsured, and culturally diverse communities of San Joaquin County.
Measurable Objective(s) with Indicator(s)	Implement the GME program.
Intervention Actions for Achieving Goal	Strong collaboration with committed academic partner Touro University California, who constructed a continuity clinic across from the hospital for weekly continuity clinics. The residents are mandated to attend these clinics each postgraduate year.
Collaboration	Community Medical Centers, Touro California, Oakland Children's Hospital, San Joaquin County Hospital, Alpine Orthopedic, Center for Sight, Central Valley Eye, Gill Group, Kaiser Permanente Otorhinolaryngology Specialty.
Performance / Impact	Graduated first class of Emergency Medicine Residents and Family Medicine Residents. Successful launch of Internal Medicine program, Anesthesia program, Psychiatry program, and Transitional Year program.
Hospital's Contribution / Program Expense	$12,126,250
FY 2022 Plan	
Program Goal / Anticipated Impact	Same as noted in the FY 2021 Report section of this digest.
Measurable Objective(s) with Indicator(s)	Same as noted in the FY 2021 Report section of this digest.
Intervention Actions for Achieving Goal	Regular didactic trainings with topics that include, Simulation training; Cultural Competency training during their first year of training; Health Literacy; Care of the Homeless; Caring for Patients with Disabilities; Immigrant and Refugee Health; Global Health including community health concerns; and Health Disparities including Social Determinants of Health.

Planned Collaboration	A partnership with St. Mary's Dining Hall and their free clinic leadership is in an exploratory phase to determine if family and internal medicine residents can rotate as providers to expand existing free clinic services.

Frontlines Of Communities in the United States (FOCUS)

Significant Health Needs Addressed	➢ Mental Health ➢ Access to Care
Program Description	This grant funded program integrates opt-out Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), and as of June 2021 Syphilis testing services for eligible patients within the SJMC Emergency Department. Individuals testing positive are offered linkages to treatment and supportive services.
Community Benefit Category	A3e – Information & Referral

FY 2021 Report

Program Goal / Anticipated Impact	Improve in the early detection and intervention of HIV and HPC to improve health and quality of life of patients.
Measurable Objective(s) with Indicator(s)	# of tests, Positivity rates, # of connections to resources and education.
Intervention Actions for Achieving Goal	Strong collaboration with the emergency room leadership, IT team as well as community partners to ensure automated and seamless workflows from patient testing to treatment.
Collaboration	Gilead, San Joaquin County Public Health Services, Community Medical Centers, San Joaquin General Hospital Clinics, Health Plan of San Joaquin, El Concilio.
Performance / Impact	July 1, 2020 through May 31, 2021

HIV	**Total/Actual**
# HIV Tests Performed	9913
# HIV Positive Results	53
(Identified Through Testing)	(0.50% seropositive rate)
Linked to Care	8 (15%)

	Already in Care: 24 (45%) Unable to Reach for Follow up: 2 (4%) Declined: 1 (2%) Deceased: 3 (6%) In Progress: 15 (28%) **HCV** / **Total/Actual** # HCV Ab Tests Performed: 5,612 # HCV RNA Positive Patients: 172 Linked to Care: 66 (38.4%) Already in Care: 2 (1.1%) Unable to Reach for Follow up: 54 (31.4%) Deceased: 18 (10.5%) In Progress: 31 (18%) Incarcerated: 1 (0.6%)
Hospital's Contribution / Program Expense	$176,732
FY 2022 Plan	
Program Goal / Anticipated Impact	Same as noted in the FY 2021 Report section of this digest.
Measurable Objective(s) with Indicator(s)	Same as noted in the FY 2021 Report section of this digest.
Intervention Actions for Achieving Goal	Same as noted in the FY 2021 Report section of this digest.
Planned Collaboration	Same as noted in the FY 2021 Report section of this digest.

Other Programs and Non-Quantifiable Benefits

The hospital delivers community programs, services and non-quantifiable benefits in addition to those described elsewhere in this report. Like those programs and initiatives, the ones below are a reflection of the hospital's mission and its commitment to improving community health and well-being.

- **Community Investment Program project "Stocktonians Taking Action to Neutralized Drugs"** (STAND). In January 2020, Dignity Health approved a 3-year renewal of a $1,000,000 revolving loan to STAND, A community Housing Development Organization founded to create positive change in southeast Stockton communities that had been devastated by gang and drug activity. The funds for this loan will be used to purchase tax-default lots and blighted homes for rehabilitation and to provide permanent housing for low-income families and individuals experiencing homelessness. The revolving loan will also be used to support the development of affordable housing for seniors and the development of single-family homes for low-income families.

- **Community Vision (formerly Northern California Community Loan Fund):** Dignity Health has partnered with Community Vision since 1992, and was one of Dignity Health's first community investments. This CDFI has invested more than $254 million in projects throughout Northern and Central California, promoting economic justice and alleviating poverty by increasing the financial resilience and sustainability of community-based nonprofits and enterprises. In 2016 and 2017 Dignity Health approved two 7-year $1,000,000 loans respectively—the first as lending capital for NCCLF's many projects, and the second as lending capital in a "FreshWorks" Fund for $1,000,000 supporting the bringing of grocery stores and other innovative forms of healthy food retail to underserved communities ("food deserts").

- **Delta Community Developers Corporation (DCDC):** Founded in 2000, Delta Community Developers Corporation (DCDC) is a 501(c)(3) nonprofit public benefit corporation and a subsidiary of the Housing Authority of the County of San Joaquin (HACSJ). The company is the development entity of HACSJ, and has numerous projects throughout the county focusing on the revitalization of communities. CommonSpirit Health approved a $3,850,000 loan for 3 years with proceeds used to acquire and rehabilitate 601 Wimbledon Drive in Lodi, California, for the development of 40 units of permanent affordable housing for low-income seniors.

- **California FarmLink:** In June 2020, CommonSpirit approved a $500,000 loan to California FarmLink used to support the organization's loan program, which in turn provides affordable financing for small-scale farmers, beginning farmers, and farmers of color. California FarmLink is a nonprofit public benefit corporation formed in 1999 with a mission to invest in the prosperity of farmers and ranchers through lending, education, and access to land throughout farming communities in Central Coast, Sacramento, San Joaquin, and North Coast, California.

- **Homeless Health Initiative:** Approximately $3 million.
    - STAND and Project Homekey – $1.8 million – 7 units shared scattered site permanent housing for at least 16 previously housing ready Whole Person Care clients and potential offset for Town Center Studios (39 units, housing up to 41 previously homeless individuals)
    - Emergency Department Social Workers – 3 Full Time Employees (FTE's) dedicated to supporting patients experiencing homelessness, providing short term case management
    - Salvation Army Mobile Street Outreach – Funding to provide a mobile outreach team with a fully equipped office van to provide social service navigation and case management to those experiencing homelessness county-wide.

- **Dignity Health Social Innovation Partnership Grant**: $130,000 Transform Fairview Terrace Neighborhood proposal submitted by the Reinvent South Stockton Foundation, Build Healthy Places Network, and Stocktonians Taking Action to Neutralize Drugs (STAND). Working closely with the St. Joseph's Community Health team, this two-year project will address the social determinants of health by investing in stable, affordable housing; access to healthcare; education; and community facilities through the leveraging of Community Development Financial Institutions Funds, to empower health for approximately 2,000 economically distressed households in the Airport Way commercial corridor. The success of this neighborhood-focused project will ultimately develop a project roadmap that can then be replicated in other neighborhoods throughout Stockton and in other CommonSpirit Health markets.

- **Pathways Community Hub (PCH):** The PCH is an integrated model that utilizes a localized, outcomes-based approach that connects individuals to Community Health Workers (CHWs) who assess and help resolve identified, modifiable risk factors that could lead to poor health outcomes if left unaddressed. Dedicated Community Health staff from St. Joseph's Medical Center is leading the socialization and implementation of a certified PCH in San Joaquin County, alongside other community stakeholders to build a sustainable CHW workforce to address the social determinants of health impacting the community.

- **Community Health Advocate:** This initiative, scheduled to launch September 2021, will implement a health related social needs screening process for Emergency Room patients. As a three-year pilot the goal is to proactively identify and support patients needing social services, and mitigate needs before they progress into negative health outcomes. After establishing a streamlined workflow, the social needs screening process will expand into other departments to comprehensively address all aspects of an individual's health and wellbeing by looking beyond the clinical needs that originally brought them into the hospital.

Economic Value of Community Benefit

The economic value of all community benefit is reported at cost. Patient financial assistance (charity care) reported here is as reported to the Office of Statewide Health Planning and Development in Hospital Annual Financial Disclosure Reports, as required by Assembly Bill 204. The community benefit of Medicaid and other means-tested programs is calculated using a cost-to-charge ratio to determine costs, minus revenue received for providing that care. Other net community benefit expenses are calculated using a cost accounting methodology. Restricted offsetting revenue for a given activity, where applicable, is subtracted from total expenses to determine net benefit in dollars.

192 St. Joseph's Medical Center (Stockton)
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2020 through 6/30/2021

	Persons	Expense	Revenue	Net Benefit	% of Expense
Benefits for Poor					
Financial Assistance	**10,961**	**7,520,079**	**207,457**	**7,312,622**	**1.1%**
Medicaid	**51,288**	**210,237,694**	**190,925,505**	**19,312,189**	**3.0%**
Community Services					
A - Community Health Improvement Services	5,765	801,464	267,623	533,841	0.1%
C - Subsidized Health Services	294	13,301	0	13,301	0.0%
E - Cash and In-Kind Contributions	1,110	676,100	374,154	301,946	0.0%
G - Community Benefit Operations	0	931,614	346,811	584,803	0.1%
Totals for Community Services	**7,169**	**2,422,479**	**988,588**	**1,433,891**	**0.2%**
Totals for Poor	**69,418**	**220,180,252**	**192,121,550**	**28,058,702**	**4.3%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	1,319	2,259,887	151,567	2,108,320	0.3%
B - Health Professions Education	708	17,824,775	4,192,415	13,632,360	2.1%
D - Research	0	387,527	29,898	357,629	0.1%
E - Cash and In-Kind Contributions	0	1,725,242	0	1,725,242	0.3%
F - Community Building Activities	0	130,535	0	130,535	0.0%
Totals for Community Services	**2,027**	**22,327,966**	**4,373,880**	**17,954,086**	**2.8%**
Totals for Broader Community	**2,027**	**22,327,966**	**4,373,880**	**17,954,086**	**2.8%**
Totals - Community Benefit	**71,445**	**242,508,218**	**196,495,430**	**46,012,788**	**7.1%**
Medicare	**39,053**	**257,435,908**	**237,716,205**	**19,719,703**	**3.1%**
Totals with Medicare	**110,498**	**499,944,126**	**434,211,635**	**65,732,491**	**10.2%**

Hospital Board and Committee Rosters

Port City Board Managers

Marty J. Ardron	Senior Vice President for Health Plan and Hospital Operations Northern California, Kaiser Permanente
Debra Cunningham	Senior Vice President, Strategy, Kaiser Permanente
James DeSoto, MD	Chief Medical Officer, Northern California Division, CommonSpirit Health/Dignity Health
Corwin Harper	Senior VP/Area Manager, Kaiser Permanente
Julie Sprengel	Senior Vice President Operations Southern Calif. Division, CommonSpirit Health/Dignity Health
John Petersdorf	Vice Chair SVP Operational Effectiveness, Dignity Health
Jon VanBoening	Senior Vice President, Dignity Health

Community Grants Committee

Barbara Alberson	Senior Deputy Director, San Joaquin County Public Health Services
Jamie Lynne Brown	Community Benefit Specialist, Dignity Health
Cathy Mangaoang-Welsh	Director of Social Services, St. Joseph's Behavioral Health Center, Dignity Health
Steve Morales	Community Member
Sister Abby Newton	Vice President of Mission Integration & Spiritual Care, Dignity Health
Louis Ponick	Director of Grants and Scholarships, Community Foundation of San Joaquin
Paul Rains	President of St. Joseph's Behavioral Health Center, Dignity Health
Tammy Shaff	Director of Community Benefits, Dignity Health
Danielle Tibon	Philanthropy Senior Data Analysis, Dignity Health