Dominican Hospital

Community Benefit 2020 Report and 2021 Plan

Adopted November 2020

Dignity Health.
Dominican Hospital

A message from

Nanette Mickiewicz, MD, President and CEO of Dominican Hospital, and Steve Snodgrass, Chair of the Dignity Health Dominican Hospital Community Board

Dignity Health Dominican Hospital's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments 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 and with community partners, and investing in efforts that address social determinants of health.

Dominican Hospital shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The Community Benefit 2020 Report and 2021 Plan describes much of this work. This report meets requirements in 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 offer this report to our community.

In fiscal year 2020 (FY20), Dominican Hospital provided $29,828,390 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. The hospital also incurred $55,186,061 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved, and adopted the Community Benefit 2020 Report and 2021 Plan at its November 18, 2020 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. Please reach out to Dominique Hollister, Director, Administrative Services and Community Benefit, at Dominique.Hollister@DignityHealth.org.

Nanette Mickiewicz, MD
President/CEO

Steve Snodgrass
Chairperson, Board of Directors

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At-a-Glance Summary

Community Served	Santa Cruz County has a population of approximately 293,014 and covers 445 square miles. The two major cities are Santa Cruz, located on the northern side of the Monterey Bay, and Watsonville, situated in the southern part of the county. The City of Santa Cruz, which is the county seat, had an estimated population of 63,993 in 2017. Santa Cruz is one of California's most popular seaside resorts with its historic Boardwalk, spectacular coastline, and accessible beaches. The City of Watsonville is the center of the county's agricultural activity, with major industries including food harvesting, canning, and freezing. In 2017, Watsonville had an estimated population of 53,452. Other incorporated areas in the county include the cities of Scotts Valley and Capitola. Approximately 48 percent of the population lives in the unincorporated parts of the county, including the towns of Aptos, Davenport, Freedom, Soquel, Felton, Ben Lomond, and Boulder Creek, and districts including the San Lorenzo Valley, Live Oak, Pajaro, and portions of North Monterey County.
Economic Value of Community Benefit	$29,828,390 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants, and other community benefits. $55,186,061 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 form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by targeted strategies and programs are: 1. Behavioral Health 2. Continuum of Care: prevention, access, and delivery 3. Economic Security: income, employment, education, housing, and food security 4. Human Trafficking
FY20 Programs and Services	The hospital delivered several programs and services to help address identified significant community health needs. These included: • The hospital's Personal Enrichment Program (PEP), a resource for community health and wellness education. PEP classes and programs focus on total joint care, childbirth and parenting, lifestyle management, improving neurological function, exercise and fitness, cancer resources, and heart health.

- The hospital's Mobile Wellness Clinic, which benefits from bilingual staff who provide evaluation and treatment of episodic medical conditions, identification of medical homes for those patients with chronic needs, and identification of social services and resources in the community. The Mobile Wellness Clinic visits six locations every week, Monday through Friday.
- Funding to Janus of Santa Cruz, a substance use disorder (SUD) treatment clinic, for their Project Unite Program. Through this program, a substance abuse counselor meets with hospital patients to help transition the patients to inpatient/outpatient SUD treatment programs in Santa Cruz.
- An Emergency Department (ED) navigator, who meets with Central Coast Alliance for Health (CCAH) patients in the ED to help connect or reconnect them with patient care providers post hospital discharge. Services also include provision of food, clothing, and medications for patients who are homeless.
- The hospital's Human Trafficking Taskforce, comprised of staff from the ED, social work, case management, patient registration, sponsorship, and maternal child health, as well as community partners. The Taskforce meets every other month to review local cases of human tracking and identify staff training and education opportunities.
- The hospital's Medical Guidance Area, a specialized area for patients with substance abuse and mental health disorders. A psychiatric registered nurse (psych RN) is present on the unit as part of the Psychiatric Resource Team (PRT).
- Funding to Housing Matters (formerly the Homeless Services Center) Recuperative Care Center (RCC), a transitional medical shelter for the homeless.
- Funding for ED Bridge, which provides an ED navigator with an expanded scope of services than previously provided.

FY21 Planned Programs and Services

FY20 programs will continue, with the following changes:

- Dominican's PEP program will become a part of Dominican's newly created Wellness Center. Wellness Center services are designed to deliver a continuum of care through a variety of hospital services, provide early interventions to high-risk patient groups, and help reduce emergency room visits and unnecessary hospital admissions.

This document is publicly available online at https://www.dignityhealth.org/bayarea/locations/dominican/about-us/community-benefits/benefits-reports

Written comments on this report may be submitted to the Dominican Hospital Administration, 1555 Soquel Drive, Santa Cruz, CA 95065 or by e-mail to Dominique.Hollister@DignityHealth.org.

Our Hospital and the Community Served

About Dominican Hospital

Dominican Hospital is a member of Dignity Health, which is a part of CommonSpirit Health.

- Dignity Health Dominican Hospital (hospital) is located at 1555 Soquel Avenue, Santa Cruz, CA. It is licensed for 222 inpatient beds, has a staff of 1,650 employees, and professional relationships with more than 560 local physicians and allied health professionals.

- The hospital's major programs and service lines include:
  - Cardio/Thoracic/Vascular Surgery
  - Cardiovascular
  - Emergency Services
  - General Surgery
  - Intensive Care Unit
  - Maternal/Child Health
  - Neonatal Intensive Care Unit, Level III
  - Neurosciences
  - OB/GYN
  - Oncology
  - Orthopedics
  - Pulmonary
  - Rehabilitation

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

Dominican Hospital delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of our mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services.

A plain language summary of the financial assistance policy is included at the end of this report. The financial assistance policy and plain language summary also are available on the hospital's website.

Description of the Community Served

The hospital serves Santa Cruz County, which has a population of approximately 293,014 and covers 445 square miles.

The race/ethnicity breakdown is:

- 37 percent Latino
- 54 percent White (non-Latino)
- 9 percent other race/ethnicity

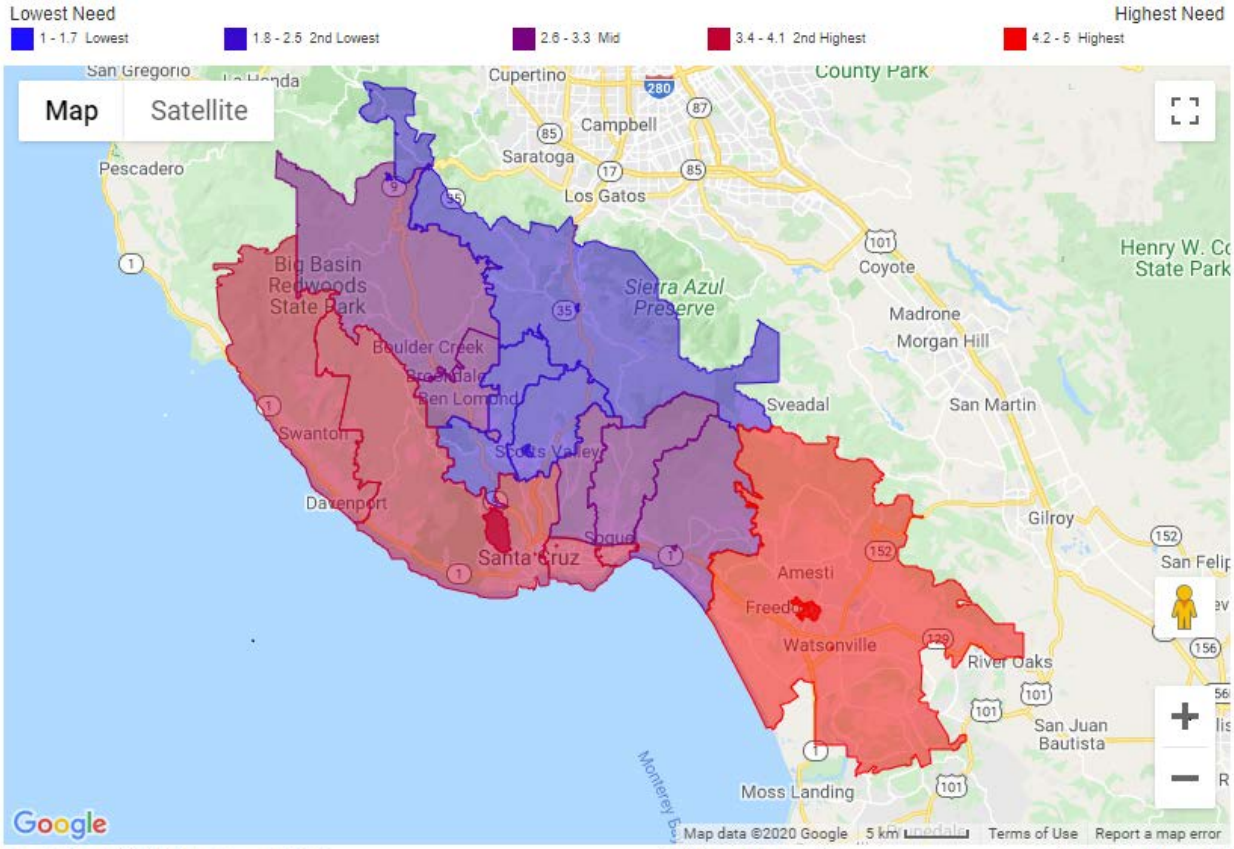
The median family income is $90,531. Fourteen percent of the population does not have a high school diploma. Twenty-three percent of the county population (66,917 individuals) are Central California Alliance for Health (CCAH) members enrolled in Medi-Cal. The medically underserved areas/populations are Watsonville, Freedom, and the city of Santa Cruz.

The median sales price for homes in Santa Cruz County was $1,099,000 as of August 2020, while the median estimated market rate rent across all home types in the county was $2,591 in the same period.

Community Need Index

One tool used to assess health need 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 health care 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. In the map, the red areas are those with higher levels of need. 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): 3.1 / Mean(person): 3.5 CNI Score Median: 3.4 CNI Score Mode: 2.8

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 May 2019.

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.
- 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/about-us/communityhealth/community-health-programs-and-reports/community-health-needs-assessments 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:

1. **Behavioral Health**: Behavioral health is the idea that physical and emotional health are connected and can be addressed together to produce the best possible health outcomes. Providers collaborate to address physical, developmental, social, behavioral, and emotional needs, including mental health and substance abuse conditions, depression, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, and stress-related physical symptoms.

2. **Economic Security**: Economic security includes employment, access to education and/or vocational training, affordable housing, homelessness, food insecurity, and other factors related to poverty and lack of income. The Social Determinants of Health (SDOH) framework confirms that economic security includes stable employment, food security, and housing stability.

3. **Continuum of Care (prevention, access, and delivery)**: The continuum of care is an integrated system that guides and tracks patients over time through a comprehensive array of health services spanning all levels and intensity of care. It combines prevention and early intervention, while addressing the SDOH and serving the un-/under-insured.

4. **Human Trafficking**: Human trafficking has been identified by Dignity Health as a priority health need because, while every state in the nation is affected, California and Nevada record among the highest number of cases. For that reason, human trafficking is prioritized by the hospital.

2020 Report and 2021 Plan

This section presents strategies and program activities the hospital is delivering, funding, or collaborating with others to address significant community health needs. It summarizes actions taken in FY20 and planned activities for FY21, 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 impacts and sets priorities for its community health programs in triennial Community Health Needs Assessments.

Creating the Community Benefit Plan

Dominican Hospital is dedicated to improving community health and delivering community benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

As a matter of Dignity Health policy, the hospital's community health and community benefit programs are guided by five core principles. All of our initiatives relate to one or more of these principles:

1. Focus on disproportionate unmet health-related needs.
2. Emphasize prevention.

3. Contribute to a seamless continuum of care.
4. Build on community capacity.
5. Demonstrate collaboration.

Impact of the Coronavirus Pandemic

Due to the coronavirus pandemic physical distancing concerns, two of the hospital's FY20 programs and services were paused. In mid-March, the Mobile Wellness Clinic and PEP programs discontinued in-person patient engagement. Staff from both programs connected with patients through phone calls and, in early June, PEP began offering classes via Zoom.

Both programs plan to resume in-person services when Santa Cruz County regulations allow.

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: Behavioral Health

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
Dominican Hospital Psychiatric Resource Team (PRT)	Psychiatric clinical assessment, case management, and social services teams provide referrals to individuals with substance abuse and mental health disorders.	☒	☒
Funding support for Janus of Santa Cruz	Program to support eligible patients to: 1) Transition efficiently from the hospital to treatment for substance use disorder (SUD) and co-occurring disorder (COD); and 2) Transition effectively from SUD/COD treatment to community living with individualized recovery maintenance plans. The Project Unite care navigation team coordinates their efforts with the patient's health care, housing, and mental health service providers.	☒	☒

Impact: The hospital's initiatives to address substance use and mental health disorders anticipate:

- Improved case management and care coordination.
- Increased focus on prevention and early intervention.
- Increased education for professionals regarding risk assessment, intervention strategies, and protocols.

Collaboration: The PRT works closely with the Santa Cruz County Psychiatric Health Facility to address mental health disorders and reduce the suicide rate in Santa Cruz County by providing access to a myriad of behavioral health services. The partnership with Janus of Santa Cruz provides the hospital's care coordination team and emergency department staff ready access to expertise in addiction treatment.

Health Need: Economic Security

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
Dominican Hospital Care Coordination Team	Several needs were combined during the consolidation process: employment, access to education and/or vocational training, affordable housing, homelessness, food insecurity, and other factors related to poverty and lack of income. When these areas are identified with a patient, they are addressed and solutions sought by the team.	☒	☒
Passport to Health (P2H)	Program designed to provide coordination, education, prioritization, and integration by community health leaders for high-need, high-cost patients in Santa Cruz County around health and health-related social needs.	☒	☒
Funding for Housing Matter's Recuperative Care Center (RCC)	Program which provides shelter services with meals, housekeeping, security, onsite case management, and medical care until recovery is achieved.	☒	☒

Impact: The hospital's initiatives to address economic security anticipate:

- A decrease in the number of preventable utilization visits to the Emergency Department (ED) and inpatient hospital stays.
- Improvement in referrals to community programs which address issues related to economic security.
- A safe place for recovery of homeless individuals coming out of the hospital including support for a full recovery, linkage to primary care, and transition to temporary or permanent housing as often as possible.

Collaboration: Through the hospital's referral system, the care coordination team partners with a number of community organizations to provide resources related to economic security. Additionally the P2H is a collaboration between community health leaders to ensure the health and continued recovery of high need patients after they are discharged.

Health Need: Continuum of Care

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
Funding for RotaCare Free Health Clinic at the Live Oak Senior Center	A walk-in clinic providing primary health care services, treatment, referral for diagnostic testing, and follow-up care. Services provided once a week by physicians, nurses, allied health professionals, and other volunteers from local Rotary clubs and the county.	☒	☒
Dominican Hospital Personal Enrichment Program (PEP)	PEP is a resource for community health and wellness education. PEP classes and programs focus on total joint care, childbirth and parenting, lifestyle management, improving neurological function, exercise and fitness, cancer resources, and heart health.	☒	☒
Dominican Hospital Mobile Wellness Clinic	Provides episodic health and preventive services Monday-Friday throughout Santa Cruz County at no cost to the patient.	☒	☒
Passport to Health (P2H)	Program designed to provide coordination, education, prioritization, and integration by community health leaders for high-need, high-cost patients in Santa Cruz around health and health-related social needs.	☒	☒
Community Bridges Wellness Navigation Project	The project is designed to increase patient access to healthy food, nutrition education, and other services identified during the intake process, and to increase clients' understanding of their health and how to stay healthy. The Wellness Navigation Project will offer mobile health screenings, a lifestyle health class, Navihealth referrals, and food pantry distribution.	☒	☐
Dominican Hospital Wellness Center	The Wellness Center will address the needs of chronically ill and high-risk patients throughout the continuum of care. Wellness Center services will provide ambulatory care and support to keep people out of the hospital, and offer opportunities to manage high-risk patient groups. Program will offer patients the full spectrum of care, from preventive to post-acute.	☐	☒
Teen Kitchen Project (TKP)	The hospital provides funding to the TKP though the Community Grant's Program. This program is run by the TKP. TKP provides medically-tailored meals to individuals and families in crisis due to a life-threatening illness, particularly those who are low income, lack a support network of family or friends, or do not qualify for other free food services. TKP's meal delivery service is unique in that the program engages	☒	☒

	teens (ages 13-18) as both volunteers and employees in preparing and packaging the meals.		

Impact: This initiative targets the un-/underinsured residents of Santa Cruz County. Health care services, testing, and will provide earlier identification of illness and treatment, and will decrease the utilization of the hospital ED.

Collaboration: The hospital will partner with RotaCare, the Teen Kitchen Project, local faith-based organizations, and other community partners to deliver this access-to-care strategy. In addition to funding, the hospital will provide in-kind services.

Health Need: Human Trafficking

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
Monarch Services Ending the Game – Human Trafficking Program	By collaborating with partner organizations, as well as utilizing existing partnerships with social service agencies in Santa Cruz County, Monarch Services builds community capacity to prevent human trafficking and assist survivors of trafficking in exiting the life. Through its comprehensive case management model, Monarch ensures a continuum of care so that clients' needs are met in a holistic manner. Monarch emphasizes prevention by identifying those at risk and offering services and support.	☒	☒
Dominican Hospital Human Trafficking Taskforce	The hospital's Human Trafficking Taskforce is comprised of staff from the ED, social work, case management, patient registration, sponsorship, maternal child health, and community partners. The Taskforce meets every other month to review local cases of human tracking and identify staff training and education opportunities. The taskforce collaborates with the Coalition to End Human Trafficking on best practices and a community-wide approach to end human trafficking.	☒	☒

Impact: Both the hospital taskforce and Monarch Services programs work to identify and provide support to victims of human trafficking. Eighty-five percent of those identified by Monarch Services will have increased access to social support services.

Collaboration: The hospital partners with Monarch Services, the Santa Cruz County District Attorney, the Santa Cruz County Sheriff, and the Monterey and Santa Cruz Counties' Coalition to End Human Trafficking.

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 FY20, the hospital awarded the grants below totaling $189,646. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Community Bridges	Wellness Navigation Project	$25,000
Dientes Community Dental Care	Creating a Dental Home for People Experiencing Homelessness	$35,000
Monarch	Human Trafficking Case Management	$39,645
Santa Cruz RotaCare	Free Medical Clinic	$25,000
Teen Kitchen Project	Home-Delivered, Medically-Tailored Meals	$40,000
United Way	United 4 Youth	$25,000

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.

Housing Matters Recuperative Care Center (RCC) Program

Significant Health Needs Addressed	✓ Behavioral Health ✓ Economic Security ✓ Continuum of Care
Program Description	The RCC is a medical respite program located on the Housing Matter's campus. Up to 12 individuals experiencing homelessness are able to stay at a time and recover/stabilize while receiving integrated social services including housing planning, mental health care, benefits enrollment, and substance abuse treatment. The RCC aims to reduce recovery time from significant medical events, and to decrease the likelihood of recurring hospital stays.

Community Benefit Category	E-2 Grants – Operating Grants
FY 2020 Report	
Program Goal / Anticipated Impact	To provide a safe haven to recuperate fully and to address other social needs prior to discharge.
Measurable Objective(s) with Indicator(s)	Number of patients discharged from acute care to RCC.
Intervention Actions for Achieving Goal	The RCC aims to reduce recovery time from significant medical events, and to decrease the likelihood of recurring hospital stays.
Collaboration	This program is a collaboration between Housing Matters and the County of Santa Cruz Homeless Persons' Health Project, Dominican and Watsonville Hospitals, Palo Alto Medical Foundation (PAMF), Hospice of Santa Cruz County, Kaiser Permanente, and Central California Alliance for Health.
Performance / Impact	Thirty one patients were discharged from Dominican Hospital to the RCC. Five patients were discharged from a skilled nursing facility (SNF) via Dominican to the RCC.
Hospital's Contribution / Program Expense	$135,104
FY 2021 Plan	
Program Goal / Anticipated Impact	Continue to support the RCC and measure the effect on the number of people experiencing homelessness who fully recover following discharge from the hospital.
Measurable Objective(s) with Indicator(s)	Continue to provide health-related services, medications, education for diabetes, eye exams/glasses, and diagnostic testing to un-/underinsured populations at no cost to the patient. The hospital will provide pharmaceuticals, other medical supplies, and in/outpatient services at no cost to the patient.
Intervention Actions for Achieving Goal	Plan/coordinate for the delivery of home health care services at the RCC to ensure that these services are available when needed for full recovery.
Planned Collaboration	Continue current collaborations with local hospitals, health agencies, and other related agencies.

RotaCare Free Health Clinic

Significant Health Needs Addressed	✓ Behavioral Health ✓ Economic Security

	✓ Continuum of Care
Program Description	RotaCare is a volunteer-driven organization that provides health care for the uninsured or underserved in our community.
Community Benefit Category	E-2 Grants – Operating Grants
FY 2020 Report	
Program Goal / Anticipated Impact	To increase the number of persons accessing episodic health care at the clinic in an effort to decrease the number of preventable ED visits and inpatient admissions to the hospital.
Measurable Objective(s) with Indicator(s)	Continue to provide health-related services, medications, education for diabetes, eye exams/glasses, and diagnostic testing to un-/underinsured populations in the clinic at no cost to the patient. The hospital provides pharmaceuticals, other medical supplies, and outpatient services at no cost to the patient.
Intervention Actions for Achieving Goal	Clinic provides health care at no cost to the patient. All staff are volunteers.
Collaboration	RotaCare collaborates with community physicians, pharmacies, and the hospital lab to provide services.
Performance / Impact	Prior to ceasing services due to the COVID-19 pandemic, 89 patients were provided free health care. Services resumed in late July with extremely limited capacity, for the protection of patients and volunteers.
Hospital's Contribution / Program Expense	$25,000 grant and in-kind lab services.
FY 2021 Plan	
Program Goal / Anticipated Impact	Continue to support the RotaCare Free Health Clinic and provide self-management information for patients with diabetes.
Measurable Objective(s) with Indicator(s)	Continue to provide health-related services, medications, education for diabetes, eye exams/glasses and diagnostic testing to un-/underinsured populations in the clinic or in the hospital at no cost to the patient. The hospital will provide pharmaceuticals, other medical supplies, and in/outpatient services at no cost to the patient.
Intervention Actions for Achieving Goal	The RotaCare Free Health Clinic will continue operations weekly at the local senior center seeing a limited number of patients. Once the Santa Cruz County Shelter in Place order and associated restrictions are lifted, the Rotacare Free Health Clinic will increase the number of patient visits.
Planned Collaboration	Continue program collaborations with local health care providers.

Mobile Wellness Clinic

Significant Health Needs Addressed	✓ Behavioral Health ✓ Economic Security ✓ Continuum of Care
Program Description	The Mobile Wellness Clinic provides episodic health and preventive services Monday–Friday throughout Santa Cruz County. Services are provided by physicians, allied health professionals, registered nurses, and registrars. The program primarily targets the un-/underinsured populations, but also reaches the broader community. The program serves children, youth, and adults.
Community Benefit Category	A2- Community Based Clinical Services – Primary Care.
FY 2020 Report	
Program Goal / Anticipated Impact	Continue to support the Mobile Wellness Clinic, partnered with other agencies, to expand services and determined methods to decrease preventable episodic visits to the hospital ED.
Measurable Objective(s) with Indicator(s)	Increased number of participants seeking episodic care at the Mobile Wellness Clinic.
Intervention Actions for Achieving Goal	Through collaboration with other health care providers in the county, the Mobile Wellness Clinic evaluated each patient, developed a plan, and referred patients to health homes in close proximity to their site of access. Patients received referral documentation at the time of discharge.
Collaboration	Continued collaboration with health care agencies and added non-health care services.
Performance / Impact	Prior to pausing services due to the COVID-19 pandemic, the Mobile Wellness Clinic had 1,005 episodic encounters and 431 patient contacts for prevention (screening and education).
Hospital's Contribution / Program Expense	$463,330
FY 2021 Plan	
Program Goal / Anticipated Impact	Continue to support the Mobile Wellness Clinic and measure the effect on the number of preventable episodic visits to the ED.
Measurable Objective(s) with Indicator(s)	When the Santa Cruz County Shelter in Place order and associated restrictions are lifted, the Mobile Wellness Clinic will return to service and work to increase the number of participants receiving episodic and preventative care.
Intervention Actions for Achieving Goal	Continue marketing strategies, including social media for advertising, and distribution of informational brochures and monthly calendars throughout the county.

Planned Collaboration	Continue program collaborations with local health care providers.

Teen Kitchen Project (TKP)

Significant Health Needs Addressed	✓ Economic Security ✓ Continuum of Care
Program Description	The Teen Kitchen Project (TKP) brings volunteer teens into the kitchen to prepare medically-tailored meals for delivery to individuals and families in crisis due to a life-threatening illness. TKP receives referrals from Dominican Hospital's social workers, nurse navigators, and home health nurses.
Community Benefit Category	E-2 Grants – Operating Grants

FY 2020 Report

Program Goal / Anticipated Impact	Deliver 26,500 home-delivered, medically-tailored meals to Santa Cruz County critically-ill individuals and their families.
Measurable Objective(s) with Indicator(s)	Seventy-five percent of clients will report that TKP's meals helped them recover from their illness more quickly. Eighty-five percent of meal recipients will report that TKP's meals helped them feel better physically.
Intervention Actions for Achieving Goal	TPK provides meal delivery service to households in Santa Cruz County impacted by a life-threatening illness. Food is sourced from local organic vendors, and clients are provided with nutrition information and tips on healthy cooking.
Collaboration	TPK project collaborates with Lakeside Organic Gardens and Community Bridges.
Performance / Impact	Due to COVID-19, TPK expanded services to include additional clients and created a new partnership with County of Santa Cruz to provide emergency food relief to clients who have In Home Support Services (IHSS).
Hospital's Contribution / Program Expense	$40,000

FY 2021 Plan

Program Goal / Anticipated Impact	TKP will continue to service individuals in crisis due to life threatening illness, particularly those who are low income, lack a network of family or friends, or do not qualify for other free food services.
Measurable Objective(s) with Indicator(s)	Continue to grow the percentage of clients who will report that TKP's meals helped them recover from their illness more quickly and the

	percentage of recipients who report that TKP's meals helped them feel better physically.
Intervention Actions for Achieving Goal	Deliver meals weekly for six to 24 weeks to individuals and families in crisis due to a critical/chronic illness. Include a menu with nutrition information and health tips in each meal bag.
Planned Collaboration	TPK will collaborate with Lakeside Organic Gardens and Community Bridges' Lift Line Program.

United Way United 4 Youth

Significant Health Needs Addressed	✓ Economic Security ✓ Human Trafficking
Program Description	United 4 Youth provides wrap-around services and leadership support to promote college and career readiness, health and wellness, economic sustainability, and community connection among Santa Cruz County's highest-needs youth. This new framework is a community empowerment model, assembling teams of nonprofits to co-design asset development programs that lead to positive and sustainable outcomes for youth throughout Santa Cruz County.
Community Benefit Category	E-2 Grants – Operating Grants

FY 2020 Report

Program Goal / Anticipated Impact	Increase youth access to multiple health and human services that promote health and wellness, college and career readiness, and community connection.
Measurable Objective(s) with Indicator(s)	Eighty percent of youth participants will identify that they have a positive connection to their community and feel safe as measured by pre/post survey. Seventy percent of parent/family participants will report improvements in their child's academic progress. Twenty-five percent of youth participants will report improved mental health as a result of participating in United 4 Youth and accessing services.
Intervention Actions for Achieving Goal	Fifty youth participating in a minimum of three (3) pro-social activities (ie. Yoga, College/Career Exploration, Healthy Relationship workshops, outdoor activities) and homework help per week during academic calendar. Fifty youth participating in a minimum of three (3) prosocial activities (ie. Family counseling, family weekend camping and outdoor activities,

	job skills development) and homework help per week during the academic year.
Collaboration	United Way will partner with Community Bridges and Pajaro Valley Prevention and Student Assistance.
Performance / Impact	Provide comprehensive activities and services that are prevention focused to serve predominately low-income Latino youth and families in Live Oak's Emerald Bay neighborhood. Provide comprehensive activities and services that are prevention focused in the areas of mental health and career/job readiness to serve youth and families in Watsonville neighborhoods.
Hospital's Contribution / Program Expense	$35,000
FY 2021 Plan	
Program Goal / Anticipated Impact	Continue to increase youth access to multiple health and human services that promote health and wellness, college and career readiness, and community connection.
Measurable Objective(s) with Indicator(s)	Forty youth participating in a minimum of three (3) pro-social activities (i.e. Yoga, College/Career Exploration, Healthy Relationship workshops, outdoor activities) and homework help per week during academic calendar. Sixty youth participating in a minimum of three (3) pro-social activities (i.e. family counseling, job skills development, healthy eating, and active living) and homework help per week during the academic calendar. The partner organization will also provide home visits to students with individualized education plans (IEPs) to ensure family support and access to family services including emergency financial assistance.
Intervention Actions for Achieving Goal	Continue prior year activities and services that are prevention focused in the areas of mental health, college and career exploration, and job readiness.
Planned Collaboration	The United Way will collaborate with Community Bridges and Pajaro Valley Prevention and Student Assistance.

Community Grants Program	
Significant Health Needs Addressed	✓ Economic Security ✓ Continuum of Care
Program Description	Provide funding to support community-based services to improve the quality of life and health status of the communities they serve. The objective of the Dominican Hospital Community Grants Program is to

	award grants to organizations whose proposals respond to the health priorities identified in the current CHNA and are located within Santa Cruz County.
Community Benefit Category	E2-a.-Grants-Program Grants
FY 2020 Report	
Program Goal / Anticipated Impact	To build capacity by identifying organizations and funding programs that are in alignment with the needs identified in the most recent CHNA.
Measurable Objective(s) with Indicator(s)	Funding will be awarded to organizations whose programs respond to one or more needs identified in the most recent CHNA and aligned with at least one of the four core principles identified above in the program emphasis section of this report. Grantees provide mid-year and final reports with program results.
Intervention Actions for Achieving Goal	Letters of Intent were reviewed and select organizations were invited to submit a full proposal. Full proposals were reviewed by a subcommittee of the Dominican Hospital Community Advisors and determination was made as to which proposals were recommended for funding.
Collaboration	Each community grant recipient must have at least two partner organizations.
Performance / Impact	Partnership grants were awarded to the following organizations: 1. Community Bridges 2. Dientes Community Dental Care 3. Monarch Services 4. RotaCare Santa Cruz 5. Teen Kitchen Project 6. United Way
Hospital's Contribution / Program Expense	$189,646
FY 2021 Plan	
Program Goal / Anticipated Impact	Provide funding for programs that align with strategies developed by the Dominican Hospital Community Board, Dominican Hospital Community Advisors and the communitywide efforts of the local health agencies.
Measurable Objective(s) with Indicator(s)	Each grant award will have measurable objectives and indicators specific to their proposal.
Intervention Actions for Achieving Goal	Partnership grants will be awarded to proposals that align with the 2019 CHNA priorities.
Planned Collaboration	Collaborate and follow-up with chosen agencies.

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, those below are a reflection of the hospital's mission and its commitment to improving community health and well-being.

Improving Access to Health Care	
Community Service	Consultation and referrals
Human Trafficking	Education and referrals

Preventing and/or Managing Chronic Conditions	
Lifestyle Management	Physical, Neuro, Diabetes, Cardio
Annual Crisis Intervention Symposium	Community education
Well Health Checks	Health fairs
Health Screenings	Church locations
Cardiac Stroke Program	Education
Diabetes Program	Education
Personal Enrichment Program	Education addressing health problems
Dare to C.A.R.E.	Vascular screening

Improving Physical Activity/Nutritional Health	
First Aid at Community Events	Health treatment
Athletic Training Program	High school students

Improving Women's Health and Birth Outcomes	
Lactation	Consultation
Cancer Detection	Early identification and treatment
Katz Cancer Resource Center	Navigation system once identified
Early Infant Development	Collaboration with Stanford

Improving Care Continuum	
Homelessness	Recuperative Care Center

Economic Value of Community Benefit

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Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2019 through 6/30/2020

	Persons	Net Benefit	% of Expenses
Benefits for Poor			
Financial Assistance	**4,294**	**3,978,678**	**1.0%**
Medicaid	**23,551**	**17,554,395**	**4.4%**
Means-Tested Programs	**153**	**288,616**	**0.1%**
Community Services			
A - Community Health Improvement Services	4,545	650,991	0.2%
E - Cash and In-Kind Contributions	8	374,658	0.1%
F - Community Building Activities	52	1,756,863	0.4%
Totals for Community Services	**4,605**	**2,782,512**	**0.7%**
Totals for Poor	**32,603**	**24,604,201**	**6.1%**
Benefits for Broader Community			
Community Services			
A - Community Health Improvement Services	9,774	4,173,312	1.0%
E - Cash and In-Kind Contributions	16	941,105	0.2%
F - Community Building Activities	0	52,795	0.0%
G - Community Benefit Operations	0	56,977	0.0%
Totals for Community Services	**9,790**	**5,224,189**	**1.3%**
Totals for Broader Community	**9,790**	**5,224,189**	**1.3%**
Totals - Community Benefit	**42,393**	**29,828,390**	**7.4%**
Medicare	**28,187**	**55,186,061**	**13.7%**
Totals with Medicare	**70,580**	**85,014,451**	**21.2%**

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.

Hospital Board and Committee Rosters

Dominican Hospital Community Board FY 2020

Board Member	Affiliation
Jessica Cohen, MD	Physician
Erick Eklund, DDS	Dentist
Dean Kashino, MD	Physician
Karl Knudson Johsens, MD	Physician
Carol Lezin	Realtor
Marjory O'Connor, RN	Retired Nurse
Elisa Orona	Executive Director, Health Advocate Organization
Erica Padilla Chavez	Executive Director, Nonprofit
Rajinder Singh, MD	Physician
Carolyn Roeber, OP	Religious Sponsor, Attorney
Jon Sisk	Banker
Stephen Snodgrass	Business, Chief Financial Officer
Ex Officio Board Members	Affiliation
Jared Bogaard	Philanthropic Foundation President, Construction
Rema Hanna, MD	Chief of Staff, Physician
Nanette Mickiewicz, MD	Hospital President and CEO, Physician

Member	Affiliation
David Brody	First Five Santa Cruz County
Leslie Conner	Santa Cruz Community Health Center
Keisha Frost	United Way of Santa Cruz County
Cara Pearson	Pacific Cookie Company
Stephen Snodgrass	Granite Rock
Martine Watkins	Santa Cruz County Office of Education
Staff to Community Advisors	
Nanette Mickiewicz, MD	Hospital President and CEO, Physician
Dominique Hollister	Director Administrative Services and Community Benefit

Financial Assistance Policy Summary

Summary Of Financial Assistance Programs

Dignity Health's Financial Assistance Policy describes the financial assistance programs available to uninsured or underinsured patients who meet certain income requirements to help pay for medically necessary hospital services provided by Dignity Health. An uninsured patient is someone who does not have health coverage, whether through private insurance or a government program, and who does not have the right to be reimbursed by anyone else for their hospital bills. An underinsured patient is someone who has health coverage, but who has large hospital bills that are not fully covered by their insurance.

Free Care

- If you are uninsured or underinsured with a family income of up to 250% of the Federal Poverty Level you may be eligible to receive hospital services at no cost to you.

Discounted Care

- If you are uninsured or underinsured with an annual family income between 250-350% of the Federal Poverty level, you may be eligible to have your bills for hospital services reduced to the highest amount reasonably expected to be paid by a government payer, which is usually the amount that Medicare would pay for the same services.
- If you are uninsured or underinsured with an annual family income between 350-500% of the Federal Poverty level you may be eligible to have your bills for hospital services reduced to the Amount Generally Billed, which is an amount set under federal law that reflects the amount that would have been paid to the hospital by private health insurers and Medicare (including co-pays and deductibles) for the medically necessary services.

If you are eligible for financial assistance under our Financial Assistance Policy you will not be required to pay more than the Amount Generally Billed described above. If you qualify, you may also request an interest-free extended payment plan.

You will never be required to make advance payment or other payment arrangements in order to receive emergency services.

Free copies of the hospital's Financial Assistance Policy and financial assistance application forms are available online at your hospital's website listed below or at the hospital Admitting areas located near the main entrance. (Follow the signs to "Admitting" or "Registration"). Copies of these documents can also be mailed to you upon request if you call Patient Financial Services at the telephone number listed below for your hospital.

Traducción disponible: You may also obtain Spanish and other language translations of these documents at your hospital's website, in your hospital's Admitting area, or by calling your hospital's telephone number.

Dignity Health Financial Counselors are available to answer questions, provide information about our Financial Assistance Policy and help guide you through the financial assistance application process. Our staff is located in the hospital's Admitting area and can be reached at the telephone number listed below for your hospital.

Dominican Hospital 1555 Soquel Dr, Santa Cruz, CA 95065 | **Financial Counseling** 831-462-7831
Patient Financial Services 831-457-7001 | www.dignityhealth.org/dominican/paymenthelp

Sequoia Hospital 170 Alameda de las Pulgas, Redwood City, CA 94062 | **Financial Counseling** 650-367-5551
Patient Financial Services 888-488-7667 | www.dignityhealth.org/sequoia/paymenthelp

Saint Francis Memorial Hospital 900 Hyde St, San Francisco, CA 94109 | **Financial Counseling** 415-353-6136
Patient Financial Services 888-488-7667 | www.dignityhealth.org/saintfrancis/paymenthelp

St. Mary's Medical Center 450 Stanyan St, San Francisco, CA 94117 | **Financial Counseling** 415-750-5817
Patient Financial Services 888-488-7667 | www.dignityhealth.org/stmarys/paymenthelp

Bay Area_CA2016

Dignity Health.