St. Joseph's Medical Center

Community Benefit 2020 Report and 2021 Plan

Adopted October 2020

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.

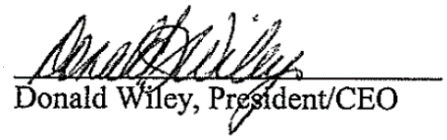
Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our initiatives to deliver community benefit include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital and 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 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 voluntary 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 2020 (FY20), St. Joseph's Medical Center provided $28,430,125 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $30,212,769 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 October 29, 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, by reaching to 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

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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 in one hand growth opportunities and a variety of assets and resources to support health, and in the other hand significant challenges in terms of economic security, health and health disparities.
Economic Value of Community Benefit	$28,430,125 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits. $30,212,769 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 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
FY20 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 Trauma Informed Collaborative • Economic Security: Increased involvement in San Joaquin County Whole Person Care and San Joaquin County Continuum of Care • Obesity/Diabetes: Diabetes Navigator and Diabetes Education programs • Violence and Injury: Human Trafficking Awareness and Education. • Access to Care: St Mary's Free Medical Clinic, Graduate Medical Education (GME) program, Breast Cancer Screenings, and Recuperative Care which also increase housing access along with linkages to mental health and substance use treatment • Substance Use: Bridge Program was established to expand medication assisted treatment with Buprenorphine • Oral Health: Support of St Mary's Free Dental Clinic

FY21 Planned Programs and Services

The hospital intends to continue many of the FY 20 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 Investments 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.

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'Conner and the Dominican Sisters of San Rafael, St. Joseph's Medical Center continues the legacy of caring for the poor and disenfranchised.
- 355 beds, 2,600 employees, 700 physicians, 21,000 patient admissions, 90,000 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 World Health Organization and UNICEF.
- Designated STEMI and Stroke Receiving Center by County EMS.
- Certified Green Business by the State of California Green Business Program.
- Awarded Environmental Leadership Circle Award by Practice Greenhealth.
- 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 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 policy is at the end of this report. The financial assistance policy and plain language summary are on the hospital's web site.

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 is comprised 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 in the other hand significant challenges in terms of economic security, health and health disparities.

St. Joseph's Medical Center Service Area Demographics

Total Population	387,484

Race

White - Non-Hispanic	20.7%
Black/African American - Non-Hispanic	9.4%
Hispanic or Latino	47.3%
Asian/Pacific Islander	18.7%
All Others	4.1%

% Below Poverty	16.1%
Unemployment	9.2%
No High School Diploma	24.4%
Medicaid (household)	11.9%
Uninsured (household)	6.2%

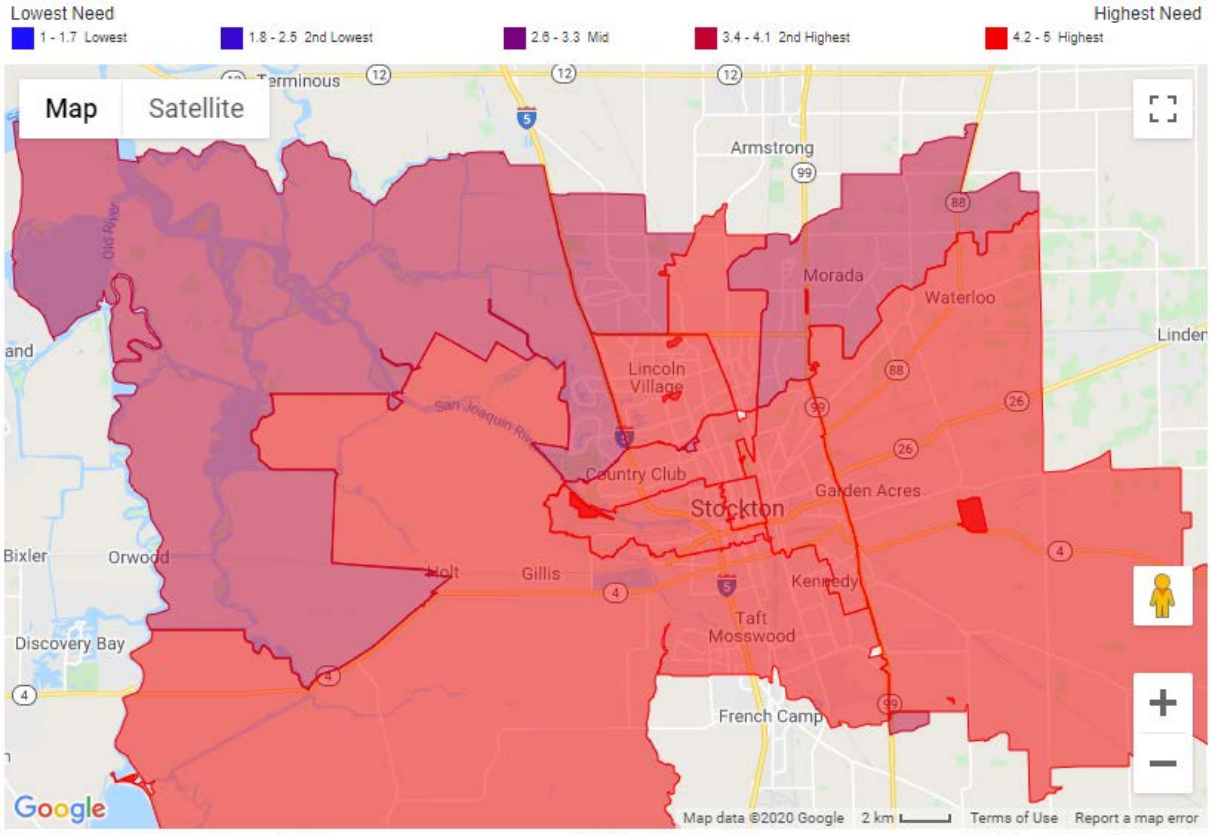
Source: Claritas Pop-Facts® 2020; *SG2 Market Demographic Module*

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. 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.

Figure 1. CNI score for each zip code in the city of Stockton as of September 2020



Mean(zipcode): 4.4 / Mean(person): 4.4 CNI Score Median: 4.6 CNI Score Mode: 3.4,4.6,4.8,5

Zip Code	CNI Score	Population	City	County	State
95202	5	6721	Stockton	San Joaquin	California
95203	5	16863	Stockton	San Joaquin	California
95204	4.6	28941	Stockton	San Joaquin	California
95205	5	40850	Stockton	San Joaquin	California
95206	4.8	71114	Stockton	San Joaquin	California
95207	4.6	50046	Stockton	San Joaquin	California
95209	3.6	43317	Stockton	San Joaquin	California
95210	4.8	42103	Stockton	San Joaquin	California
95211	3.8	1547	Stockton	San Joaquin	California
95212	3.4	29933	Stockton	San Joaquin	California
95215	4.4	24632	Stockton	San Joaquin	California
95219	3.4	31417	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 March 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; 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:** Deaths by suicide, drug overdose and alcohol poisoning combined are higher in San Joaquin County when compared to the state average. Primary data indicates there is a perception of limited access to providers and culturally competent services. Poor mental health was also linked to stigma, low incomes, substance abuse, and homelessness.
- **Economic Security:** San Joaquin County benchmarks poorly compared to the state on many economic security indicators and there are a significant number of ethnic/racial disparities within the county. Black and Latino populations are among those most impacted by poverty. Unemployment is also higher in the County relative to the state. Homelessness and housing instability, lack of employment, poor recovery post-recession, transportation access and substance abuse are connected with economic security and were mentioned as important issues by key informants and in the focus groups
- **Obesity/Healthy Eating and Active Living (HEAL)/Diabetes**: Obesity rates and diabetes prevalence were higher in San Joaquin County as compared to the state. Physical inactivity is higher among youth and adults in San Joaquin County compared to the state, and disparities are higher for Latino and Black youth in particular. Poverty, lack of access to healthy food and safe places for physical activity, and easy access to unhealthy foods were frequently mentioned as

barriers in primary data and confirmed by secondary data.

Medium Priority

- **Violence/Injury Prevention**: Non-Hispanic Whites and Blacks are disproportionately impacted by motor vehicle crash deaths. Injury deaths and violent crime rates are both higher in San Joaquin County compared to the state. Key informants and focus group participants linked violence and injury prevention to poor lighting, loose dogs, traffic and drug use. Poverty and the economy's impact on jobs were mentioned in primary data as well.
- **Access to Care:** In San Joaquin County, almost a third more county residents have public health insurance when compared with state averages, which is a factor related to overall poverty. Latinos are most likely to be uninsured. Secondary data revealed that poor access to affordable health insurance and the lack of high-quality providers, including urgent care and mental health, impact access to care. Language and cultural barriers, including poor language access, were also discussed by key informants and in the focus groups.
- **Substance Abuse/Tobacco:** Substance abuse is linked with community violence, sexually transmitted infections, and teen pregnancies. Impaired driving deaths are higher in San Joaquin County than the state. Marijuana, methamphetamine, tobacco and alcohol use were frequently mentioned in primary data, as was the intersection of substance abuse, homelessness and poverty, and mental illness. Although opioids were not mentioned specifically in primary data, key informants discussed challenges associated with drug use in general.

Lower Priority

- **Asthma:** Asthma prevalence and the asthma hospitalization rate are greater in San Joaquin County than in the state. Focus group participants discussed allergies, unsafe air from farming, and bad smelling air as factors impacting this health need.
- **Oral Health:** San Joaquin County performs similarly to the rest of California when it comes to oral health outcomes. Insufficient insurance coverage and high out of pocket costs, as well as a lack of high quality dental care providers, were mentioned as key concerns by key informants and focus groups.
- **Climate and Health:** Unsafe drinking water and poor air quality were mentioned in focus groups. Traffic pollution and farming are factors that contribute to this health need.

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.

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.

2020 Report and 2021 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 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 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 benefit 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 comprised 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 multisector 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.
- Health Education & Literacy: Community Health staff time was provided to San Joaquin County Public Health Services to assist with Risk Communications to assist with the design and translation of COVID related messaging. Staff also supported with contact tracing, along with providing education and support to skilled nursing facilities to mitigate outbreaks.
- PPE for the vulnerable: In partnership with Public Health and the United Way of San Joaquin County, Dignity Health led the organization of volunteers to assemble 100,000 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. The approach with dissemination included partnering with community based organizations to provide culturally appropriate education along with the kits, and it targeted migrant farm workers, the unsheltered, and low income communities.
- Food Insecurity: As part of the continued effort to address food insecurities and in response to COVID-19 for those experiencing homelessness and housing insecurities, Dignity Health, AARP and 211 partnered to end hunger for food insecure African American, Latinx, and Native American/Alaskan Native seniors 50 years and older in California by delivering 5,000 non-perishable food boxes to older adults. San Joaquin County was one of 11 counties in California offered access to added resources for eligible seniors, who received a one-time emergency food box delivery with shelf-stable foods that could prepare up to 125 meals to ensure accessibility to healthy food during COVID-19.
- Healthcare Access: In March of 2020, Dignity Health offered Virtual Urgent Care visits for individuals experiencing COVID-19 symptoms. The associated visit fee of $35 was waived with coupon code COVID19, for anyone experiencing COVID-19 symptoms. This prompt response allowed providers to meet the increased demand for care while reducing potential transmission of the coronavirus, and offered the community a safe and convenient way to seek medical professional advice without leaving their home.

In FY21, the hospital plans to expand health promotion 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 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.

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 FY20	Planned FY21
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, 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.	☐	☒
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. Key approaches include, but are not limited to: • Friends of Seniors Links Project – This program supports the reduction of isolation and depression in older adults. • Community Health Social Worker – This person is responsible for providing outreach and education regarding through 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 comprised 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. • San Joaquin Mental Health Consortium membership to share mental health resources and best practices. • Connected Community Network (CCN) – 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 FY20	Planned FY21
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 pilot, 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	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 plan and links individuals to resources for housing, employment, and other services to help them become self-sufficient.	☒	☒
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 program awarded funding in 2020, are addressing economic security: • Visionary Home Builders of California, Inc. – Job skills for 240 residents along with digital training and support. • Lutheran Social Services – Life and job skills for youth exiting the foster care program to minimize homelessness among youth.	☐	☒

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 FY20	Planned FY21
St. Joseph's Community Health Department Education Programs	• 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. • Certified Diabetes Educator Consultations: Free one-on-one, personalized diabetes education for populations who face significant barriers to better health. • Sweet Journey 101: A highly interactive diabetes basics workshop to encourage individuals to pursue additional classes and/or diabetes support services. • Sugar Fix Support Group: Monthly diabetes support group offering multi-disciplinary professional presentations along with peer support. • Matters of Balance: This nine week workshop offers older adults 2 hour weekly sessions that provide practical tips to overcome fears of falling.	☒	☒
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 program awarded funding in 2020, 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.	☐	☒

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 FY20	Planned FY21
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 description in 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 Improvement Plan (CHIP)	Please see description in the above section. Through the increased utilization of parks in priority 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 FY20	Planned FY21
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 work force 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.	☒	☒
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, are addressing access to care: • Dentists Organized for Veterans (DOV) – Dental care for veterans who do not qualify for the VA. • Delta Health Care and Management Services Corporation – Mental health support for high school aged youth in SUSD.	☐	☒
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 FY20	Planned FY21
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 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 FY20	Planned FY21
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, are addressing access to care: • Dentists Organized for Veterans (DOV) - Dental care for veterans who do not qualify for the VA.	☐	☒

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, 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. 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 home bound 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 2020 Report	
Program Goal / Anticipated Impact	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)	Via an annual survey program participants reported: On a scale of 1(poor) to 10 (excellent), the Friends of Seniors Program scored: 9 – On assisting with level of stress related to transportation challenges. 8 – On assisting with levels of loneliness and feelings of isolation. 9 – On assisting with level of safety and well-being in place of residence. 9 – On assisting with level of confidence and independence.
Intervention Actions for Achieving Goal	Regular meetings with volunteers, along with survey, help to ensure program quality and impact.
Collaboration	This program and the pilot rely 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	The pandemic ceased volunteer recruitment efforts, and the existing volunteers increased their telephonic friendly visiting and social service support referrals. 1,229.5 total volunteer service hours, representing:

	42% Medical Transport 21% Friendly visiting 16% Other activities (such as social events) 15% Shopping 4% Phone reassurance 2% Other transportation
Hospital's Contribution / Program Expense	Total program expense was $65,353, which is 100% supported by St. Joseph's Medical Center's Operational Budget.
FY 2021 Plan	
Program Goal / Anticipated Impact	Increase program volunteers in order to serve more seniors. Implement the Friends of Seniors Links Project to pilot the infusion of technology in the existing service line to expand the ability to serve transportation and basic needs more efficiently and sustainably. 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.
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 in ensure program effectiveness.
Planned Collaboration	In addition to the 2020 collaboration, continued partnership with local colleges and additional community based organizations will be essential for both volunteer and senior recruitment.

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:

	• Diabetes Navigator: Resource and referral service for patients and community members seeking health education and support. • Diabetes Education Empowerment Program (DEEP): Comprehensive series of classes targeting individuals with diabetes and pre-diabetes. - 2 hours per week, 6 weeks program. • Sweet Journey 101: A highly interactive diabetes basics workshop to encourage individuals to pursue additional classes and/or diabetes support services. 2 hour workshop, available monthly. • Sugar Fix: Led by a RN, Certified Diabetes Educator, this monthly diabetes support group offers multi-disciplinary professional presentations along with peer support. Certified Diabetes Educator (CDE) Consultations: Free one-on- one, personalized diabetes education for populations who face significant barriers to better health.
Community Benefit Category	A1 Community Health Education
FY 2020 Report	
Program Goal / Anticipated Impact	Diabetes Navigator – Provide resource/referral services to individuals with diabetes regarding health education/support in order to better manage condition. DEEP – Increase knowledge of ways to handle stress, increase confidence with goal setting and asking for support, increase physical activity. Sweet Journey 101 – Increase knowledge on the following; signs and symptoms of diabetes, potential complications of diabetes, MyPlate method, and recognizing a low blood sugar level needing immediate action. Sugar Fix Support Group – Increase knowledge of important health topics. CDE Consultations – Increase knowledge of how to take medications, increase confidence in managing diabetes, reduce consumption of sugary beverages, and reduce A1C levels.
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	**Diabetes Navigator:** 268 Total referrals, 264 unduplicated persons and 61 (23%) of those persons confirmed attendance of a diabetes education

class, and 5 (2%) individuals attended at least one support group session.

DEEP: 31 Total Participants, 58% Female, 19% Male, 23% Gender not Specified.

DEEP Pre/Post Survey Data:

- 76% increase in knowing healthy ways to handle stress related to diabetes.
- 26% increase in confidence with asking for support on how to live and take care of diabetes.
- 9% increase in confidence with asking doctor questions about treatment.
- 11% increase in confidence with making a plan with goals to help control diabetes.

Sweet Journey 101:

- 6 total participants, 83% Female, 17% Male.
- 64% increase in knowledge regarding the signs and symptoms of diabetes.
- 81% increase in knowledge regarding the potential diabetes complications.
- 183% increase in knowledge on the MyPlate Method.
- 100% of participants pledged to implement something they learned from the workshop.

Sugar Fix Support Group:

Total number of participants: 120
Total number of individual (unduplicated) participants: 64
Please rate the meeting facilitator's performance overall: 9.8 out of 10
Please rate the guest speaker's (s') presentation(s) overall: 9.8 out of 10
Today's session was a good investment of my time: 9.7 out of 10
Average knowledge increase for all session topics: 141%

CDE Consultations:

133 total consultations, 53% female, 47% male, Average Age 59 years. In 112 surveys, on a 1 (poor) to 10 (excellent) rating scale, participants reported the following:

CDE Consultation Surveys	PRE	3 mo. Post	6 mo. Post
Confidence w/managing diabetes	2.4	6	6
Yes, I have supplies to manage diabetes	53%	83%	100%
Not using a log sheet	82%	42%	38%
Last know A1C level	9.3	8.2	7.7

Hospital's Contribution / Program Expense	Total expense for all programs was $190,075, which is 100% supported by St. Joseph's Medical Center's Operational Budget.

FY 2021 Plan	
Program Goal / Anticipated Impact	Same as noted in the FY 2020 Report section of this digest.
Measurable Objective(s) with Indicator(s)	Continue current data collection as noted in 2020 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.

Connected Community Network

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	This county-wide network of stakeholders, navigation and convening partners, along with community based organizations will create a fully integrated repository of resources and referrals through a shared technology platform. This strategy has the potential of addressing all CHNA identified needs among others.
Community Benefit Category	G1 Community Benefit Operations

FY 2020 Report	
Program Goal / Anticipated Impact	Socialize the Connected Community Network framework to gain a minimum of five funding partners in the initiative.
Measurable Objective(s) with Indicator(s)	Network will launch by January, 2021 with a minimum of five funding partners.
Intervention Actions for Achieving Goal	Establish partnership with local 211 and United Way of San Joaquin so that they can act as navigation and convening partners respectively.

Collaboration	The full list of collaborative partners will be an ongoing development, but initial key partners include 211 of San Joaquin, Family Resource and Referral Center, and United Way of San Joaquin and United Way Worldwide. Funding Partners: Adventist Health Lodi Memorial & Dameron Hospital, Blue Shield of California, Community Medical Centers, Dignity Health, and Health Plan of San Joaquin, San Joaquin County Health Care Services, San Joaquin County Office of Education, Sutter Health, and University of the Pacific.
Performance / Impact	The CCN was launched February 2020, and as of October 2020, consisted of nine funding partners, with 42 community based organizations on the platform, representing 92 programs.
Hospital's Contribution / Program Expense	$414,216
FY 2021 Plan	
Program Goal / Anticipated Impact	Network was launched February 2020.
Measurable Objective(s) with Indicator(s)	Increased # of funding partners, # of CBOs in platform, increased network utilization measured by the % increase of referrals and connection outcome data.
Intervention Actions for Achieving Goal	Regularly scheduled CCN convening led by United Way to ensure successful launch of network.
Planned Collaboration	Ongoing engagement with partners as listed above, as well as with multi-sector stakeholders in San Joaquin County, including but not limited to; health systems, local government, education, law enforcement and justice system.

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 plan and connection to housing and other social services.

Community Benefit Category	E2 Grants
FY 2020 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 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 2019 there were 60 total enrollments into Recuperative Care 1,564 total Recuperative Care days. Average length of stay in Recuperative Care 26 days. Over 33% were placed at home, assisted living, treatment programs, or other shelters. With intervention there was a 16% decrease in ED visits, and a 22% decrease in Total Direct Variable Cost.
Hospital's Contribution / Program Expense	$100,000
FY 2021 Plan	
Program Goal / Anticipated Impact	Same as noted in the FY 2020 Report section of this digest.
Measurable Objective(s) with Indicator(s)	Same as noted in the FY 2020 Report section of this digest.

	Within 6 Months Pre-Intervention	Within 6 Months Post-Intervention	Change
Total ED & Inpatient Visits	292	246	16%
# of Unique Pts w/ an ED or Inpatient Visit	53	37	30%
Total Direct Variable Cost	$835,748.69	$647,926.28	22%

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 2020 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 plan 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 2020 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 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	699 referrals, 644 unduplicated persons, 401 referred to Catholic Charities, 263 enrolled in program, 52 declined enrollment, and 52 individuals were unable to be reached. Met goal of maintaining readmission rate under 15%. FY 2019-2020 readmissions were at 14.5%.

Service Type for 287 Enrolled Clients	Total Services Utilized	% of Services
House-making	219	76%
Mental Health	10	3%
Transportation	126	44%
Rx Express	48	17%
DME	26	9%
CC Food Pantry	26	9%
Incontinence Supplies	6	2%

Hospital's Contribution / Program Expense	$239,359
FY 2021 Plan	
Program Goal / Anticipated Impact	Same as noted in the FY 2020 Report section of this digest.
Measurable Objective(s) with Indicator(s)	Same as noted in the FY 2020 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 2020 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	Cancer Awareness Events: It's estimated that approximately 150 people visited the Cancer Awareness Fair in the Lobby of St. Joseph's Medical Center. 78 surveys were collected: - 67% Strongly agreed that the event made them aware of ways to improve their health. - 69% Strongly agreed that they will use what they learned at the event to help improve their health. - 70% Strongly agreed that they learned about a new resource that they were not aware of before. - 73% Strongly agree that they plan to use at least one of the new resources. - 40 Blood glucose tests with an average 104 BGL mg/dl. **Breast Cancer Events** Event on 09/29/19 • 20 total mammograms. • 100% negative results. • 100% received transportation assistance to their screening. • 100% received interpretation services. Event on 11/23/19 • 150 Hmong community members. • A lunch and learn style presentation to help participants learn about signs and symptoms of breast cancer and how to reduce risks through diet and exercise. **Prostate Cancer Events** Event on 12/13/19 • 180 Cambodian community members. • Lunch and learn presentation for the year with guest speaker, Dr. Hort Seng for members of the Cambodian community to learn about the risks and, signs and symptoms of prostate cancer. **Skin Cancer Events** Event on 08/21/19 Registration counts: • 52 – Total Registered • 4 – Cancelled • 12 – No Shows • 5 – Walk-ins • 5 – Screenings recommended for biopsy 100% of participants received a follow up (either call, email or both) from Community Health to assist with access to care referrals and day

	of the event local free clinic and community clinics (offering sliding scale) resources were provided.
Hospital's Contribution / Program Expense	Total expense for all programs was $114,936 which is 85% supported by St. Joseph's Medical Center's Operational Budget and 15% supported by Foundation Funds.
FY 2021 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 collaboration referenced above, existing partnerships in the faith community will be strengthen.

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 Practice: 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) • Orthopedics: 2 new residents each year x5 year (to start 6/2021) • Psychiatry: 7 new residents each year x4 years (to start 6/2021) • Urology: 2 new residents each year x5 years (to start 6/2021) • Anesthesia: 6 new residents each year x4 years (to start 06/21)
Community Benefit Category	B1 – Physicians/Medical Students
FY 2020 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	Successful launch of first year family medicine and emergency medicine residency.
Hospital's Contribution / Program Expense	$7,201,577

FY 2021 Plan	
Program Goal / Anticipated Impact	Same as noted in the FY 2020 Report section of this digest.
Measurable Objective(s) with Indicator(s)	Same as noted in the FY 2020 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	In addition to collaboration referenced above, existing partnerships in the faith community as well with other community based organizations will be strengthened.

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) and Hepatitis C Virus (HCV) 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 2020 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	

HIV	**Total/Actual**
# HIV Tests Performed	**23,166**
# HIV Positive Results	120
(Identified Through Testing)	(0.52% seropositive rate)
Newly Dx	18
(Identified Through Testing)	(12.08% newly diagnosed)
Linked to Care	18 (15%)
Already in Care	80 (67%)
Unable to Reach for Follow up	11 (9%)
Declined	3 (3%)
Deceased	4 (3%)
In Progress	4 (3%)
HCV	
# HCV Ab Tests Performed	**7,318**
#HCV Ab Positive Patients	327
(Identified Through Testing)	(12.27% never exposed to HCV)
# HCV RNA Positive Patients	347
(Identified Through Testing)	(4.56% currently infected w/ HCV)
Linked to Care	181 (55.4%)
Already in Care	7 (31.2%)
Unable to Reach for Follow up	102 (31.2%)
Deceased	9 (2.8%)
In Progress	27 (8.3%)

Hospital's Contribution / Program Expense	$260,145
FY 2021 Plan	

Program Goal / Anticipated Impact	Same as noted in the FY 2020 Report section of this digest.
Measurable Objective(s) with Indicator(s)	Same as noted in the FY 2020 Report section of this digest.
Intervention Actions for Achieving Goal	Same as noted in the FY 2020 Report section of this digest.
Planned Collaboration	Same as noted in the FY 2020 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 June 2019, Dignity Health approved a 3-year renewal of a $500,000 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 help cover the costs of purchasing and refurbishing former drug houses, thereby creating homes for sale to low-income homebuyers.

- **Faith Community Health Partnership:** Through partnership with Public Health Advocates, Kaiser, Sutter, Health Plan of SJC and SJMC Community Health provides support and technical assistance to expand health education and services to residents through the faith communities.

- **Multisector, Countywide Collaboration:** Hospital staff is actively involved in a variety of countywide initiatives such as the San Joaquin County Continuum of Care, Healthier Community Coalition, Diabetes and Obesity Prevention Workgroup, SJC Trauma Initiative, Human Trafficking Awareness and Prevention groups, just to name a few. Involvement in these and other groups are to lead change and reduce disparities in a range of health issues like; obesity diabetes, violence, mental health, substance abuse, homelessness, health literacy, health equity, and access to care.

- **San Joaquin Coalition for Compassionate Care:** County-wide initiative to educate both community and health care providers of the importance of completing Advanced Directives. This collaborative is made possible through the in-kind and financial support of the following stakeholders; Dignity Health, Kaiser Permanente, Sutter Health, and Blue Shield of 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 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 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 Health 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.

Economic Value of Community Benefit

192 St. Joseph's Medical Center Stockton
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	**6,112**	**6,805,738**	**1.1%**
Medicaid	**61,550**	**7,801,913**	**1.3%**
Community Services			
A - Community Health Improvement Services	8,517	945,061	0.2%
C - Subsidized Health Services	223	11,535	0.0%
E - Cash and In-Kind Contributions	1,644	0	0.0%
G - Community Benefit Operations	0	776,155	0.1%
Totals for Community Services	**10,384**	**1,732,751**	**0.3%**
Totals for Poor	**78,046**	**16,340,402**	**2.7%**
Benefits for Broader Community			
Community Services			
A - Community Health Improvement Services	1,329	2,116,045	0.3%
B - Health Professions Education	757	9,216,478	1.5%
D - Research	0	505,233	0.1%
E - Cash and In-Kind Contributions	0	251,967	0.0%
Totals for Community Services	**2,086**	**12,089,723**	**2.0%**
Totals for Broader Community	**2,086**	**12,089,723**	**2.0%**
Totals - Community Benefit	**80,132**	**28,430,125**	**4.7%**
Medicare	**42,379**	**30,212,769**	**5.0%**
Totals with Medicare	**122,511**	**58,642,894**	**9.7%**

*Cash and in-kind contributions reported at $0 net benefit due to return of a large donation in the fiscal year.

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

Debra Cunningham	Senior Vice President, Strategy Kaiser Permanente
Corwin Harper	Senior VP/Area Manager, Kaiser Permanente
John Petersdorf	Vice Chair SVP Operational Effectiveness, Dignity Health
Jon VanBoening	Senior Vice President, Dignity Health
Kevin Walters	CSO/SAO Central California Service Area, Dignity Health

Community Health Department Advisory Committee

In development and to be establish by 2020, and be comprised of the following multi-disciplinary members; VP, Mission Integration, Clinical Nutrition Manager, Clinical Nurse Specialist, Social Worker Supervisor, and Nursing Director.

Integrated Quality Council

A monthly meeting of over 60 hospital administrators and multidisciplinary leaders to monitor, oversee and improve organizational performance in an effort to consistently deliver exemplary, quality hospital services.

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.

Bakersfield Memorial Hospital 420 34th St., Bakersfield, CA 93301 | **Financial Counseling** 661-327-4647 ext 4692
Patient Financial Services 866-397-9272 | www.dignityhealth.org/bakersfieldmemorial/paymenthelp

Mark Twain 768 Mountain Ranch Rd, San Andreas, CA 95249 | **Financial Counseling** 209-754-2622
Patient Financial Services 866-397-9272 | www.dignityhealth.org/marktwainmedical/paymenthelp

Mercy Hospital Downtown 2215 Truxtun Ave, Bakersfield, CA 93301 | **Financial Counseling** 661-327-1792 ext 4692
Patient Financial Services 866-397-9252 | www.dignityhealth.org/mercy-bakersfield/paymenthelp

Mercy Hospital Southwest 420 34th St, Bakersfield, CA 93301 | **Financial Counseling** 661-327-4647 ext 4692
Patient Financial Services 866-397-9252 | www.dignityhealth.org/bakersfieldmemorial/paymenthelp

Mercy Medical Center 333 Mercy Ave, Merced, CA 95340 | **Financial Counseling** 209-564-5105
Patient Financial Services 866-626-6583 | www.dignityhealth.org/mercymedical-merced/paymenthelp

St. Joseph's Behavioral Health Center 2510 North California St, Stockton, CA 95204 | **Financial Counseling** 209-461-2000
Patient Financial Services 866-397-9252 | www.dignityhealth.org/stjosephsbehavioral/paymenthelp

St. Joseph's Medical Center 1800 North California St, Stockton, CA 95204 | **Financial Counseling** 209-461-5281
Patient Financial Services 866-397-9272 | www.dignityhealth.org/stjosephs-stockton/paymenthelp

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