St. Joseph's Medical Center

Community Benefit 2022 Report and 2023 Plan

Adopted October 2022

Dignity Health®
St. Joseph's Medical Center

A message from

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

Dignity Health St. Joseph's Medical Center's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessment 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, a part of CommonSpirit Health, 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 2022 Report and 2023 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 report to our community.

In fiscal year 2022 (FY22), St. Joseph's Medical Center provided $76,005,414 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $13,228,495 in unreimbursed costs of caring for patients covered by Medicare fee-for-service.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2022 Report and 2023 Plan at its October 27, 2022 meeting.

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

Donald Wiley
President and CEO of St. Joseph's Medical Center

Debra Cunningham
Chairperson, Board of Directors

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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 on one hand growth opportunities and a variety of assets and resources to support health, and on the other hand significant challenges in terms of economic security, and health disparities.

Economic Value of Community Benefit

$76,005,414 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits.

$13,228,495 in unreimbursed costs of caring for patients covered by Medicare fee-for-service.

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 2019 and 2022 Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are:

2019 CHNA Prioritized Needs:

- Mental Health
- Economic Security
- Obesity/Healthy Eating, Active Living/Diabetes
- Violence/Injury Prevention
- Access to Care
- Substance Abuse/Tobacco
- Asthma
- Oral Health
- Climate and Health

2022 CHNA Prioritized Needs:

- Mental Health/Behavioral Health Including Substance Use
- Access to Care
- Income and Employment
- Housing
- Chronic Disease/Healthy Eating Active Living (HEAL)
- Community Safety
- Family and Social Support
- Education
- Transportation

FY22 Programs and Services

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

- **Mental Health:** Mental Health First Aid Training, San Joaquin County Transforming Communities for Healing, Youth Overcoming Life's Obstacles (YOLO) Group, Social Needs Support through diabetes education programming, and by supporting the Boys & Girls Club at Sierra

Vista and Delta Health Care & Management Services Corporation through the Community Benefit Grants Program

- **Economic Security & Income and Employment:** Continued involvement in the San Joaquin County Continuum of Care and as a partner of San Joaquin County Whole Person Care, as well as supporting Visionary Home Builders of California, Inc. and Lutheran Social Services through the Community Benefit Grants Program
- **Obesity/Healthy Eating Active Living (HEAL)/Diabetes and Chronic Disease:** Diabetes Navigator services and Diabetes Education programs, along with supporting the Triple Play Program at the Boys & Girls Club at Sierra Vista through the Community Benefit Grants Program
- **Housing:** Reduce challenges such as rent affordability, crowded households, etc. that can increase mental health difficulties & domestic violence through increased investments through Homeless Health Initiative (HHI). Increased permanent housing solutions in collaboration with STAND Affordable Housing and San Joaquin County Whole Person Care (WPC). Continued collaboration with Gospel Center Rescue Mission (GCRM) and active involvement with the San Joaquin County Continuum of Care (COC)
- **Violence and Injury & Community Safety:** Human Trafficking Awareness and Education and development of programming around trauma informed care
- **Access to Care:** St Mary's Free Medical Clinic, Graduate Medical Education (GME) program, and by supporting Dentists Organized for Veterans and Delta Health Care & Management Services Corporation through the Community Benefit Grants Program
- **Substance Use**: Bridge Program to expand medication assisted treatment with Buprenorphine
- **Asthma:** Support of asthma mitigation efforts byLittle Manila Rising, through the Community Grants Program
- **Oral Health:** Support of St Mary's Free Dental Clinic services and a grant to Dentists Organized for Veterans through the Community Benefit Grants Program
- **Family and Social Support**: Create & sustain healthy communities via large support networks through the Connected Community Network (CNN), Pathways Community HUB, the Community Health Advocate (CHA) program and by continuing the Lifeline home monitoring service
- **Education:** Address systemic barriers related to education to improve community health & lift families out of poverty through the Connected Community Network (CNN) and expanding internships and mentoring of highschool and college students in various departments
- **Transportation:** Address barriers related to transportation and increase active transportation (biking or walking) by improving referral linkages

FY22 Planned Programs and Services

The hospital intends to continue many of the FY22 programs and plans to further develop interventions in an effort to respond to priority needs found in the 2019 and the 2022 CHNA. The following is a brief summary of the strategies and program level detail can be found in the Program Digest section of this report.

- Community benefit program expenditures provide financial support to various community programs that are often essential safety net services for the most vulnerable of populations. The primary needs addressed through reinvestments in the community include, but are not limited to: Economic Security, Access to Care and Oral Health.
- Community grants program annually assesses and funds programs and services dedicated to significantly impacting CHNA findings. This strategy encompasses the potential to help address all identified needs.
- Community health programming delivers 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.
- Initiatives to address Social Determinants of Health and other prevention related activities including Community Health Improvement Plan (CHIP) work around park activation and beautification, CHA, Pathways Community Hub.

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

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

Our Hospital and the Community Served

About St. Joseph's Medical Center

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

- The facility has been delivering quality, compassionate care for residents of the greater San Joaquin County since 1899.
- Centrally located in the City of Stockton and San Joaquin County.
- Founded by Father William B. O'Connor and the Dominican Sisters of San Rafael, St. Joseph's Medical Center continues the legacy of caring for the poor and disenfranchised.
- 2022 American College of Cardiology - Chest Pain/MI Platinum Achievement Award for STEMI/NSTEMI
- 2022 Fortune/Merative 100 Top Hospitals®
- 2022 Get with the Guidelines - Stroke GOLD PLUS with Target: Type 2 Diabetes Honor Roll Achievement Award (American Heart Association/American Stroke Association)
- 2022 Mission: Lifeline - STEMI Receiving Center - GOLD PLUS Achievement Award (American Heart Association/American Stroke Association)
- 2022 Mission: Lifeline - NSTEMI Silver Achievement Award (American Heart Association)
- Accredited by the American College of Surgeon's Commission on Cancer
- Accredited by the National Accreditation Program for Breast Centers
- Advanced Certification as a Primary Stroke Center by The Joint Commission
- Certificate of Distinction in the Management of Joint Replacement - Knee and Hip by The Joint Commission
- Designated Baby-Friendly™ hospital by World Health Organization and UNICEF
- Designated as a Blue Distinction Center® for Cardiac Care and Maternity Care by Blue Shield of California
- LGBTQ+ Healthcare Equality Leader by the Human Rights Campaign
- Recipient of an "A" Grade for Patient Safety by the Leapfrog Group for six consecutive periods
- 3-Star Rating for Coronary Artery Bypass Grafting (CABG) from the Society of Thoracic Surgeons

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

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay. This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

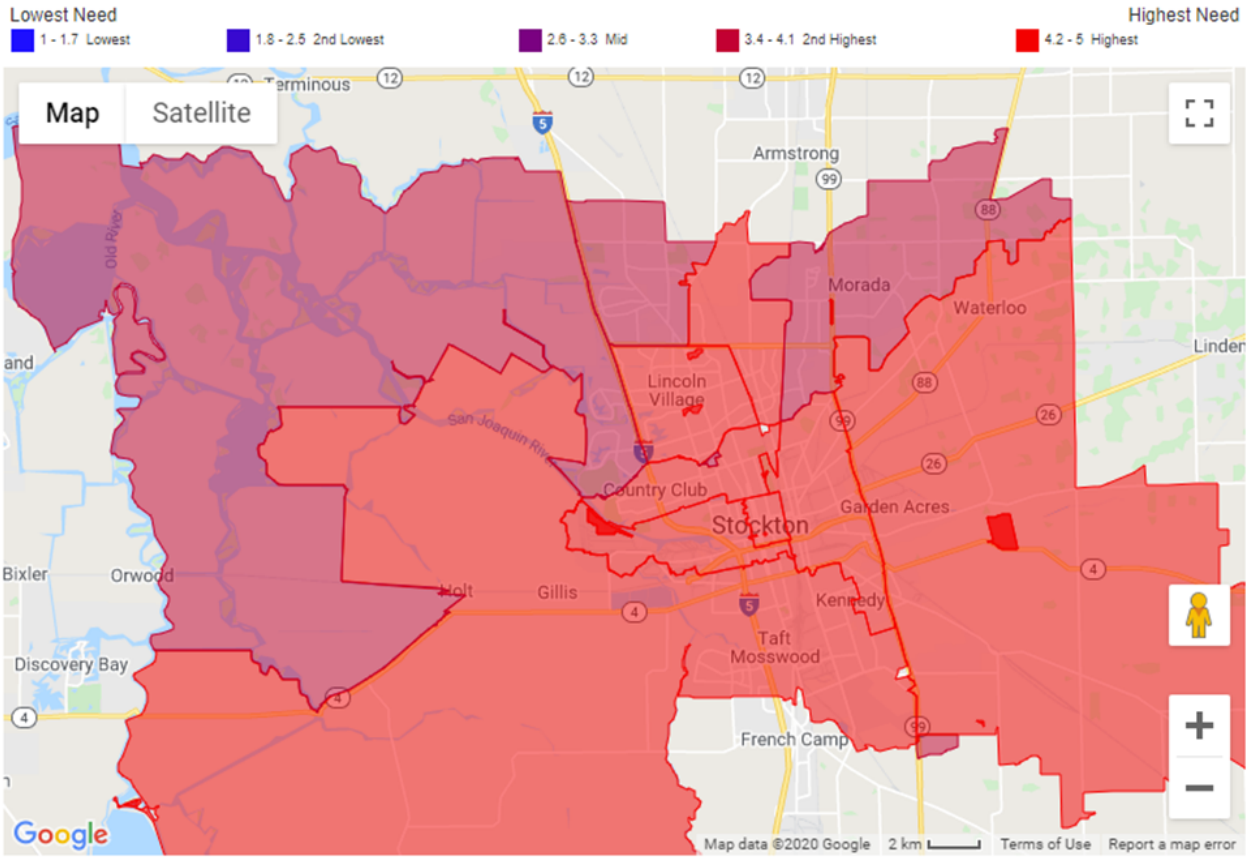
Description of the Community Served

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

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

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

Total Population	321,404
Race	
White - Non-Hispanic	18.7%
Black/African American - Non-Hispanic	9.4%
Hispanic or Latino	51.5%
Asian/Pacific Islander	16.4%
All Others	4.0%
Total Hispanic & Race	
% Below Poverty	17.0%
Unemployment	8.5%
No High School Diploma	25.7%
Medicaid (household)	12.7%
Uninsured (household)	6.6%
Source: Claritas Pop-Facts® 2021; *SG2 Market Demographic Module*	
SG2 Analytics Platform Reports:	
Demographics Market Snapshot	
Population Age 16+ by Employment Status	
Families by Poverty Status, Marital Status and Children Age	



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 May 2022, by the hospital board.

This document also reports on programs delivered during fiscal year 2022 that were responsive to needs prioritized in the hospital's 2019 CHNA report.

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 2022 CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors and health care services, and also health-related social needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Mental Health	Mental health affects physical wellbeing, job performance, and community activities.	Y
Access to Care	Quality healthcare is important for health and is essential for maintaining a higher quality of life.	Y
Income and Employment	Barriers such as low income, high unemployment, and pervasive poverty can exacerbate poor health outcomes.	Y
Housing	Stable, affordable housing is strongly associated with health, well-being, educational achievement, and economic success.	Y
Chronic Disease/Healthy Eating and Living (HEAL)	Those who have limited access to healthy foods have a higher risk of developing a chronic disease, such as obesity and heart disease.	Y

Significant Health Need	Description	Intend to Address?
	Along with a healthy diet, physical activity is key to preventing and reducing complications from chronic diseases.	
Community Safety	Safe communities promote community cohesion and economic development, and provide more opportunities to be active and improve mental health while reducing untimely deaths and serious injuries.	Y
Family and Social Support	The presence or absence of a strong social support network affects all aspects of life, including physical and mental wellbeing.	Y
Education	The link between education and health is well known – those with higher levels of education are more likely to be healthier and live longer.	Y
Transportation	Without reliable and safe transportation, individuals struggle to meet basic needs such as earning an income, accessing health care, and securing food.	Y

2022 Report and 2023 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 FY22 and planned activities for FY23, with statements on impacts and community collaboration. Program Highlights provide additional detail on select programs goals, measurable objectives, expenses and other information.

Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Creating the Community Benefit Plan

The hospital is dedicated to improving community health and delivering community benefits with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

Hospital and health system participants included hospital leadership across multiple departments and disciplines to obtain input and guidance on priority needs as well as intentional partnerships to explore local needs and a dedication to improving the health of everyone in the community.

Community input or contributions to this implementation strategy included interviews with 10 key informants, 29 focus group discussions with 291 diverse community residents, and data analyses of over 100 indicators, creating a robust picture of the issues affecting people's health where they live, work, and play. These individuals included representatives from local governmental and public health agencies, community-based organizations, and leaders, representatives, or members of underserved, low-income, and racial/ethnic populations. Additionally, where applicable, other individuals with expertise on local health needs were consulted. The hospital plans to continue the momentum that these focus groups and surveys have garnered.

The programs and initiatives described here were selected on the basis of social determinants of health framework and examined San Joaquin County's social, environmental, and economic conditions that impact health in addition to exploring factors related to diseases, clinical care, and physical health. Analysis of this broad range of contributing factors resulted in identification of the top health needs for the County.

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

- Existing program 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

Community Health Strategic Objectives

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources and engagement of participants both inside and outside of the health care delivery system.

CommonSpirit Health has established four core strategic objectives for community health improvement activities. These objectives help to ensure that our program activities overall address strategic aims while meeting locally-identified needs.

Advance Community Health Alignment and Integration

Create robust alignment with multiple departments and programmatic integration with relevant strategic initiatives to optimize system resources for advancing community health.

Expand Clinical - Community Partnerships and Linkages

Scale initiatives that complement conventional care to be proactive and community-centered, and strengthen the connection between clinical care and social health.

Build Capacity for More Equitable Communities

Work with community members and agency partners to strengthen the capacity and resiliency of local ecosystems of health, public health, and social services.

Inspire, Innovate and Scale High Impact Initiatives

Partner, invest in and catalyze the expansion of evidence-based programs and innovative solutions that improve community health and well-being.

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	Summary Description	Active FY22	Planned FY23
Community Grants Program	The following programs awarded funding in 2020 for November 1, 2020 through December 31, 2021 and are addressing mental health: ● Boys & Girls Club at Sierra Vista – By teaching sculling, this program will work with youth on social emotional health ensuring that participants make the connection that physical activity is a stress reliever. ● Delta Health Care and Management Services Corporation – Mental health support for high school aged youth in SUSD.	☒	☒
Community Benefit Operations and Programs	In partnership with St. Joseph's Behavioral Health Center and in collaboration with other mental health experts and service providers, the hospital's Community Health department will deploy several programs to address community needs	☒	☒
Community Mental Health Programming	● Youth Overcoming Life's Obstacles (YOLO) Group to address anxiety and depression in youth. ● Mental Health First Aid: A certificated training to help adults and teens working with the community,to identify and respond to signs of addictions and mental illnesses.	☒	☒
SJC Trauma Initiative	A collaborative group of over 70 members, representing 41 organizations throughout the county focusing on addressing trauma and promoting equity through the development of a Trauma Informed Care train-the-trainer training model for sustainability. This initiative focuses on addressing diversity, inclusion and cultural humility for both medical staff and providers, as well as social service providers.	☒	☒
Friends of Seniors Link Program	This program supports the reduction of isolation and depression in older adults.	☒	☒

San Joaquin Mental Health Consortium	Membership in this consortium supports sharing mental health resources and best practices.	☒	☒
GME Psychology Residency	Dignity Health is committed to increasing access to care through workforce development and SJMC is a leader in growing future medical providers in San Joaquin County. In partnership with Touro University, the GME program started in 2018 with 15 residents and is set to expand to approximately 200 residents by 2025. ● Psychiatry: 7 new residents each year x4 years (started 06/2021)	☒	☒
Community Health Advocate (CHA) Program	Launched in October of 2021 in partnership with Community Partnership for Families of San Joaquin (CPFSJ), the CHA is a strategy to address multiple identified unmet needs through a universal screening of the social determinants of health for patients in the hospital emergency department. The CCN technology is utilized to provide a ten question screening spanning seven social domains and is used to make community referrals. All of the CHNA health needs are assessed in the screening. A question to identify and support feelings of isolation is included in the screening.	☒	☒
Connected Community Network (CNN)	This network was created to provide the general population with access to resources and programs offered through various community based organizations (CBOs) and is an initiative to address the complex needs of hospital patients and the broader community . Many 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.	☒	☒

Goal and 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.

Collaborators: 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 of San Joaquin, Catholic Charities, Housing Authority County of San Joaquin, STAND, along with the growing number of CCN and SJC Trauma Initiative partners.

Health Need: Economic Security

Strategy or Program	Summary Description	Active FY22	Planned FY23
Community Health Advocate Program	Please reference the Mental Health Need section above for the program description. There is a specific screening question to identify financial insecurity.	☒	☒
Connected Community Network (CCN)	Please reference the Mental Health Need section above for the program description.	☒	☒
San Joaquin County Continuum of Care (SJCoC)	Community Health staff participate actively in the SJCoC in the following capacities; general membership, Education and Membership Committee, the Strategic Planning Committee, as well as the Coordinated Entry System Committee to develop solutions to end homelessness.	☒	☒
San Joaquin County Whole Person Care (WPC)	As a partner in this countywide collaborative project, the hospital identifies and refers homeless patients to WPC in an effort to secure stable housing and income for individuals experiencing or at-risk of homelessness. With the implementation of Cal-AIM and Community Supports, collaboration has expanded to ensure smooth transitions of care for unhoused patients.	☒	☒
Community Grants Program	The following programs awarded funding in 2020 for November 1, 2020 through December 31, 2021 to address economic security: ● Lutheran Social Services – Life and job skills for youth exiting the foster care program to minimize homelessness among youth. ● Visionary Home Builders of California, Inc. – Job skills for 240 residents along with digital training and support.	☒	☒
Goal and 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.			
Collaborators: 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, Catholic Charities, San Joaquin Delta College, and Guardian Scholars Program			

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

Strategy or Program	Summary Description	Active FY22	Planned FY23
St. Joseph's Community Health Department Education Programs	• Power Hour:1 hour, monthly presentations focused on increasing individuals' diabetes self-management skills. Topics cover the American Association of Diabetes Educators, AADE7™ Self-Care Behaviors. (launch July 2022) • Certified Diabetes Educator Consultations: Free one-on-one, personalized diabetes education for populations who face significant barriers to better health. • Diabetes Education and Empowerment Program (DEEP): 2 hour/week, 6 week program focusing on healthy living and diabetes prevention and management. • Diabetes Navigator: Resource and referral service for patients and community members seeking health education and support. • Matters of Balance: This nine week workshop offers older adults 2 hour weekly sessions that provide practical tips to overcome fears of falling. • Sugar Fix Support Group: Monthly diabetes peer-to-peer support group co-facilitated by a Certified Diabetes Care and Education Specialist and Community Health Social Worker.	☒	☒
San Joaquin Community Health Improvement Plan (CHIP)	As a core team and steering committee member, hospital staff played 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	The following programs awarded funding in 2020 for November 1, 2020 through December 31, 2021 and are addressing obesity and healthy eating active living: • Boys & Girls Club at Sierra Vista – Row and Rise Together! is a program that promotes physical activity and community support for underprivileged youth through sculling, a lifelong sport that has proven physical and emotional benefits.	☒	☒

	The following programs awarded funding in 2022 from January 1, 2022 through December 31, 2022 and are addressing obesity and healthy eating active living: ● Boys & Girls Club at Sierra Vista – Triple play is a comprehensive health and wellness program that will demonstrate how eating smart, keeping fit and forming positive relationships add up to a healthy lifestyle. ● The Edible Schoolyard Farm (ESY Farm) – Will foster a culture of care, belonging, and beauty while welcoming students and families from across San Joaquin County to engage with food and nature in a meaningful, culturally relevant way. ● Black Urban Farmers Association (BUFA) – Deliver low cost fresh, nutrient rich fruits and vegetables to corner stores in South Stockton, weekly and host quarterly mobile markets that provide food demos, educational material and qualified on site presence to answer questions.		

Goal and 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.

Collaborators: In addition to the partners noted above, the Matter of Balance program is in collaboration with the University of the Pacific (UOP) Health Sciences program, and social work interns from UOP support the psychosocial assessments and community referrals through Diabetes Navigation. The CHIP strategy will be deployed alongside various stakeholders, including city Parks and Recreation, Reinvent South Stockton Coalition, the Trust for Public Land and other healthcare systems and community partners.

Health Need: Violence/Injury Prevention

Strategy or Program	Summary Description	Active FY22	Planned FY23
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.	☒	☒
Community Mental Health Programming	Please see the description in the Mental Health section. Through a comprehensive strategy, a community health social worker is implementing programs to reduce cycles of violence within families and vulnerable communities.	☒	☒

San Joaquin Community Health Improvement Plan (CHIP)	Please see the description in the above section. Through the increased utilization of parks in priority neighborhoods, a reduction in neighborhood crime is an anticipated outcome.	☒	☒

Goal and 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.

Collaborators: 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	Summary Description	Active FY22	Planned FY23
Certified Diabetes Care and Education Specialist (CDCES) Consultations	CDCES 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.	☒	☒
Community Grants Program	The following programs awarded funding in 2020 for November 1, 2020 through December 31, 2021 and are addressing access to care: ● Delta Health Care and Management Services Corporation – Mental health support for high school aged youth in the Stockton Unified School District. ● Dentists Organized for Veterans (DOV) – Dental care for veterans who do not qualify for Veteran Administration benefits.	☒	☒
Graduate Medical Education (GME)	Dignity Health is committed to increasing access to care through workforce development and SJMC is a leader in growing future medical providers in San Joaquin County. In partnership with Touro University, 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, such as San Joaquin County Public Health Services, Gilead Sciences, California Department of Public Health and other FOCUS funded partners, to develop and share replicable model programs that embody best practices in HIV and HCV screening and linkage to care. As of FY22 Syphilis screening was added in.	☒	☒
Homecoming Program	In partnership with Catholic Charities, this program provides comprehensive community case management for up to six-weeks post discharge for SJMC patients identified with limited family support and resources.	☒	☒
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.	☒	☒
Goal and 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.			
Collaborators: Program partners are noted in the respective program summaries above.			

Health Need: Substance Abuse/Tobacco

Strategy or Program	Summary Description	Active FY22	Planned FY23
CA Bridge Program Opioid Grant	Provide medication assisted treatment with Buprenorphine to those struggling with opioid use disorder. Provide education to both the community and other healthcare providers regarding opioid use disorder and treatment options such as buprenorphine. Participate in the San Joaquin County Opioid Safety Coalition.	☒	☒
Goal and Impact: Decrease in opioid overdose deaths, increase prescriptions of Buprenorphine.			
Collaborators: 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	Summary Description	Active FY22	Planned FY23
Free Dental Clinic	Financial Support for St. Mary's Dining Room Dental Clinic. Provides free oral care for the uninsured.	☒	☒
Community Grants Program	Through a formal process, grants are administered annually to non-profit organizations that best demonstrate their ability to impact community health needs as they pertain to the most recent needs assessment. The following programs awarded funding in 2020 for November 1, 2020 through December 31, 2021 and are addressing oral health: ● Dentists Organized for Veterans (DOV) - Dental care for veterans who do not qualify for the VA. The formal grant process for calendar year 2023 will conclude at the end of 2022 and all projects will include one or more of the 2022 CHNA health needs.	☒	☒

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

Collaborators: 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, St. Mary's Dining Room, VA Palo Alto Health Care System, and VA Northern California Health Care System.

Health Need: Asthma

Strategy or Program	Summary Description	Active FY22	Planned FY23
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 2022 from January 1, 2022 through December 31, 2022 and are addressing Asthma: ● Little Manila Foundation (dba Little Manila Rising) – DAWN (Decreasing Asthma Within Neighborhoods) will mitigate asthma through in-home assessments, education, and referrals of families to both social and health care services.	☒	☒

	The formal grant process for calendar year 2023 will conclude at the end of 2022 and all projects will include one or more of the 2022 CHNA health needs.		
Goal and Impact: Improvement in asthma symptom days, decrease in school days missed, and reduction in acute health care visits (hospitalization, emergency room, unscheduled office visit).			
Collaborators: The hospital will partner with Little Manila Foundation and with their partners, San Joaquin County Clinics (SJCC), Health Plan of San Joaquin (HPSJ), Bulosan Center for Filipino Studies - UC Davis, and San Joaquin County Public Health (SJCPHS).			

Community Health Improvement 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 related to CHNA priorities.

In 2022, the hospital awarded the grants below totaling $298,449, in conjunction with St. Joseph's Behavioral Health Center. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Boys & Girls Clubs at Sierra Vista-Stockton	Triple Play: A Game Plan for the Mind, Body and Soul Program	$50,000
Black Urban Farmers Association-BUFA	Healthy Corner Store Project	$67,084
Little Manila Foundation (dba Little Manila Rising)	D.A.W.N. (Decreasing Asthma Within Neighborhoods) Asthma Mitigation Project	$81,365
The Edible Schoolyard Project Stockton	The Edible Schoolyard Project - Stockton	$100,000

Program Highlights

The following pages describe a sampling of programs and initiatives listed above in additional detail, illustrating the work undertaken to help address significant community health needs.

Friends of Seniors & Links Programs	
Significant Health Needs Addressed	• Mental Health • Economic Security • Access to Care
Program Description	This volunteer based program provides friendly visiting, transportation assistance, and resource and referral services to address basic needs for homebound seniors. The Links Project, piloted in Fall 2019, encourages seniors to utilize technology tools and social media to increase their independent living and reduce their feelings of stress, isolation, and depression.
Population Served	Low income, homebound seniors.
Program Goal / Anticipated Impact	Increase volunteer recruitment and retention in order to meet the growing needs of older adults experiencing limited social support. Improve access to care via transportation assistance, improve on feelings of stress and loneliness, and assist with level of safety and independence.
FY 2022 Report	
Activities Summary	Increase program volunteers in order to serve more seniors. Increase telephonic and in-person support. Increase access to care and food security. Increase independence and safety in place of residence and reduce feelings of isolation, loneliness, and depression.
Performance / Impact	In FY22, the pandemic continued to cease volunteer recruitment efforts to expand programming, and the existing volunteers increased their telephonic friendly visiting and social service support referrals with 540 total volunteer service hours from 17 volunteers, serving 52 of seniors
Hospital's Contribution / Program Expense	Total program expense was $32,026, which is 100% supported by St. Joseph's Medical Center's Operational Budget.
FY 2023 Plan	
Program Goal / Anticipated Impact	Increase program outreach and volunteer recruitment efforts. Establish comprehensive volunteer orientation to ensure program quality and ideal volunteer/senior matching. Update the annual survey to include an assessment of depression, and use completed surveys to evaluate if the program is meeting intended goals, as well as provide regular program oversight and interaction with program volunteers to ensure program effectiveness. Train and provide volunteers with access to the Unite Us platform for resource and referrals.
Planned Activities	Same as noted in the FY 2022 Report section of this digest.

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: ● Power Hour:1 hour, monthly educational workshop (FY 2023) ● Certified Diabetes Care Education Specialist (CDCES) Consultations: Free one-on-one, personalized diabetes education for populations who face significant barriers to better health. ● Diabetes Education Empowerment Program (DEEP): Comprehensive series of classes targeting individuals with diabetes and pre-diabetes. - 2 hours per week, 6 weeks program. ● Diabetes Navigator: Resource and referral service for patients and community members seeking health education and support. ● Sugar Fix: Led by a RN, Certified Diabetes Educator, this monthly diabetes support group offers multi-disciplinary professional presentations along with peer support.
Population Served	San Joaquin residents who are needing support with diabetes management or have pre-diabetes.
Program Goal / Anticipated Impact	● Certified Diabetes Care and Education Specialist Consultations – Increase knowledge of how to take medications, increase confidence in managing diabetes, reduce consumption of sugary beverages, and reduce A1C levels. ● DEEP – Increase knowledge of ways to handle stress, increase confidence with goal setting and asking for support, increase physical activity. ● Diabetes Navigator – Provide resource/referral services to individuals with diabetes regarding health education/support in order to better manage conditions. ● Sugar Fix Support Group – Increase knowledge of important health topics.
FY 2022 Report	
Activities Summary	● Education - Increase knowledge of medication, nutrition, A1C levels, importance of physical activity ● Provide referrals to diabetes education and support ● Provide referrals to address health related social needs ● Outreach to both clinical and community audiences
Performance / Impact	In FY22 SJMC had the following participation:

Diabetes Navigator: 289 Total referrals, 265 unduplicated persons. 136 (50%) of those persons interested or scheduled for 1:1 Certified Diabetes Care and Education Specialist (CDCES) consults and 129 (95%) of those completed consultations with the CDCES. Mailed out information packets to 70 persons. In the 6 months that the portal was active, 79 persons received health library resources. Average known AIC % at time of referral was 10.9.

DEEP: 72 Total Participants with 31 completing 4 of 6 sessions

- 16% Male; 84% Female
- 87% Hispanic; 3% Asian; 10% White
- 58% Spanish speaking; 42% English speaking
- 10% 30 years old and under; 19% 31-40 years old; 52% 41-50 years old; 13% 51-60 years old; 6% 60+ years old
- 58% reside in Stockton; 19% reside in Manteca; 13 reside in Modesto; 3% reside in Lathrop, Ceres and French Camp each

DEEP Survey Questions: 1 -10 rating scale to rate participant knowledge of class topics.	**Pre**	**Post**
The body's systems (i.e. nervous, cardiovascular, digestive, respiratory and urinary) and how they work.	5.2	**8.3**
The seven strategies, or things I can do, to help control diabetes.	5.4	**9.2**
What an A1C test measures and what is considered to be a safe value	4	**8.8**
What an ideal fasting blood glucose level is for me.	4.2	**9.1**
The symptoms of hyperglycemia and hypoglycemia.	3.4	**8.7**
My knowledge of the MyPlate method.	3.4	**9.1**
How long term hyperglycemia can damage the body's organs.	3.7	**9**
How medications for diabetes work on the body.	3.7	**9.3**

Certified Diabetes Care and Education Specialist Consultations: 131 Total Participants

- 64% Male; 36% Female
- 60% Hispanic; 13% Black; 11% White; 6% Asian; 10% Other
- 9% Under 30 years old; 18% 30-39 years old; 17% 40-49 years old; 25% 50-59 years old; 31% 60+ years old
- Needed assistance with: 40% Diet/Nutrition; 28% Medication; 14% Diabetes Overview; 11% Social Services (i.e. housing, transportation, food assistance, etc.); 7% Other

Certified Diabetes Care and Education Specialist Consult Survey Questions (1 -10 rating scale)	**Pre/Post 1st Consult**	**3 month Consult**
Level of confidence with managing diabetes?	4.6 / 5.7	7.9
Sufficient supplies to monitor blood sugar?	72% Yes	100% Yes
Using a daily log sheet?	44%Yes	84%Yes
Understanding how to take medications?	5 / 6.5	9
Last known HbA1c	10.9%	7/9%

Sugar Fix: 14 Total Participants; 50% attended 11 or more times; 21% attended 2-5 times.
Survey Data:

- I feel like I gained emotional support
  - 71% significant emotional support
  - 21% moderate
  - 8% no emotional support gained
- I feel like I gained knowledge from the group
  - 71% significant knowledge
  - 15% moderate
  - 7% some
  - 7% no new knowledge gained
- I feel confident in my abilities to control my diabetes
  - 50% extremely confident
  - 29% moderately confident
  - 21% some confidence

Hospital's Contribution / Program Expense	Total expense for all programs was $567,160, which is 100% supported by St. Joseph's Medical Center's Operational Budget.

FY 2023 Plan

Program Goal / Anticipated Impact	Same as noted in the FY 2022 Report section of this digest, and including the following impact of the Power Hour workshop: ● increased knowledge of health topics ● increased confidence in managing diabetes ● increased diabetes self-management skills
Planned Activities	Same as noted in the FY 2022 Report section of this digest, in addition to expanding social media outreach.

Homecoming Project

Significant Health Needs Addressed	● Mental Health ● Economic Security ● Obesity/Healthy Eating Active Living (HEAL)/Diabetes ● Violence/Injury Prevention ● Access to Care
Program Description	Safe hospital discharge for high risk individuals lacking family support. Case management services help to ensure compliance with discharge plans and a safe recovery in their place of residence. St. Joseph's Medical Center provides grant funding to Catholic Charities for this program.
Population Served	High risk patients with little to no family support upon discharge.
Program Goal / Anticipated Impact	Hospital to home transition of care management for high risk and underserved individuals. In partnership with Catholic Charities, patients receive 4-6 weeks of assistance to address their medical and social service needs to help ensure a successful recovery.

FY 2022 Report

Activities Summary	Accept referrals from the hospitals care coordination department to assess and enroll patients into the Homecoming services. Refer patients who accept services to Catholic Charities for case management services and monitor outcomes.
Performance / Impact	Care coordination referrals to community health for program assessments: 285 referrals; 275 unduplicated persons; 157 (55%) referred to Catholic Charities; 123 (45%) not enrolled in the program; and 5 (2%) individuals were pending as of June 30, 2022.

Reasons St Joseph's Medical Center Not Referred to Catholic Charities	**Total Persons** (of the 123 Not Referred)	**% of Persons**
Deceased	7	5.7%

Declined	7	5.7%
Discharged to SNF/Hospice/Other Medical Facility	41	33.3%
Has Support per Patient/Family	17	13.8%
Unable to Reach	37	30.1%
Waiting Discharge	7	5.7%
Wrong or Missing Contact Information	7	5.7%

Community health referrals to Catholic Charities
157 referred to Catholic Charities; 7 (4%) refused services; 11 (7%) unable to reach. Of the 139 persons enrolled, 22 were readmitted within 30 days. Did not meet the goal of maintaining a readmission rate under 15%. FY 2021-2022 readmissions were at 15.8%.

Service Type for 139 Enrolled Clients	Total Services Utilized	% of Services
House-Making	69	50%
Mental Health	12	9%
Transportation	101	73%
Rx Express	23	17%
DME	62	45%
Health Education	18	13%
Advance Directive/Palliative Care/POLST	96	69%
COVID Preventative Measures	139	100%
Home Modification (Grab bars, Ramps, Repairs, etc)	31	22%

Reasons Catholic Charities Referrals Were Not Enrolled in Homecoming Program	**Total Persons** (of the 18 Not Enrolled or Declined)	**% of Persons**
Deceased	1	5.6%

Declined	4	22.2%
Has Support per Patient/Family	5	27.8%
Non-Compliant	1	5.6%
Readmitted before Enrolled	1	5.6%
Unable to Reach	6	33.3%

Hospital's Contribution / Program Expense	Total expense for all programs was $125,151 which is 100% supported by St. Joseph's Medical Center's Operational Budget.
FY 2023 Plan	
Program Goal / Anticipated Impact	Continued and expanded outreach in both community and clinical settings to ensure that community residents take advantage of the no fee services.
Planned Activities	Same as noted in the FY 2022 Report section of this digest, and monitor the implementation and alignment of Cal-AIM Enhanced Care Management and Community Supports for older adults benefitting from Homecoming services..

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.
Population Served	Community at large.
Program Goal / Anticipated Impact	Increase understanding of the importance of regular cancer screenings for members of the community.
FY 2022 Report	
Activities Summary	Planning for outreach and screenings for when we are able to get back into the community, pandemic permitting.
Performance / Impact	Due to the pandemic, cancer outreach and screening events were canceled in FY 2021. Moreover, due to the challenges with computer knowledge and access within this subset of the community, virtual outreach and education was not considered to be an effective alternative strategy. However, general cancer awareness information was provided on a monthly basis through a Community Health e-newsletter to nearly 400 recipients.

Hospital's Contribution / Program Expense	Total expense for all programs was $9,766 which is 100% supported by St. Joseph's Medical Center's Operational Budget.
FY 2023 Plan	
Program Goal / Anticipated Impact	Expand cancer awareness outreach and screenings to additional at risk populations, such as Latino and African American residents.
Planned Activities	Breast cancer screenings events in partnership with Health Plan of San Joaquin and St. Joseph's Women's Imaging Center.

Graduate Medical Education (GME)

Significant Health Needs Addressed	• Mental Health • Access to Care
Program Description	Dignity Health is committed to workforce development, and SJMC is a leader in growing future medical providers in San Joaquin County. The GME program started in 2018 and below is a summary of the implemented and planned expansion of the program: • Family Medicine: 6 new residents each year x3 years (started 06/2018). Increased to 10 residents per year as of 06/2022 • Emergency Medicine: 9 new residents each year x3 years (started 06/2018). Increased to 12 residents per year as of 06/2022 • Internal Medicine: 10 new residents each year x3 years (started 06/2020) • Transitional Year: 10 new residents each year 1 year (started 06/2020). Increased to 16 residents per year as of 06/2022 • Anesthesia: 6 new residents each year x4 years (started 06/2021) • Psychiatry: 7 new residents each year x4 years (started 06/2021) • Urology: 2 new residents each year x5 years (started 06/2022) • Neurology: 4 new residents each year x4 years (started 06/2022) • Orthopedic Surgery: 3 new residents each year x5 years (to start 06/2023)
Population Served	Physicians, medical students, the patients they serve, and the broader community
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.
FY 2022 Report	
Activities Summary	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. Additionally, residents participate in a Community Engagement Program where they experience the provisioning of social services.
Performance / Impact	Graduated second class of Emergency Medicine Residents, Family Medicine Residents and Transitional Year Residents. Continued support of the Internal Medicine program. Successful launch ofAnesthesia program, Psychiatry program, Urology program, Neurology program, Interventional Radiology program and Orthopedic Surgery program.
Hospital's Contribution / Program Expense	Net expense after restricted offsetting revenue was $12,456,306 which is 100% supported by St. Joseph's Medical Center's Operational Budget. $12,456,30
FY 2023 Plan	
Program Goal / Anticipated Impact	Same as noted in the FY 2022 Report section of this digest.
Planned Activities	Same as noted in the FY 2022 Report section of this digest

Frontlines of Communities on the United States (FOCUS)

Significant Health Needs Addressed	• Access to Care
Program Description	This grant funded program integrates opt-out Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), and Syphilis testing services for eligible patients within the SJMC Emergency Department. Individuals testing positive are offered linkages to treatment and supportive services.
Population Served	Hospital patients encountered through the Emergency Room.
Program Goal / Anticipated Impact	Improve in the early detection and intervention of HIV,HCVand Syphilis to improve health and quality of life of patients.
FY 2022 Report	
Activities Summary	Strong collaboration with the emergency room leadership, laboratory, Clinical Informatics, as well as community partners to ensure automated and seamless workflows from patient testing, to linkage to treatment.
Performance / Impact	**July 1, 2021 through June 30, 2022**

Measurement Description	Total/Actual		
	HIV	HVC	Syphilis
# Tests Performed	14,407	25,139	29,564
# Positive Results	94	1,173	1,381

(Identified Through Testing)	76	394	596
Linked to Care	13	153	199
Already in Care	45	2	100
Unable to Reach for Follow up	3	94	146
Declined	1	0	5
Deceased	2	28	17
In Progress	10	117	159

Hospital's Contribution / Program Expense	Total expense for all programs was $258,393 which is 100% supported by St. Joseph's Medical Center's Operational Budget.

FY 2023 Plan

Program Goal / Anticipated Impact	Same as noted in the FY 2022 Report section of this digest.
Planned Activities	Same as noted in the FY 2022 Report section of this digest.

Mental Health First Aid

Significant Health Needs Addressed	• Mental Health • Access to Care
Program Description	Teaches how to identify, understand and respond to signs of mental illness and substance use disorders.
Population Served	• Employers • Police Officers • Hospital Staff • First Responders • Faith Leaders • Community Members • Caring Individuals • Social Service Providers
Program Goal / Anticipated Impact	Working with other community partners to improve the mental health of those who have experienced traumas and adverse childhood experiences (ACEs) through the education of the community and community providers.

FY 2022 Report

Activities Summary	• Recognize common signs and symptoms of mental illness. • Recognize the common signs and symptoms of substance use. • Learn how to interact with a person in crisis and connect them to help.

	• Expanded content on trauma, addiction and self-care
Performance / Impact	In FY22 SJMC had the following participation: **Adult Mental Health First Aid:** 84 Total Participants with 55 (65.5%) completing the course. • 23% Male; 58% Female; 8% Non-Binary/Genderqueer; 4% Two Spirit; 8% Undisclosed • 12% Hispanic; 15% Black; 15% White; 23% Asian; 8% American Indian or Alaskan Native; 12% Multi/Bi Racial; 15% Prefer not to Answer • 54% Under 30 years old; 23% 30-39 years old; 12% 40-49 years old; 12% 50+ years old

MHFA Survey Questions (1 - 5 rating)	Pre - Coursework	Post - Coursework
Describe the purpose of Adult MHFA and the role of the First Aiders.	3 Moderate - Have basic knowledge.	4 High - Consider myself very knowledgeable.
Recognize the signs and symptoms of mental health or substance use challenges that may impact adults:	3 Moderate - Have basic knowledge.	4 High - Consider myself very knowledgeable.
Explain ways in which a First Aider may cope with feelings of discomfort in providing MHFA:	3 Moderate - Have basic knowledge.	4 High - Consider myself very knowledgeable.

Hospital's Contribution / Program Expense	Total expense for all programs was $74,725 which is 100% supported by St. Joseph's Medical Center's Operational Budget.
FY 2023 Plan	
Program Goal / Anticipated Impact	Same as noted in the FY 2022 Report section of this digest.
Planned Activities	Same as noted in the FY 2022 Report section of this digest.

Community Health Advocate

Significant Health Needs Addressed	• Mental Health • Access to Care • Economic Security	• Obesity/Healthy Eating, Active Living/Diabetes • Violence/Injury Prevention

Program Description	Three-year pilot program focused on proactively supporting the community through a health related social needs screening. Started October of 2021. Initial phase includes manually identifying and screening alert and oriented emergency room patients, with the goal of automating the screening into the course of the visit.
Population Served	Segment of the St. Joseph's Medical Center Emergency Room and scaling up to all unit patients as well across other departments.
Program Goal / Anticipated Impact	Promote measures to help manage patient health, identify health risks, and improve access to care as well as connecting patients to other resources within the community according to their needs.
FY 2022 Report	
Activities Summary	The CHA screens emergency room patients for health related social needs, and makes community referrals to support any identified unmet needs that the patient would like assistance with. By using a closed loop referral system, the CHA is able to see the outcomes of the referrals.
Performance / Impact	**October 1, 2021 - June 30, 2022** **1,291 Unduplicated Persons**

Positive Screen Responses	#	%
Do problems getting child care make it difficult for you to work or study?	51	4%
How often do you feel alone?	353	27%
How often does anyone, including family and friends, threaten to harm or physically hurt you?	22	2%
How often does this describe you? I don't have enough money to pay my bills:	314	24%
In the last 12 months, the food that you bought just didn't last, and you didn't have money to get more.	409	32%
In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?	41	3%
In the past 12 months, how often did you go without health care because you didn't have a way to get there?	186	14%
In the past 12 months, how often did you skip medications to save money?	95	7%
Would you like to receive assistance with any of the above?	412	32%

Hospital's Contribution / Program Expense	Total expense for all programs was $43,913 which is 100% supported by St. Joseph's Medical Center's Operational Budget.
FY 2023 Plan	
Program Goal / Anticipated Impact	Same as noted in the FY 2022 Report section of this digest.
Planned Activities	Scale up the screening efforts, and identify methods to establish a universal screening algorithm.

Other Programs and Non-Quantifiable Benefits

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

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

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

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

- **Rural Community Assistance Corporation (RCAC):** In June 2017 Dignity Health approved a 7-year $500,000 loan to RCAC for projects in rural California, Nevada and Arizona. RCAC assists rural communities in building social capital, environmental infrastructure, and affordable housing. It also provides nonprofit organizations with access to financing. RCAC financing creates employment opportunities, affordable housing, safe and reliable environmental infrastructure, and much-needed community facilities and services. RCAC operates in rural California, Nevada and Arizona, and several other states west of the Rockies. In March 2021, CommonSpirit approved another $1,000,000 to RCAC to continue to support the organization's mission in rural areas.

- **Homeless Health Initiative:** Over $3 million has been invested in a multifaceted and collaborative approach to support persons experiencing homelessness..
    - 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 a

$722,650 contribution to support Town Center Studios (39 units, housing up to 41 previously homeless individuals)
    - Emergency Department Social Workers – 3 Full Time Employees (FTE's) dedicated to supporting patients experiencing homelessness, providing short term case management
    - Salvation Army Mobile Street Outreach – Funding to provide a mobile outreach team with a fully equipped office van to provide social service navigation and case management to those experiencing homelessness county-wide.

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

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

- **Connected Community Network (CCN):** The CCN seeks to create health equity in communities by bringing together multiple stakeholders and community-based organizations (CBOs) to connect community resources to underserved populations in need of vital services. As one of many funding partners of the CCN, SJMC supports the Community Bank Model led by the United Way of San Joaquin as the convener, to provide network sustainability and CBO capacity building.

- **Gospel Center Rescue Mission (GCRM):** Safe hospital discharge for those experiencing homelessness with medical conditions that could worsen if returned to the streets. Case management services help to ensure compliance with discharge plans and link individuals to resources for housing, employment, and other services to help them become self-sufficient. GCRM also converted some of their housing to specifically take homeless COVID positive patients that were able to be discharged from the hospital

Economic Value of Community Benefit

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

192 St. Joseph's Medical Center (Stockton)
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2021 through 6/30/2022

	Persons	Expense	Offsetting Revenue	Net Benefit	% of Expenses
Benefits For Poor					
Financial Assistance	**15,877**	**8,168,562**	**0**	**8,168,562**	**1.3%**
Medicaid	**61,374**	**202,703,587**	**153,433,561**	**49,270,026**	**7.6%**
Community Services					
A - Community Health Improvement Services	5,071	1,304,295	230,986	1,073,309	0.2%
E - Cash and In-Kind Contributions	1,800	490,318	0	490,318	0.1%
F - Community Building Activities	0	32,026	0	32,026	0.0%
G - Community Benefit Operations	27	476,644	0	476,644	0.1%
Totals for Community Services	**6,898**	**2,303,283**	**230,986**	**2,072,297**	**0.3%**
Totals for Poor	**84,149**	**213,175,432**	**153,664,547**	**59,510,885**	**9.2%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	2,696	2,534,714	330,262	2,204,452	0.3%
B - Health Professions Education	459	20,564,934	6,649,544	13,915,390	2.1%
D - Research	0	242,787	27,974	214,813	0.0%
E - Cash and In-Kind Contributions	0	115,961	0	115,961	0.0%
F - Community Building Activities	635	43,913	0	43,913	0.0%
Totals for Community Services	**3,790**	**23,502,309**	**7,007,780**	**16,494,529**	**2.5%**
Totals for Broader Community	**3,790**	**23,502,309**	**7,007,780**	**16,494,529**	**2.5%**
Totals - Community Benefit	**87,939**	**236,677,741**	**160,672,327**	**76,005,414**	**11.7%**
Medicare	**22,048**	**116,472,718**	**103,244,223**	**13,228,495**	**2.0%**
Totals with Medicare	**109,987**	**353,150,459**	**263,916,550**	**89,233,909**	**13.8%**

Hospital Board and Committee Rosters

Port City Board Managers

Marty J. Ardon	Senior Vice President for Health Plan and Hospital Operations, Northern California, Kaiser Permanente
Debra Cunningham	Senior Vice President, Strategy Kaiser Permanente
Aphriekah Duhaney	West Vice President/Area Manager, Central Valley Kaiser Permanente
Sue Pietrafeso	Division Chief Strategy Officer, CommonSpirit/Dignity Health
John Petersdorf	Vice Chair SVP Operational Effectiveness, Dignity Health
Julie Sprengel	Senior Vice President Operations Southern Calif. Division, CommonSpirit Health/Dignity Health

Community Grants Committee

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