Dignity Health
St. Joseph's Medical Center

St. Joseph's Medical Center

Community Health Implementation Strategy 2016-2018

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EXECUTIVE SUMMARY

St. Joseph's Medical Center primarily serves Stockton, California with a secondary service area of San Joaquin County. This community has great potential and also has great challenges. The community has strength in its diversity, agricultural heritage and geographic location. However, there are also great needs with nearly a fifth of the residents of Stockton (19.4%) living below the poverty line. There is a large immigrant population in the area with twenty-three percent of people who were born in another country and nearly forty percent who speak a language other than English at home. Primary languages include Spanish, Hmong, Khmer (Cambodian), and Vietnamese. In several of the low-income neighborhoods violence is a major concern. In addition many residents do not have a safe and affordable housing, nearly a quarter of adults in San Joaquin County do not have a high school diploma, and the unemployment rate is over ten percent across the county.

The disproportionate health needs of the Stockton area are perhaps best reflected in the Community Needs Index score. The Community Needs Index (CNI), developed in 2005 by Dignity Health, accounts for the underlying economic and structural barriers that affect overall health. Using a combination of research, literature, and experiential evidence, Dignity Health identified five prominent barriers for health care access: income, culture/language, education, insurance, and housing. A score of 1.0 indicates a zip code with the lowest socio-economic barriers, while a score of 5.0 represents a zip code with the most socio-economic barriers. The median CNI score for the service area of St. Joseph's Medical Center is 4.8.

The significant community health needs that form the basis of this report and plan were identified in the hospital's most recent Community Health Needs Assessment (CHNA), which is publicly available at http://dignityhealth.org/stjosephs-stockton/. Additional detail about identified needs, data collected, community input obtained, and prioritization methods used can be found in the CHNA report.

The significant community health needs identified are:

1. Obesity/ Diabetes
2. Education
3. Youth Development
4. Economic Security
5. Violence and Injury
6. Substance Use
7. Access to Housing
8. Access to Care
9. Mental Health
10. Oral Health
11. Asthma/ Air Quality

For FY17-19, the hospital plans to continue the existing programs and add two new programs:

- Healing South Stockton – providing mental health services in low income neighborhoods
- Smart Moves - Childhood Obesity intervention

The economic value of community benefit provided by St. Joseph's Medical Center in FY16 was $43,982,399, excluding unpaid costs of Medicare. With Medicare included, community benefit was $57,460,753. Details are in the Economic Value of Community Benefit section of this report.

St. Joseph's Medical Center maintains its strong, mission-based commitment to caring for Medi-Cal enrollees and all members of the community. The hospital served 65,292 Medi-Cal patients in FY16, compared to 77,733 in FY15, a 19 percent decrease.

This report and plan is publicly available at http://dignityhealth.org/stjosephs-stockton/. The 2013 and 2016 Community Health Needs Assessment executive summaries and full reports are available on this website as well as on a public website that is owned collectively by the local collaborative that conducts the Community Health Needs Assessment, www.healthiersanjoaquin.org. Executive summaries of the Community Health Needs Assessment will be published and distributed broadly to community groups and at public events.

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

MISSION, VISION AND VALUES

Our Mission

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

Our Vision

A vibrant, national health care system known for service, chosen for clinical excellence, standing in partnership with patients, employees, and physicians to improve the health of all communities served.

Our Values

Dignity Health is committed to providing high-quality, affordable healthcare to the communities we serve. Above all else we value:

Dignity - Respecting the inherent value and worth of each person.

Collaboration - Working together with people who support common values and vision to achieve shared goals.

Justice - Advocating for social change and acting in ways that promote respect for all persons.

Stewardship - Cultivating the resources entrusted to us to promote healing and wholeness.

Excellence - Exceeding expectations through teamwork and innovation.

Hello humankindness

After more than a century of experience, we've learned that modern medicine is more effective when it's delivered with compassion. Stress levels go down. People heal faster. They have more confidence in their health care professionals. We are successful because we know that the word "care" is what makes health care work. At Dignity Health, we unleash the healing power of humanity through the work we do every day, in the hospital and in the community.

Hello humankindness tells people what we stand for: health care with humanity at its core. Through our common humanity as a healing tool, we can make a true difference, one person at a time.

OUR HOSPITAL AND OUR COMMITMENT

St. Joseph's Medical Center is nationally recognized as a quality leader and consistently chosen as the "most preferred hospital" by local consumers. With 366 beds it is the largest hospital in Stockton, California and serves as a regional hospital specializing in cardiovascular care, comprehensive cancer services, and women and children's services, including neonatal intensive care. With more than 2,000 employees, St. Joseph's is also the largest private employer in Stockton. St. Joseph's Medical Center celebrates a history of 116 years of service to the community and is a part of Dignity Health, a not-for-profit network of hospitals and health services providing an extensive continuum of care throughout the western United States.

Rooted in Dignity Health's mission, vision, and values, St. Joseph's Medical Center is dedicated to delivering community benefit with the engagement of its management team and board, and in collaboration with the Healthier Community Coalition. The Healthier Community Coalition is composed of community members who provide input to the management team for stewardship and direction of the hospital as a community resource.

The Healthier Community Coalition is a robust consortium of all the local hospitals, the Medi-Cal managed care plans, the county public health department, and numerous community based organizations. The coalition has shared governance by all members, the chair position rotates annually, and St. Joseph's Medical Center serves as the fiscal sponsor. In 2015 St. Joseph's Medical Center's Director of Community Health served as the chair person. The Healthier Community Coalition provides continuous input on the community benefit work of the hospital. This coalition meets monthly to discuss community needs, revise strategies and programs to respond to changing needs, and monitor progress toward goals. It represents the community's needs, oversees and adopts the Community Health Needs Assessment, ranks the priority of community needs, develops a community action plan/strategy, creates programs to intervene in priority areas, and monitors programs that are developed. Feedback from the Healthier Community Coalition is provided to the hospital management to inform decisions regarding the hospital's community benefit strategies, and the board approves the implementation plan. Appendix A lists a roster of the board and the members of the Healthier Community Coalition, with affiliations. Key staff positions dedicated to planning and carrying out the community benefit program include the following:

- Director of Community Health – oversees the hospital's community benefit programs and is the primary link with the Healthier Community Coalition and other partnerships in the community
- Front Line Supervisor – manages the CareVan mobile unit and health education programs
- Community Benefit Specialist – monitors community benefit finances and programs
- Outreach and Engagement staff – five full-time Community Health Education Coordinators, one Certified Diabetes Educator (RN), one LVN, and a part-time driver

Employees are also actively involved with community benefit activities including volunteering for numerous charitable organizations and events. Through St. Joseph's employee philanthropic organization, the Spirit Club, fundraising and volunteerism has assisted local organizations with donations of holiday meals, school supplies, holiday gifts, books and clothing.

Community Benefit is linked to the hospital's overall planning process and is incorporated into the strategic plan. In addition the Director of Community Health meets regularly with the Executive Management Team regarding evolving needs, new initiatives and program outcomes. Community Benefit work is also incorporated in the hospital's quality improvement process, including an annual report to the Integrated Quality Committee.

St. Joseph's Medical Center's community benefit program includes financial assistance provided to those who are unable to pay the cost of medically necessary care, unreimbursed costs of Medicaid, subsidized health services that meet a community need, community health improvement services, as well as health professions education and research. Our community benefit also includes monetary grants provided to not-for-profit organizations that are working together to improve health on significant needs identified in our Community Health Needs Assessment. Many of these programs and initiatives are described in this report.

In addition we are investing in community capacity to improve health – including by addressing the social determinants of health – through Dignity Health's Community Investment Program. In Stockton the program provides a $500,000 loan to a community-based organization for the purchase and rehabilitation of foreclosed homes in high need neighborhoods. This work by the group called Stocktonians Taking Action to Neutralize Drugs (STAND) is eliminating the havens for drug activity while simultaneously providing houses to low and moderate income families.

DESCRIPTION OF THE COMMUNITY SERVED

St. Joseph's Medical Center serves Stockton as its primary service area and San Joaquin County as the hospital's secondary service area. A summary description of the community is below, and additional community facts and details can be found in the CHNA report online.

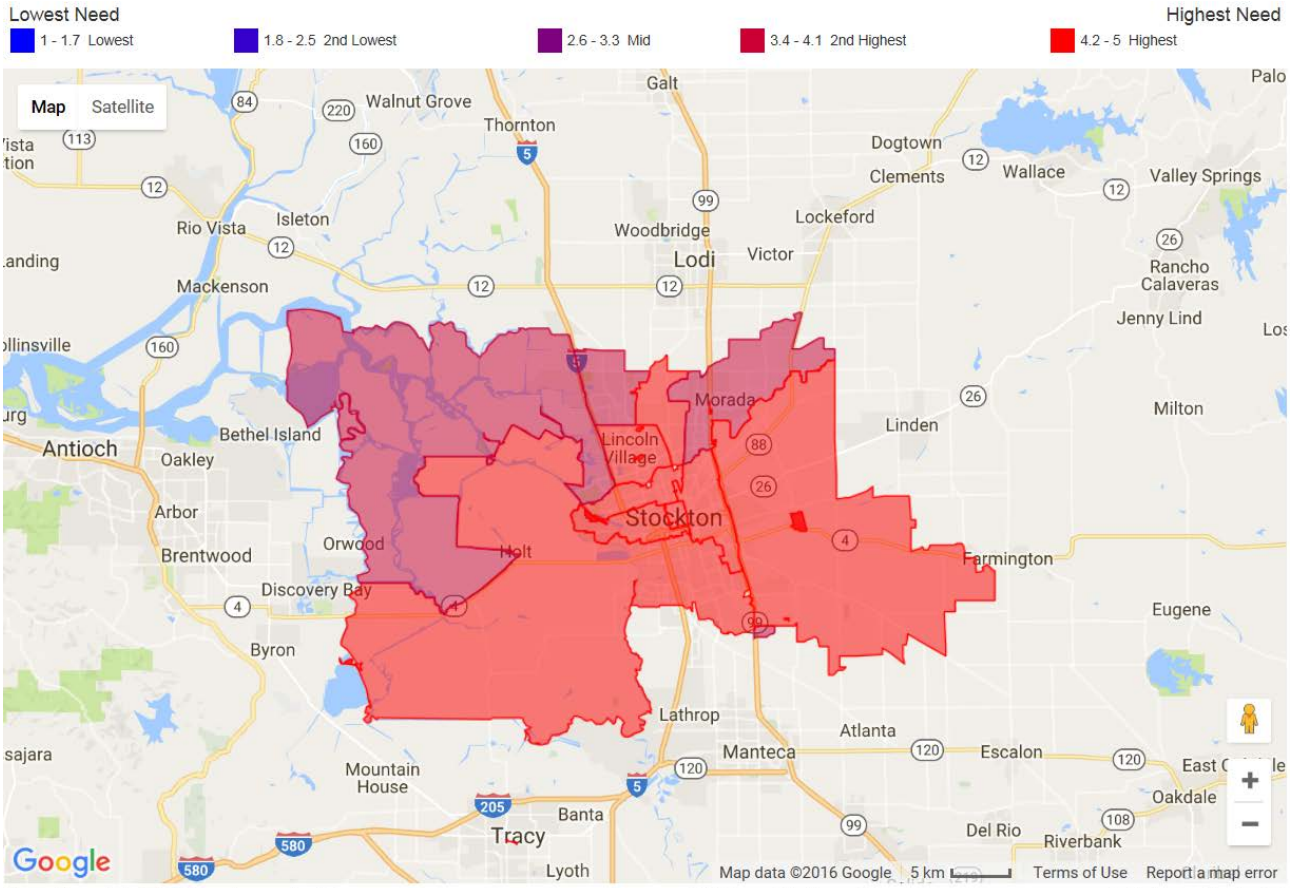
The service area of St. Joseph's Medical Center, San Joaquin County, lies in the midst of one of the most successful agricultural areas of the world, and at the same time is home to one of the largest cities in America to file for bankruptcy. The county is celebrated for its diverse communities of Latinos and African Americans as well as Asian immigrants; but there is also a big gap in health outcomes between ethnic groups. Some parts of the county have robust commuter neighborhoods with linkage to jobs in nearby counties, while other areas struggle with some of the highest homicide rates in the nation. There are some unique challenges such as access to care for the large undocumented immigrant population, the great need for substance use disorder treatment, and the high rates of asthma in the Central Valley. San Joaquin County also struggles with the same issues that are seen across the state or nationally such as rising obesity, poor oral health, and high rates of mental illness; but these issues are compounded by underlying social determinants of health including education, economic security and affordable housing. It is a county of contrasts, holding in one hand enormous challenges and in the other hand exciting new opportunities. The direction that is taken now to address these various needs will determine the future of the 726,000 residents who make San Joaquin County their home.

San Joaquin County faces many of the same challenges seen throughout the state, but often to a greater degree. In the County Health Rankings report San Joaquin County ranks as 41 out of 57 counties on overall health outcomes. On average, San Joaquin residents rate their health as poorer than the state overall and Stockton has some of the poorest health outcomes. Below is some data from Stockton.

Total Population	373,238
Race	
White	23.6%
Black/ African American	9.2%
Hispanic or Latino	45.3%
Asian/ Pacific Islander	17.8%
All Others	4.1%
Median Income	$46,770
Unemployment	9.8%
No High School Diploma	26.2%
Medicaid *	37.4%
Uninsured	9.4%

* Does not include individuals dually-eligible for Medicaid and Medicare

Source: 2016 The Nielsen Company, 2016 Truven Health Analytics, Inc.



Mean(zipcode): 4.4 / Mean(person): 4.4 CNI Score Median: 4.8 CNI Score Mode: 4.8

Zip Code	CNI Score	Population	City	County	State
95202	5	6602	Stockton	San Joaquin	California
95203	4.8	16117	Stockton	San Joaquin	California
95204	4.4	28240	Stockton	San Joaquin	California
95205	5	39165	Stockton	San Joaquin	California
95206	4.8	69151	Stockton	San Joaquin	California
95207	4.6	48170	Stockton	San Joaquin	California
95209	3.4	41804	Stockton	San Joaquin	California
95210	5	40673	Stockton	San Joaquin	California
95212	3.6	28892	Stockton	San Joaquin	California
95215	4.8	23709	Stockton	San Joaquin	California
95219	3.4	30715	Stockton	San Joaquin	California

One tool used to assess health need is the Community Need Index (CNI), created and made publicly available by Dignity Health and Truven Health Analytics. 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. The median CNI score for the service area of St. Joseph's Medical Center is 4.8. 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.

IMPLEMENTATION STRATEGY DEVELOPMENT PROCESS

The hospital engages in multiple activities to conduct its community benefit and 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; using five core principles to guide planning and program decisions; measuring and tracking program indicators; and engaging the Port City Board of Managers, the Healthier Community Coalition and other stakeholders in the development of the annual community benefit plan and triennial Implementation Strategy.

Community Health Needs Assessment Process

The Community Health Needs Assessment (CHNA) is a collaborative process that provides a deep exploration of health in San Joaquin County, updating and building upon work done in prior years. The most recent CHNA was approved by St. Joseph's Medical Center board in May 2016.

The San Joaquin County CHNA was a collaborative effort that included San Joaquin's nonprofit hospitals and San Joaquin County Public Health Services, as well as many partner organizations and individuals throughout the county. The process was guided by a Steering Committee that supported and provided input along the way, and was led by a Core Planning Group that was responsible for planning and key decision-making, including providing substantial assistance in developing the data collection instruments, working alongside consultants to collect and analyze data, and ultimately producing the report.

Core Planning Group Members

- Community Medical Centers
- Community Partnership for Families of San Joaquin
- Dameron Hospital Association
- Dignity Health—St. Joseph's Medical Center
- First 5 San Joaquin
- Health Net
- Health Plan of San Joaquin
- Kaiser Permanente
- San Joaquin County Public Health Services
- Sutter Tracy Community Hospital

Guided by the understanding that health encompasses more than disease or illness, the 2016 CHNA process placed emphasis on the social, environmental, and economic factors—"social determinants"—that impact health. Thus, the CHNA process identified top health needs by analyzing a broad range of

social, economic, environmental, behavioral, and clinical care factors that may act as contributing factors to each health issue.

This assessment also explored the impact of identified health issues among vulnerable populations that disproportionately have poorer health outcomes across multiple health needs. These populations may be residents of particular geographic areas, or may represent particular ethnic, income, or age groups. In striving towards health equity, strong emphasis was placed on the needs of these high-risk populations.

In order to identify health needs, the Core Planning Group utilized a mixed-methods approach, examining existing data sources (secondary data), as well as key informant interviews, focus group discussions and a survey of residents (primary data). The Core Planning Group and consulting team reviewed secondary data and compiled additional data from national, statewide, and local sources to provide a more complete picture of health in San Joaquin County. These data were compared to benchmark data and analyzed to identify potential areas of need. In addition examples of existing resources that work to address those needs, and suggestions for continued progress in improving these issues was obtained. The analyzed quantitative and qualitative data were triangulated to identify the top health needs in the county. A summary health need profile was then created for each of these.

Once these health needs were identified, a larger group of community stakeholders met to discuss the health need profiles and reached consensus as to which of the health needs should be a priority for action. This prioritization was based on criteria identified by the Core Planning Group.

A major focus of the CHNA was to ensure input from persons who represent the broad interests of the community. This included the local public health department and other local government officials as well as members of the medically underserved, low-income families, and minority populations. This was done through 34 key informant interviews, 27 focus groups, and 2,927 resident surveys. In addition, representatives from all of these groups participated on the Steering Committee to guide the CHNA process.

The hospital identified community and hospital resources potentially available to address identified needs, including any community input to do so. These can be found in the CHNA report. To date no public comments have been received regarding the CHNA or the annual report from 2015. A complete CHNA report is publicly available at: http://dignityhealth.org/stjosephs-stockton/. This report will be published and distributed widely with the community.

CHNA Significant Health Needs

The secondary data were compared to a benchmark estimate, in most cases the California state estimate. It was considered to indicate concern if the San Joaquin County estimate was poorer by at least 1% when compared to the benchmark estimate. Additionally, content analysis was used to analyze key themes in both the Key Informant Interviews and Focus Groups.

Potential health needs were included in the prioritization process if:

a. Multiple distinct indicators reviewed in secondary data demonstrated that the county estimate was poorer by more than 1% when compared to the benchmark estimate (in most cases, California state average).
b. Health issue was identified as a key theme in at least five interviews.
c. Health issue was identified as one of the top three health issues, health behaviors, or social and economic issues by at least 20% of survey respondents.

If a health need was mentioned overwhelmingly in interviews but did not meet criteria related to secondary data, the analysis team conducted an additional search of secondary data to confirm that all valid and reliable data concurred with the initial secondary data finding and to examine whether indicators for the health need disproportionately impact specific geographic, age, or racial/ethnic subpopulations. However, no potential health need was identified to move forward for discussion and prioritization by the Steering Committee unless it was confirmed by both secondary and primary data.

Harder+Company summarized the results of this analysis in a matrix which was then reviewed and discussed by the Core Planning Group.

Eighteen health needs were identified that met the first criterion of having a high secondary data score. Only 12 of these health needs met the additional criteria of being identified as a theme in key leader interviews or focus groups. Of these, the salient theme related to Climate and Health was poor air quality. For this reason, the Core Planning Group decided not to include Climate and Health as an identified health need, but rather to capture data about poor air quality data with data about Asthma and COPD. As such, the final prioritized list reflects 11 distinct health needs.

Process and Criteria Used for Prioritization of the Health Needs

The Criteria Weighting Method, a mathematical process whereby participants establish criteria and assign a priority ranking to issues based on how they measure against the criteria, was used to prioritize the 11 health needs. This enabled consideration of each health need from different facets, and allowed the Core Planning Group to weight certain criteria to use a multiplier effect in the final score.

Additionally, while the calculated values provide an overall priority score to help indicate which health needs are the highest priorities, the results are not intended to dictate the final policy decision, but offer a means by which choices can be ordered.[1]

To determine the scoring criteria, the Core Planning Group reviewed a list of potential criteria and selected a total of four:

[1] www.cdc.gov/od/ocphp/nphpsp/documents/Prioritization.pdf

Criteria	Definition
Severity	The health need has serious consequences (morbidity, mortality, and/or economic burden) for those affected.
Disparities	The health need disproportionately impacts specific geographic, age, gender, or racial/ethnic subpopulations.
Impact	Solution could impact multiple problems. Addressing this problem would impact multiple health issues.
Prevention	Effective and feasible prevention is possible. There is an opportunity to intervene at the community level and impact overall health outcomes. Prevention efforts include those that target individuals, communities, and policies.

In order to develop a weighted formula to use in prioritization, each member of the Core Planning Group assigned a weight to each criterion between 1 and 5. A weight of 1 indicated the criterion is not that important in prioritizing health issues whereas a weight of 5 indicated the criterion is extremely important in prioritizing health issues. The average of weights assigned by members of the Core Planning Group for each criterion were used to develop the formula below to use in scoring health needs for prioritization.

Overall Score = (1.5*Severity) + (1.5*Disparities) + (1.4*Impact) + (1.3*Prevention)

The Steering Committee with additional hospital representatives was convened on November 12, 2015, to review the health needs identified, discuss the key findings from CHNA, and prioritize top health issues that need to be addressed in the County. A total of 45 participants attended this half-day session.

In descending priority order, established per the rating at the end of the half-day Steering Committee convening, these priority health needs have been identified in San Joaquin County. It was also the consensus of the group that the order should not be used to discount the importance of any of the 11 problems discussed since the differences were so slight. All 11 of the health needs will be considered in the subsequent Community Health Improvement Plan (CHIP). As a key component of the Community Health Needs Assessment, the Health Profiles were created as a separate document to easily access key data elements and provide a comprehensive assessment of each priority health need.

The following health needs have been identified as priorities in San Joaquin County.

Obesity and Diabetes: Overweight and obesity are strongly related to stroke, heart disease, some cancers, and type 2 diabetes. These chronic diseases represent leading causes of death nationwide, as well as among residents of San Joaquin County. Diabetes is of particular concern as San Joaquin County has one of the highest rates in California for diabetes mortality.

Education: There is an important relationship between education and health. People with limited education tend to have much higher rates of disease and disability, whereas people with more education are likely to live longer, practice healthy behaviors, and experience better health outcomes for themselves and their children.[2] In San Joaquin County, graduation rates are lower than the California state average, as is reading proficiency among third graders.

Youth Growth and Development: Primary and secondary data indicate that youth development tends to be undermined by trauma and violence, unhealthy family functioning, exposure to negative institutional environments and practices, and insufficient access to positive youth activities, among other things. In San Joaquin County, the disparate levels of exposure to these risk factors contribute to outcome disparities during youth and throughout adulthood. This includes disparities by race, ethnicity, gender, sexual orientation, and income, with respect to outcomes such as juvenile justice involvement, foster placement, adult incarceration, educational attainment, and chronic disease.

Economic Security: Economic security is very strongly linked to health; it can impact access to healthy food, medical care, education and safe environments.[3] Poverty and unemployment are higher in San Joaquin County than California as a whole. Concerns surrounding economic security were particularly important to community members, who highlighted the need for jobs that pay a living wage and the ability to afford descent and safe housing.

Violence and Injury: San Joaquin County's injury rates remain substantially higher than the California averages. Among unintentional injuries, the leading causes of death in San Joaquin County are poisoning, motor vehicle crashes, falls, and drowning/submersion. Among intentional injuries, core concerns are often associated with family and community violence. The homicide rate is much higher than California as a whole, particularly among men of color. Human trafficking was also noted as a growing concern by interviewees. Survey respondents identified violence as a core issue in their communities and cited concerns such as gun violence, gang activity among youth, and domestic violence as key themes.

Substance Use: San Joaquin County's rate of drug-induced deaths is 56% higher than average rate across California (17.3 per 100,000 compared to 11.1 per 100,000). Primary data collection from surveys, focus group discussions and interviews highlighted the importance of this issue for the county; 41.1% of community survey respondents report that drug abuse is among the most concerning health behaviors in their community.

Access to Housing: Primary and secondary data indicate that access to safe and affordable housing is an important health concern in San Joaquin County, reflective of the rapid rise of housing costs occurring

[2] "Exploring the Social Determinants of Health: Education and Health," Robert Wood Johnson Foundation, Accessed October 19, 2015, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70447.
[3] "Health & Poverty," Institute for Research on Poverty, Accessed October 19, 2015, http://www.irp.wisc.edu/research/health.htm.

in California overall in recent years. In San Joaquin County, the foreclosure crisis, limited subsidized housing, rising rents, absentee landlords, and deteriorating housing stock are all significant contributing factors to the lack of safe and affordable housing.

Access to Medical Care: San Joaquin County has been successful in enrolling residents in Expanded Medi-Cal under the Affordable Care Act (ACA); however, learning how to use services, retention of coverage, and the shortage of primary care providers that will accept new Medi-Cal patients remain challenges. The fact that the County's many undocumented adult residents are without insurance also remains a barrier to care.

Mental Health: Mental health was a key concern among surveyed community members. Interviewees noted that the psychology of poverty, including living day-to-day and struggling to provide basic needs, can negatively impact one's ability to make long-term plans, and can interfere with parenting abilities. In addition, poor mental health frequently co-occurs with substance use disorders. Youth, notably foster youth and lesbian, gay, bisexual, transgender and queer and/or questioning (LGBTQ) youth, and residents experiencing homelessness, were noted as particularly high risk populations for mental health concerns.

Oral Health: Secondary data indicate that oral health outcomes are worse in San Joaquin County than in other parts of California, particularly among children. Access to oral health services is a concern in all age groups, marked by limited dental visits and difficulty finding affordable and nearby care.

Asthma/Air Quality: Asthma and breathing problems are a health need in San Joaquin County, as marked by high prevalence of asthma in adults and youth. In particular, asthma disproportionately impacts non-Hispanic Blacks. The percentage of days exceeding Fine Particulate Matter (PM 2.5) standards is high throughout the county and affects breathing and lung health for all residents.

The hospital will be addressing the majority of these needs either through direct programming, financial support for community partners, or participation in community collaborative efforts. The only health needs that will not be addressed by the hospital at this time are education, youth development, economic security, and asthma/air quality. The hospital will be addressing obesity/diabetes, violence and injury, substance use, access to housing, access to care, mental health, and oral health. As these are newly identified priority health needs, the hospital will be identifying best practices, current gaps, and opportunities for involvement. These additional areas may be addressed in future years.

Creating the Implementation Strategy

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

- **Focus on Disproportionate Unmet Health-Related Needs**: Seek to address the needs of communities with disproportionate unmet health-related needs.
- **Emphasize Prevention**: Address the underlying causes of persistent health problems through health promotion, disease prevention, and health protection.
- **Contribute to a Seamless Continuum of Care**: Emphasize evidence-based approaches by establishing operational linkages between clinical services and community health improvement activities.
- **Build Community Capacity**: Target charitable resources to mobilize and build the capacity of existing community assets.
- **Demonstrate Collaboration**: Work together with community stakeholders on community health needs assessments, health improvement program planning and delivery to address significant health needs.

The process used to identify, select and design the programs and initiatives described in the Implementation Strategy was done in collaboration with the Healthier Community Coalition as part of the Community Health Improvement Plan. The CHNA Core Planning Group provided guidance for the process that was led by Harder+Company consulting group. Participants included healthcare leaders from across the community, St. Joseph's Medical Center management, CHNA stakeholders, county public health, and community members. Community input was obtained at a series of community Healthier Community Coalition meetings to develop the Community Health Improvement Plan. Programs and initiatives were selected to address identified needs based on the following criteria:

- Evidence-based or promising practice
- Aligned with ongoing community efforts
- Feasible to make progress within 5 years
- Measurable via an objective and an indicator in the Community Health Needs Assessment

Planning for the Uninsured/Underinsured Patient Population

St. Joseph's Medical Center seeks to deliver compassionate, high quality, affordable health care and to advocate for those who are poor and disenfranchised. In furtherance of this mission, the hospital offers financial assistance to eligible patients who may not have the financial 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 hospital's Financial Assistance Policy is in Appendix C. The amount of financial assistance provided in FY16 is listed in the Economic Value of Community Benefit section of this report.

St. Joseph's Medical Center notifies and informs patients about the Financial Assistance Policy by offering a paper copy of the plain language summary of the Policy to patients as part of the intake or discharge process. At the time of billing, each patient is offered a conspicuous written notice containing information about the availability of the Policy.

Notice of the financial assistance program is posted in locations visible to the public, including the emergency department, billing office, admissions office, and other areas reasonably calculated to reach people who are most likely to require financial assistance from the hospital. The hospital provides brochures explaining the financial assistance program in registration, admitting, emergency and urgent care areas, and in patient financial services offices.

The Financial Assistance Policy, the Financial Assistance Application, and plain language summary of the Policy are widely available on the hospital's web site, and paper copies are available upon request and without charge, both by mail and in public locations of the hospital. Written notices, posted signs and brochures are printed and available online in appropriate languages.

Bi-lingual signage that addresses the hospital's Patient Payment Assistance Program is posted in key areas of the hospital facility. Payment Assistance information can be found at http://www.dignityhealth.org/stjosephs-stockton/patients-and-visitors/patients/billing-information/payment-assistance. In FY 2016 the hospital spent over $36 million in providing care for underserved individuals (unreimbursed costs of providing care to Medicaid and uninsured populations).

2016-2018 IMPLEMENTATION STRATEGY

This section presents strategies, programs and initiatives the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years. It includes summary descriptions, anticipated impacts, planned collaboration, and detailed "program digests" on select initiatives.

The strategy and plan 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 hospital will be addressing the majority of these needs either through direct programming, financial support for community partners, or participation in community collaborative efforts. The hospital will be addressing obesity/diabetes, violence and injury, substance use, access to housing, access to care, mental health, and oral health. The identified health needs that will not be addressed by the hospital at this time are education, youth development, economic security, and asthma/air quality. The hospital has limited resources to address every identified need, and some of these needs are outside the scope of a hospital's core capability. As these are newly identified priority health needs, the hospital will consider

best practices, current gaps, and opportunities for involvement, and may address them, potentially with or through partner organizations, in future years.

STRATEGY AND PROGRAM PLAN SUMMARY

Obesity/Diabetes

- Diabetes Education Program*: community classes in English, Spanish, and Hmong
- Chronic Disease Self-Management Program*: workshops in English and Spanish
- Faith Community Nurse Program*: outreach and health education in faith-based community groups
- Community Health Connectors* - training local residents to provide healthcare navigation, health education, and community organizing for health promotion in the language, culture and context of their faith-based community or neighborhood

Violence and Injury

-Healing South Stockton*: Initiation and leadership of the program to bring mental health services into low-income neighborhoods.

Substance Use

- Frequent User Initiative*: intensive out-patient case management services to assist patients with complicated psycho-social needs

Access to Housing

- Frequent User Initiative*: interim housing for program participants who are homeless

Access to Care

- Financial assistance for uninsured/underinsured and low income residents*: The hospital provides discounted and free health care to qualified individuals, following Dignity Health's Financial Assistance Policy.
- CareVan*: Mobile medical unit providing free medical care for the uninsured
- Dobbins Program for Breast Health Services*: free breast cancer screening services for women under 40 years old
- St. Mary's Dining Room - Virgil Gianelli Medical Clinic*: providing free medical services to the homeless, uninsured, migrant workers and other low-income populations
- Friends of Seniors Program*: providing friendly visiting, transportation and volunteer assistance to seniors to enable them to maintain independent living
- Homecoming Project*: providing transitional care services and transportation to seniors and others with limited support

- Special Needs Caregiver Program*: hospital based program to coordinate care and resources for patients with developmental disabilities or other special needs
- Human Trafficking Initiative*: Implementation of screening process in hospital to identify victims of human trafficking; community education; and coordinating community volunteer efforts
- Homeless Medical Respite Care Program* - interim shelter and services for homeless individuals recovering from an illness or injury
- Culturally Competent Care*: Training for healthcare personnel regarding special populations in the service area
- Community Health Connectors: training local residents to provide healthcare navigation, health education, and community organizing for health promotion in the language, culture and context of their faith-based community or neighborhood
- Emergency Department Patient Navigator Program*: assist patients in establishing a medical home for primary care and preventive services

Mental Health

- Frequent User Initiative*: intensive out-patient case management services to assist patients with complicated psycho-social needs
- Friends of Seniors*: providing friendly visiting, transportation, and volunteer assistance to seniors to enable them to maintain independent living

Oral Health

- St. Mary's Dining Room - St. Raphael's Dental Clinic*: providing free dental services to the homeless, uninsured, migrant workers and other low-income populations

Community Grants Addressing Significant Needs

- Dignity Health Community Grants Program*
    - Catholic Charities of the Diocese of Stockton: Community Health Connector Program
    - St. Mary's Dining Room: Providing mental health services at homeless shelter and service center
    - Homeless Medical Recuperative Care program: post-hospital residential program for homeless patients who are medically cleared for discharge to home and can benefit from a supportive home-like environment for up to 30 days

New Initiatives for FY 2016

- Healing South Stockton initiative to bring mental health services into low-income neighborhoods.
- Smart Moves program to address Childhood Obesity by providing intervention for children ages 9-15.

Anticipated Impact

The anticipated impacts of specific, major program initiatives, including goals and objectives, are stated in the program digests on the following pages. Overall, the hospital anticipates that actions taken to address significant health needs will do the following: improve health knowledge, behaviors, and status; increase access to care; and help create conditions that support good health. The hospital is committed to monitoring key initiatives to assess and improve impact. The Healthier Community Coalition, hospital executive leadership, Board, and Dignity Health receive and review program updates. The hospital creates and makes public an annual Community Benefit Report and Plan, and evaluates impact and sets priorities for its community health program by conducting Community Health Needs Assessments every three years.

Planned Collaboration

Healthier Community Coalition – St. Joseph's Medical Center chaired the Healthier Community Coalition (HCC) in 2015, and St. Joseph's Medical Center serves as the fiscal agent. HCC is a collaborative of the local hospitals, Medicaid managed care plans, county public health department, and community based organizations. The group works together to implement programs that address the needs identified in the previous Community Health Needs Assessment.

One of the initiatives developed through the Healthier Community Coalition is the Community Health Connector program. Community Health Connectors (CHCs) are outreach workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHCs to serve as a link between health/social services and the community to facilitate access to services. The CHCs focus on healthcare navigation and health education.

Community Dental Task Force – St. Joseph's Medical Center chairs this task force, which includes local hospitals, the dental society, University of the Pacific Dental Hygiene school, Community Medical Centers (the local Federally Qualified Health Center), and other community-based organizations.

Homeless Medical Recuperative Care program – The Gospel Center Rescue Mission has partnered with Community Medical Centers to create a respite program for homeless individuals in need of recuperation from an illness or injury. St. Joseph's Medical Center is a funder of this program and participates in the healthcare advisory group.

Reinvent South Stockton – Several partners have come together to focus on the needs of the underserved area of South Stockton. Coalition members include a city councilmember, Visionary Home Builders, Fathers & Families of San Joaquin, Community Partnership for Families, San Joaquin County Public Health, STAND, and St. Joseph's Medical Center.

San Joaquin Homeless Task Force - Participation in the San Joaquin Homeless Task Force, including active involvement in the Prevention Workgroup.

Asthma/COPD Coalition - St. Joseph's Manager for Respiratory services co-chairs the Asthma/COPD coalition. They host numerous awareness-raising events in the community and promote programs for improved asthma treatment and air quality.

Program Digests

The following pages include program digests describing key programs and initiatives that address one or more significant health needs in the most recent CHNA report. 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.

Community Health Education	
Significant Health Needs Addressed	2013 CHNA Identified Needs: ✓ Lack of or limited access to health education 2013 Implementation Plan: ✓ Culturally competent care ✓ Health education 2016 CHNA Identified Needs: ✓ Obesity/ Diabetes ✓ Access to Care
Program Emphasis	✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Collaborative Governance
Program Description	Health education workshops, presentations and classes are provided for free throughout the area in languages of the target population. The diabetes education program is a six part educational series taught by a team including an RN, Certified Diabetic Educator and bilingual health educators. The Chronic Disease Self-Management Program (CDSMP) is an evidence-based model developed at Stanford University. It is a six part workshop led by trained lay leaders from the community and/or community health staff from St. Joseph's Medical Center. In addition single presentations are provided to many groups as part of early intervention and prevention strategies.
Planned Collaboration	The workshops are co-led with community based organizations including Community Partnership for Family, Lao Family, Community Medical Centers and Catholic Charities. Presentations and classes are hosted by partner agencies including schools, faith-based groups, libraries and workplaces.
Community Benefit Category	A1a, Community Health Improvement Services-Community Health Education-Lectures/Workshops
Planned Actions for 2016-2018	
Program Goal / Anticipated Impact	Continue to operate the Chronic Disease Self Management Program and transition the diabetes education to an improved program for the target population by initiating the Diabetes Empowerment Education Program (DEEP) in English and Spanish.
Measurable Objective(s) with Indicator(s)	Provide health education and increase participation by at least 5-10% annually. Conduct pre and post assessment to determine effectiveness of the program. Make adjustments to ensure significant behavior change for at least 50% of program participants.
Baseline / Needs Summary	Health education will focus on the underserved communities of Hmong, Cambodian and Spanish speaking patients as well as low-income communities.
Intervention Actions for Achieving Goal	Provide DEEP training for all health education staff.

Dignity Health Community Grants Program	
Significant Health Needs Addressed	2013 CHNA Identified Needs: ✓ Lack of access to primary and preventive care services ✓ Lack of or limited access to Community Health Education ✓ Lack of or limited access to dental care 2016 CHNA Identified Needs: ✓ Access to Housing ✓ Mental Health
Program Emphasis	✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Building community capacity ✓ Collaborative Governance
Program Description	Providing funding to support community based organizations that will provide services to underserved populations to improve the quality of life. The objective of the Community Grants Program is to award grants to organizations whose proposals respond to the priorities identified in the most recent Community Health Needs Assessment (CHNA).
Community Benefit Category	E2a, Financial & In-Kind Contributions-Program Grants
Planned Actions for 2016-2018	
Program Goal / Anticipated Impact	Provide funding for programs that align with strategies developed by the community wide efforts of the Healthier Community Coalition and align with the needs identified in the most recent CHNA.
Measurable Objective(s) with Indicator(s)	FY 17 - Funding will be provided to implement programs that support the following areas: • Developing new housing opportunities for homeless individuals • Start-up funding for sustainable, community-based trauma recovery services in South Stockton FY 18 – Continue to align grant funding priorities with identified community needs. 100% of grants will correspond with an identified community need. FY 19 - Continue to align grant funding priorities with identified community needs. 100% of grants will correspond with an identified community need.
Intervention Actions for Achieving Goal	To fund non-profit community organizations, in partnerships with three or more organizations totaling $219,536
Planned Collaboration	Grantee's awarded grants in this Community Grant Cycle

Emergency Department Navigator and Frequen User Initiative	
Significant Health Needs Addressed	2013 CHNA Identified Needs: ✓ Access to care ✓ Health Education 2013 Implementation Plan: ✓ Access to primary and specialty care 2016 CHNA Identified Needs: ✓ Access to care ✓ Mental health ✓ Substance use ✓ Access to housing
Program Emphasis	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	ED Navigator: To assist patients, especially the underserved, who admit to the Emergency Department (ED) for non-urgent care or who are in need of a assistance in linking with a primary care physician/clinic in support of the patient's continuum of care. These services are provided by a Health Educator, who is stationed within the Community Health department and Emergency Department. Familiar Faces: To provide intensive case management services for patients with complex psycho-social needs who present to the ED frequently.
Community Benefit Category	A3e, Health Care Support Services – Information & Referral
Planned Actions for 2016-2018	
Program Goal / Anticipated Impact	Increase number of patients served in the ED Navigator program. Decrease the number of ED visits by Familiar Faces program participants.
Measurable Objective(s) with Indicator(s)	Provide ED Navigator services to at least 1,500 patients from July 2016-June 2017. Provide Familiar Faces program services to at least 25 additional patients from July 2016-June 2017. 2017 and 2018 – Assess effectiveness of the programs. If the programs are effective in meeting the needs of the population served, then expand programs by at least 5-10% annually.
Intervention Actions for Achieving Goal	Increasing awareness/education of alternate services available within the community (for example, using urgent-care facilities), educating patients on the importance of establishing care with a medical home (Primary Care Provider (PCP)/clinic) and scheduling follow-up appointments with PCP for medication refills in advance.
Planned Collaboration	Community Medical Centers

Friends of Seniors / HomeComing Project	
Significant Health Needs Addressed	2013 CHNA Identified Health Need: ✓ Lack of access to primary and preventative care services ✓ Limited transportation options 2016 CHNA Identified Health Need: ✓ Mental Health ✓ Access to Care
Program Emphasis	✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Building community capacity ✓ Collaborative Governance
Program Description	St Joseph's Friends of Seniors is staffed by volunteers and provides free services to seniors living at home including: transport to medical appointments, shopping and friendly visiting. Coordinator is member of SJ Community Health staff. The Homecoming Project is a partnership with Catholic Charities, Diocese of Stockton, which provides transitional care services including: transportation, medication delivery and referrals to social service programs for up to 6 weeks following hospitalization.
Community Benefit Category	E2a, Financial & In-Kind Donations-Program Grants
Planned Actions for 2016-2018	
Program Goal / Anticipated Impact	St Joseph's Friends of Seniors will increase volunteers by 5; volunteers will attend annual mandatory update meeting; participate in county Senior Fair; support the Warm Woolies for Oldsters in Winter bundles for needy elders in community. Homecoming, in partnership with Catholic charities, will serve from 200-250 patients recently discharged from St Joseph's Medical Center.
Measurable Objective(s) with Indicator(s)	FY 17 - Friends of Seniors, Coordinator will arrange for transport, shopping and friendly visiting services to >120 elders living at home; will seek new volunteers from the CDSMP classes. Homecoming Project, Coordinator will visit at least 5 patients a week referred to the program prior to discharge from SJMC and will communicate between SJMC and Catholic Charities to improve the quality of service to Homecoming Patients. 2017 and 2018 – Continue to provide Homecoming Project services to at least 100 patients annually.
Intervention Actions for Achieving Goal	Coordinator will visit 1 Homecoming patient quarterly to assess the quality of service by partner social workers; request weekly reports on referrals and appointments; request monthly tracking log and forward to Care Coordinator Director; provide quarterly and annual financial report to Community Benefit Specialist; call together annual meeting with SJMC Community Health and Catholic Charities administration and staff to evaluate quality and mutual assistance.
Planned Collaboration	Catholic Charities

Healing South Stockton	
Significant Health Needs Addressed	2016 Identified Health Need: ✓ Violence and injury ✓ Mental health ✓ Substance use
Program Emphasis	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	Mental health services will be developed at on-site community locations such as schools, faith groups, and community centers. These services, once established, can be expanded and sustained financially through FQHC billing.
Community Benefit Category	A3e Health Care Support Services, Information and Referral
Planned Actions for 2016-2018	
Program Goal / Anticipated Impact	Increase in mental health services in the South Stockton area.
Measurable Objective(s) with Indicator(s)	Mental health therapy sessions provided for at least 10% of the projected need in FY 2017, 25% in FY 2018 and 50% in FY 2019.
Intervention Actions for Achieving Goal	Train community partners on Medi-Cal billing for mental health services. Connect host sites with therapists in order to co-locate services. Identify advocacy work that will be needed to address the barriers.
Planned Collaboration	Healing South Stockton is a broad collaborative of over 30 partnering agencies. The 10-member Leadership Team includes the County Health Care Services Agency, Reinvent South Stockton, Public Health Advocates, Stockton Unified School District, Community Medical Centers, Kaiser Permanente and Health Plan of San Joaquin.

Virtual Dental Home	
Significant Health Needs Addressed	2013 Implementation Strategy: ✓ Policy Work to Improve Community Health 2016 Identified Health Need: ✓ Oral Health
Program Emphasis	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	The Virtual Dental Home provides preventive and restorative dental care services to children at school sites. This innovative program was brought to San Joaquin county through the leadership of the hospital's Director of Community Health in her role as chair of the Community Dental Task Force. In addition the hospital provided the initial start-up funding for the program.
Community Benefit Category	N/A
Planned Actions for 2016-2018	
Program Goal / Anticipated Impact	This is a pioneering program that brings the Virtual Dental Home to San Joaquin county for the first time. Once the program is firmly established, it can expand greatly and be financially sustained through FQHC billing.
Measurable Objective(s) with Indicator(s)	FY 17 - Students will be served at two school sites. FY 18 – The number of students served will increase by at least 10%. FY 19 – The number of students served will increase by at least 10%.
Intervention Actions for Achieving Goal	School board approval has already been obtained at one of the school sites, and services are scheduled to begin soon.
Planned Collaboration	The lead agency will be Community Medical Centers with technical assistance from the University of the Pacific Dental School.

APPENDIX A: BOARD AND COALITION ROSTERS

Port City Operating Company, LLC, Board of Managers

Debra Cunningham	SVOP, Strategy & Business Dev, Kaiser Permanente
Stephen Foerster	Chief Strategy Officer & VP Bay Area, Dignity Health
Deborah Friberg	Sr. Vice President/ Area Manager, Kaiser Permanente
Thomas Meier	Treasury, Kaiser Foundation Health Plan, Inc.
John Petersdorf	SVP Operational Effectiveness, Dignity Health
Karl Silberstein	SVP Financial Operations, Dignity Health
John VanBoening	Sr. Vice President, Dignity Health
Don Wiley	President & CEO, St. Joseph's Medical Center

Healthier Community Coalition

Sothea Ung	Asian Pacific Self-Development and Residential Association
Elvira Ramirez	Catholic Charities
Sandra Beddawi	Community Medical Centers
Hector Lara	Reinvent South Stockton
Brent Williams	Delta Health Care
Alejandra Gutierrez	Fathers & Families of San Joaquin
Britton Kimball	Gospel Center Rescue Mission
Martha Geraty	Health Net
Jenny Dominguez	Health Plan of San Joaquin
Marie Sanchez	Kaiser Permanente
Jason Whitney	Lodi Health
Jeff Slater	San Joaquin General Hospital
Barb Alberson	San Joaquin County Public Health
Petra Stanton	Dignity Health - St. Joseph's Medical Center
Mary Jo Cowan	Stockton Unified School District
Tammy Shaff	Sutter Tracy Community Hospital

APPENDIX B: OTHER PROGRAMS AND NON-QUANTIFIABLE BENEFITS

The hospital delivers a number of community programs 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.

St. Joseph's Medical Center serves an important role in improving the health of the community through working collaboratively with community partners, providing leadership and advocacy, carefully managing resources, assisting with local capacity building and participating in community-wide health planning. The leadership role is especially important in San Joaquin County where individual and community resources are very limited.

Leaders from St. Joseph's serve as board members of numerous community organizations and collaboratives. This includes, for example, the Vice President of Mission Integration serving on the California Health Care Facility Advisory Committee for the Department of Corrections' medical facility in the area. St. Mary's Dining Room also benefits from St. Joseph's leadership on their Board of Directors. In addition the Chief Finance Officer volunteers on the board of Community Medical Centers.

The Director of Community Health chaired the Healthier Community Coalition in 2015 and is leading the development of community-wide initiatives to address the priority health needs from the Community Health Needs Assessment. This includes initiating the San Joaquin Community Dental Task Force to address the need for dental care services in underserved communities. The hospital is also a member of the Homeless Medical Recuperative Care healthcare advisory group, the Homeless Task Force, and the San Joaquin Human Trafficking Task Force. In addition St. Joseph's is a partner in the development of the Community Health Connector program, which is being jointly created by the local hospitals, county public health department and community partners.

The hospital is also a key partner in community building and ensuring environmental improvement through the ecology initiatives. Staff members from St. Joseph's Medical Center voluntarily operate a community garden that provides over 2,000 pounds annually of fresh vegetables which are donated to organizations that prepare free meals for low-income individuals. The hospital is also currently recycling 50% of its waste stream, approximately 350,000 pounds per month. The Healthier Hospitals Initiative highlighted St. Joseph's water conservation and green initiative through its laundry program, which has drastically reduced the hospital's footprint and local landfill usage.

St. Joseph's Medical Center is the largest hospital and largest private employer in San Joaquin County. As such, the influence and benefit felt by residents extends not only to areas of highest need, but to the community in general. The goal has been to inform both staff and community partners of the programs available in the community so they can be a resource to their families, friends, clients, patients and neighborhoods.

SJMC has dedicated leadership and a Community Health Department to work closely with other healthcare providers, community based organizations and individuals to develop and share resources. The resulting strategic planning is an on-going process that provides opportunity for forming partnerships and maximizing existing resources.

The Community Benefit Report and Plan is completed and reviewed annually, and presented to the Port City Board of Managers for their review and approval. Key information is presented at the Managers Meeting. Input for the Implementation Plan and selection of interventions comes from the Healthier Community Coalition.

The Annual Community Benefit Report and Plan is posted on St. Joseph's Medical Center website www.stjosephscares.org and at www.dignityhealth.org under Who We Are/Community Health. The 2016 Community Health Needs Assessment executive summary and full report are available on both these websites, and the public website that is owned collectively by the Collaborative, has the reports from both 2013 and 2016 at www.healthiersanjoaquin.org.

The Community Benefit work of St. Joseph's Medical Center touches the lives of so many people. Hospitalized patients receive the highest quality care, and St. Joseph's continues to serve the uninsured and underinsured every day. The community health programs reach out into the neighborhoods where people live and provide them with the resources they need to have healthy lives. St. Joseph's also supports community partners who are bringing services to the most unreached parts of the service area. The impact that St. Joseph's makes can be measured in the large amount of money invested, the high number of people who participate in the programs, and in the positive health outcomes. It can also be shared through the experience of those who benefit the most. The following are a few examples.

Recently a patient came to the Emergency Department who was new to the area and had not been able to find a physician who was willing to accept her as a new patient since she was very late in her pregnancy (38 weeks). The ED Navigator worked with the community clinic to secure an OB appointment for her and established prenatal care there. She had her ultrasound and follow-up OB visit, and was also given help with obtaining Medicaid coverage for her new baby.

In October 2015 a partnering agency wrote to express their appreciation for the health education program provided by St. Joseph's Medical Center. "Thank you for the wonderful job you did on the health lecture series. The folks here were delighted with the presentations and especially appreciated your suggestions and comments regarding health issues. Many have expressed their pleasure with the material you provided; it has been very helpful. It has helped them understand health concerns for themselves as well as family members."

APPENDIX C: FINANCIAL ASSISTANCE POLICY SUMMARY

Dignity Health's Financial Assistance Policy describes the financial assistance programs available to uninsured or under-insured 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 200% 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 200-350% 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.

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

- **Approval**

  The year at their October meeting, The Port City Board of Managers reviewed the prior fiscal year's Community Benefit Report and approves the Community Benefit Implementation Plan for addressing priorities identified in the most recent Community Assessment and other plans for community benefit. This report was prepared for the October 28, 2016 meeting of The Port City Board of Managers.

  The Port City Board of Managers Approval:

Donald J. Wiley	Karl Siberstein
_____	_____
President/CEO	Chairperson, Board of Managers