Dignity Health Dominican Hospital

2019 Community Health Implementation Strategy

Adopted November 2019

Dignity Health
Dominican Hospital

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At-a-Glance Summary

Community Served	Santa Cruz County has a population of approximately 271,860 and covers 445 square miles. The two major cities are Santa Cruz, located on the northern side of the Monterey Bay, and Watsonville, situated in the southern part of the county. The City of Santa Cruz, which is the county seat, had an estimated population of 63,993 in 2017. Santa Cruz is one of California's most popular seaside resorts with its historic Boardwalk, spectacular coastline, and accessible beaches. The City of Watsonville is the center of the county's agricultural activity, with major industries including food harvesting, canning, and freezing. In 2017, Watsonville had an estimated population of 53,452. Other incorporated areas in the county include the cities of Scotts Valley and Capitola. Approximately 48 percent of the population lives in the unincorporated parts of the county, including the towns of Aptos, Davenport, Freedom, Soquel, Felton, Ben Lomond and Boulder Creek, and districts including the San Lorenzo Valley, Live Oak, and Pajaro.
Significant Community Health Needs Being Addressed	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are: 1. Behavioral Health 2. Continuum of Care: prevention, access and delivery 3. Economic Security: income, employment, education, housing and food security
Strategies and Programs to Address Needs	The hospital delivers several programs and services to help address identified significant community health needs. These include: • The hospital's Personal Enrichment Program (PEP) is a resource for community health and wellness education. PEP classes and programs focus on total joint care, childbirth and parenting, lifestyle management, improving neurological function, exercise and fitness, cancer resources and heart health. • The hospital's Mobile Wellness Clinic has bilingual staff that provides evaluation and treatment of episodic medical conditions, identification of medical homes for those patients with chronic needs, and identification of social services and resources in the community. The Mobile Wellness Clinic visits six locations every week, Monday through Friday. • The hospital provided a community grant to Janus of Santa Cruz, a substance use disorder (SUD) treatment clinic, for the Project Unite Program. Through this program, a substance abuse counselor meets with hospital patients to help transition the patients to inpatient/outpatient SUD treatment programs in Santa Cruz. • An Emergency Department (ED) navigator who meets with Central Coast Alliance for Health (CCAH) patients in the ED to help connect or reconnect them with patient care providers post hospital discharge.

	• The rollout of SB112 Safe Discharge Planning policy and procedure to all staff took place this year. The policy includes new processes for documentation and provision of food, clothing and medications for patients who are homeless. • The hospital's Human Trafficking Taskforce is comprised of care coordination, ED, and chaplain services staff and meets bi-monthly to address issues such as…. Additionally, all hospital staff has been trained on how to identify and address victims of human trafficking. • The hospital's Medical Guidance Area is a specialized area for patients with substance abuse and mental health disorders. A psychiatric registered nurse (psych RN) is present on the unit as part of the Psychiatric Resource Team (PRT). The hospital provided grant funding to the Homeless Services Center's Recuperative Care Center (RCC). The RCC is a transitional medical shelter for the homeless.
Anticipated Impact 	The hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health.
Planned Collaboration 	Dignity Health Dominican Hospital will continue collaborating with community partners, providers, government agencies, local health care agencies, behavioral health services, and other related agencies in the community.

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

Written comments on this report can be submitted to the hospital Administrative office, 1555 Soquel Drive, Santa Cruz, CA 95065 or by email to dominique.hollister@dignityhealth.org.

Our Hospital and the Community Served

About Dignity Health Dominican Hospital

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

- Dignity Health Dominican Hospital is located at 1555 Soquel Avenue, Santa Cruz, CA 95065
- Dignity Health Dominican Hospital is licensed for 222 inpatient beds.
- Dignity Health Dominican Hospital has a staff of 1650 employees and professional relationships with more than 561 local physicians and allied health professions.
- Dignity Health Dominican Hospital's major program and service lines include: Cardiovascular, OB/GYN, Orthopedics, General Surgery, Pulmonary, Neurosciences, Oncology, Maternal/Child Health, Level III Neonatal Intensive Care Unit, Cardio/Thoracic/Vascular Surgery, Intensive Care Unit, Emergency Services and Rehabilitation.

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.

Financial Assistance for Medically Necessary Care

Dignity Health Dominican Hospital delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services. The financial assistance policy and a plain language summary and other materials are on the hospital's web site.

Description of the Community Served

Dignity Health serves Santa Cruz County. A summary description of the community is below. Additional details can be found in the CHNA report online.

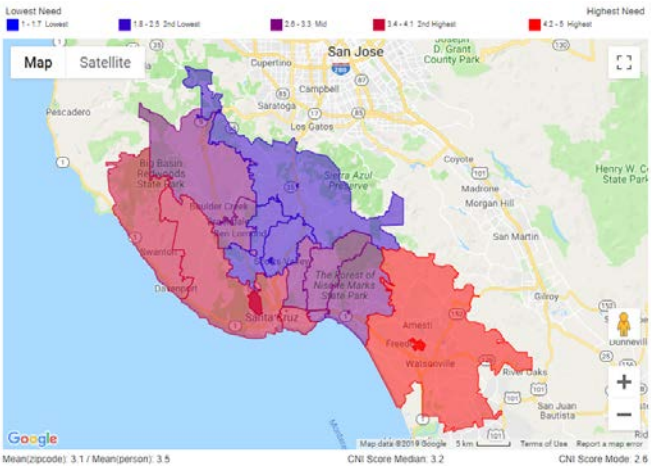
Santa Cruz County has a population of approximately 271,860 and covers 445 square miles. The race/ethnicity breakdown is 33 percent Latino, 59 percent White (non-Latino), and 9 percent other race/ethnicity. The median family income is $90,531. Fourteen percent of the population does not have a high school diploma. Twenty-five percent of the county population (69,077 individuals) are Central California Alliance for Health (CCAH) members enrolled in Medi-Cal. The medically underserved areas/populations are Watsonville, Freedom and the city of Santa Cruz (UCSC region).

The median sales price for homes in Santa Cruz County was $791,500 as of February 2019, while the median estimated market rate rent across all home types in the county was $3,118 in the same period.

Community Need Index

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

Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. 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.



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 health implementation strategy and programs were identified in the most recent CHNA report, which was adopted in May 2019. The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; 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/about-us/community-health/community-health-programs-and-reports/community-health-needs-assessments or upon request at the hospital's Community Health office.

Significant Health Needs

The CHNA identified 18 health conditions which were presented to the Dominican Community Advisors for final review, consolidation ad prioritization. This resulted in the following significant community health needs:

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

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

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

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

The hospital intends to take actions to address all of the prioritized significant health needs in the CHNA report, both through its own programs and services and with community partners. Lists and descriptions of those planned actions are included in this report.

2019 Implementation Strategy

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years. It summarizes planned activities with statements on anticipated impacts and planned collaboration. Program Digests provide additional detail on select programs.

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

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

Creating the Implementation Strategy

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

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

- Focus on disproportionate unmet health-related needs
- Emphasize prevention
- Contribute to a seamless continuum of care
- Build on community capacity
- Demonstrate collaboration

Strategy by Health Need

The tables below present strategies and program activities the hospital intends to deliver to help address significant health needs identified in the CHNA report.

They are organized by health need and include statements of the strategies' anticipated impact and any planned collaboration with other organizations in our community.

Health Need: Integrated Behavioral Health Significant Community Health Need 1

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

Anticipated Impact: The hospital's initiative to address substance use and mental health disorders anticipates:

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

Planned Collaboration: The PRT works to decrease the suicide rate in Santa Cruz County by proving access to behavioral health services.
Project Unite operated by Janus of Santa Cruz, an independent contractor and program partner with expertise in addiction treatment has been a valued addition.

Health Need: Economic Security Significant Community Health Need 2

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

Anticipated Impact: This hospital initiative anticipates a decrease in the number of preventable utilization visits to the ED and inpatient hospital stays. A group of community partners and providers convened and built a network involving care coordinators and data sharing regarding health, housing, social supports and basic living assistance.

Planned Collaboration: The hospital continues to collaborate with the RCC. The hospital is one of many partners that support this center, and that value the coordination of services and collaboration between agencies to ensure the health and the continued recovery of homelessness individuals coming out of the hospital. A safe place for recovery is provided including support for a full recovery, linkage to primary care, and transition to temporary or permanent housing as often as possible.

Health Need: Continuum of Care Significant Community Health Need 3

Strategy or Program Name	Summary Description
Grant funding for RotaCare Free Health Clinic at the Live Oak Senior Center	A walk-in clinic providing primary health care services, treatment, referral for diagnostic testing, and follow-up care. Services provided once a week by physicians, nurses, allied health professionals and other volunteers from local Rotary clubs and the county.
Personal Enrichment Program (PEP)	PEP is a resource for community health and wellness education. PEP classes and programs focus on total joint care, childbirth and parenting, lifestyle management, improving neurological function, exercise and fitness, cancer resources and heart health.
Dominican Hospital Mobile Wellness Clinic	Provides episodic health and preventative services Monday-Friday throughout Santa Cruz County at no cost to the patient.

Passport to Health (P2H)	Program designed to provide coordination, education, prioritization and integration by community health leaders for high-need, high-cost patients in Santa Cruz around health and health-related social needs
Community Bridges Wellness Navigation Project	The project is designed to increase patient access to healthy food, nutrition education, and other services identified during their intake process, and to increase clients' understanding about their health and how to stay healthy. The Wellness Navigation Project will offer mobile health screenings, a lifestyle health class, Navihealth referrals, and food pantry distribution.

Anticipated Impact: This hospital initiative, providing access to health care, targets the un-/underinsured residents of Santa Cruz County. Health care services, testing, and reduction in medicines will provide early identification of illness and earlier treatment, and will decrease in the utilization of the hospital ED.

Planned Collaboration: The hospital is one of many partners who value coordination of services and collaboration between agencies to ensure the health and wellbeing of the individuals seeking care services in the county.

Health Need: Human Trafficking Significant Community Health Need 4

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

Anticipated Impact: Both the hospital taskforce and Monarch Services programs work to identify and provide support to victims of human trafficking.

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

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.

Psychiatric Resource Team (PRT)	
Significant Health Needs Addressed	✓ Behavioral Health ❑ Economic Security ✓ Continuum of Care
Program Description	The PRT strives to ensure that patients with behavioral health needs receive the right care, in the right place, at the right time. The PRT monitors care and flow of patients in their scope in the ED, as well as with patients admitted to the hospital. The PTR facilitates communication and continuum of care planning with hospital care coordination and local and regional health care providers; and develops and presents behavioral health specific education to hospital employees. The hospital provides funding for staff and office space.
Community Benefit Category	A3- Health Care Support Services
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	1. Increased role in ED P2H collaboration. 2. Increased role in weekly hospital long stay meeting. 3. Continued participation in Telecare to address issues of flow with crisis unit regarding LOS management in the ED.
Measurable Objective(s) with Indicator(s)	1. Decrease in ED throughput time for behavioral health patients. 2. Maintain or increase program performance outcomes listed above.
Intervention Actions for Achieving Goal	PRT to attend 100 percent of collaborative work groups. Reach out to significant community partners for attendance. Work with ED Medical Director as well as ED Care Coordination Team for best outcomes; attend minimum of 75 percent of weekly care coordination meetings, with focus on patients the team is following. Continue to perform other duties as well as seek opportunities to enhance to improve upon services currently provided.

Planned Collaboration	Primary collaboration with the BHC, Encompass Community Services, as well as other related providers in this community.

Passport to Health (P2H)

Significant Health Needs Addressed	✓ Behavioral Health ✓ Economic Security ✓ Continuum of Care
Program Description	The program is designed to provide coordination, education, prioritization and integration by community providers for high-need, high-cost patients in Santa Cruz around health and health-related social needs. This initiative aims to create a lasting systematic framework for population health in the community.
Community Benefit Category	A3-h – Health Care Support Services

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	Continue to support the P2H program and measure the effect on the frequent preventable utilization of the ED and avoidable inpatient hospital stays.
Measurable Objective(s) with Indicator(s)	Decrease the visit/stay volume of the target population with four or more ED visits within the past three months and three or more inpatient stays within the past three months.
Intervention Actions for Achieving Goal	Convene a group of community partners and providers to build a network involving care coordination and data sharing among a group of providers – health, housing, social supports and basic living assistance.
Planned Collaboration	Local health care agencies and other related agencies.

Homeless Services Center (HSC) Recuperative Care Center (RCC) Program

Significant Health Needs Addressed	☐ Behavioral Health ✓ Economic Security ✓ Continuum of Care
Program Description	24-hour shelter services with meals, housekeeping, security, and on-site case management provided by the Homeless Services Center. Recuperative care provided by RCC.

Community Benefit Category	E-2-b- Grants – Operating Grants
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Continue to support the RCC and measure the effect on the number of people who are homeless to fully recover following discharge from the hospital.
Intervention Actions for Achieving Goal	Plan/coordinate for the delivery of home health care services at the RCC to ensure that these services are available when needed for full recovery.
Planned Collaboration	Continue current collaborations with local hospitals, health agencies, and other related agencies.

RotaCare Free Health Clinic

Significant Health Needs Addressed	✓ Behavioral Health ✓ Economic Security ✓ Continuum of Care
Program Description	Located in the unincorporated area of the county, this program is targeted primarily to the uninsured/underinsured.
Community Benefit Category	A2-e-Community Based Clinical Services – Ancillary/other clinical services
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Continue to support the RotaCare Free Health Clinic and provide self-management information for patients with diabetes. Develop weekly specific service activities.
Measureable Objective (s) with Indicators (s)	Continue to provide health-related services, medications, education for diabetes, eye exams/glasses and diagnostic testing to uninsured/underinsured populations at no cost to the patient in the clinic or in the hospital. The hospital will provide pharmaceuticals, other medical supplies and outpatient services at no cost to the patient.
Intervention Actions for Achieving Goal	The RotaCare Free Health Clinic will continue operations weekly at the local senior center.
Planned Collaboration	Continue program collaborations with local health care providers.

Mobile Wellness Clinic	
Significant Health Needs Addressed	✓ Behavioral Health ✓ Economic Security ✓ Continuum of Care
Program Description	This program provides episodic health and preventive services Monday – Friday throughout Santa Cruz County. Services are provided by physicians, allied health professional, registered nurses and registrars. The program primarily targets the uninsured/underinsured populations, but also reaches the broader community. It serves children, youth and adults.
Community Benefit Category	A2-e-Community Based Clinical Services – Primary Care.
Intervention Actions for Achieving Goal	Through collaboration with other health care providers in the county, the Mobile Wellness Clinic evaluated each patient, develop a plan, and refer patients to health homes in close proximity to their site of access. Patients will receive referral documentation at the time of discharge.
Collaboration	Continued the collaboration with health care agencies and add non-health care services (a minimum of two or more).
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Continue to support the Mobile Wellness Clinic and measure the effect on the number of preventable episodic visits to the ED.
Measureable Objective (s) with Indicators (s)	Increase the number of participants receiving episodic and preventative care on the Mobile Wellness Clinic.
Intervention Actions for Achieving Goal	Increase strategies for marketing – utilize social media for advertising, distribute informational brochures and monthly calendars throughout the county.
Planned Collaboration	Continue program collaborations with local health care agencies.

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

	objective of the community grants program is to award grants to organizations whose proposals respond to the health priorities identified in the most current CHNA and are located within Santa Cruz County.
Community Benefit Category	E2-a.-Grants-Program Grants
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Provide funding for programs that align with strategies developed by the Dignity Health Dominican Community Board, Dominican Community Advisors and the communitywide efforts of the local health agencies.
Measureable Objective (s) with Indicators (s)	Each grant award will have measurable objectives and indicators specific to their proposal.
Intervention Actions for Achieving Goal	Partnership grants will be awarded to proposals that align with the 2019 CHNA priorities.
Planned Collaboration	Collaborate and follow-up with chosen agencies.

Hospital Board and Committee Rosters

Dominican Hospital Community Board FY 2019

Board Member	Affiliation
Jessica Cohen, MD	Physician
Erick Eklund, DDS	Dentist
Dean Kashino, MD	Physician
Karl Knudsen Johsens, MD	Physician
Majory O'Connor, RN	Retired Nurse
Erica Padilla Chavez	Executive Director, Nonprofit
Rajinder Singh, MD	Physician
Carolyn Roeber, OP	Religious Sponsor, Attorney
Jon Sisk	Banker
Stephen Snodgrass	Buiness, Chief Financial Officer
Ex Officio Board Members	Affiliation
Carol Lezin	Philanthropic Foundation President, Realtor
Randall Nacamuli, MD	Chief of Staff, Physician
Nanette Mickiewicz, MD	Hospital CEO, Physician

Dominican Community Advisors

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