St. Joseph's Medical Center

2019 Community Health Implementation Strategy

Adopted October 2019

Dignity Health®
St. Joseph's Medical Center

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At-a-Glance Summary

Community Served

Located near the heart of downtown Stockton, St. Joseph's Medical Center primarily serves residents of Stockton along with members of neighboring communities within San Joaquin County. The overall service area is comprised of 24 ZIP Codes and approximately 50% of the Hospital's discharges originated from the top five ZIP Codes, and 83% from the top 11 ZIP codes, all of which are in the City of Stockton. The population of San Joaquin County is approximately 745,000, while the City of Stockton is home to roughly 310,000 residents.

Significant Community Health Needs Being Addressed

The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are:

- Mental Health
- Economic Security
- Obesity/Healthy Eating Active Living (HEAL)/Diabetes
- Violence/Injury Prevention
- Access to Care
- Substance Abuse/Tobacco
- Oral Health

Strategies and Programs to Address Needs

The hospital intends to take several actions and to dedicate resources to these needs, including:

1. Community Benefit Investments provide financial support to various community programs that are often essential safety net services for the most vulnerable of populations. The primary needs addressed through reinvestments in the community include, but are not limited to: Economic Security, Access to Care and Oral Health.
2. Community Grants Program annually assesses and funds programs and services dedicated to significantly impacting CHNA findings. This strategy encompasses the potential to address all identified needs.
3. Community Benefit Operations and Programs deliver direct services as well as in-kind support through a variety of approaches to address health disparities and improve on health outcomes.

Anticipated Impact

Outcomes for each program and strategy are summarized in the Strategy by Health Need and Program Digest sections of this report.

Planned Collaboration

Nearly every program and strategy implemented and highlighted in this report, is delivered via strategic partnerships. Not only does collaboration align and leverage resources, it is a significant component in Dignity Health's Mission and a fundamental approach in all community health improvement efforts.

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

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

Our Hospital and the Community Served

About St. Joseph's Medical Center

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

The facility has been delivering quality, compassionate care for residents of the greater San Joaquin County since 1899.

- Centrally located in the City of Stockton and San Joaquin County
- Founded by Father William B. O'Conner and the Dominican Sisters of San Rafael, St. Joseph's Medical Center continues the legacy of caring for the poor and disenfranchised
- 355 beds, 2,600 employees, 700 physicians, 21,000 patient admissions, 90,000 emergency visits, 3,400 babies delivered annually
- Certified Primary Stroke Center, Healthgrade's Five-Star Recipient for Carotid Surgery, and voted Best Hospital in San Joaquin County by readers of the Stockton Record, the largest newspaper of San Joaquin County
- Accredited by the American College of Surgeon's Commission on Cancer and by the National Accreditation Program for Breast Centers

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

St. Joseph's Medical Center delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of 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

Each hospital participating in the San Joaquin County CHNA defines its hospital service area to include all individuals residing within a defined geographic area surrounding the hospital. For this joint CHNA, the hospital partners chose San Joaquin County as the primary service area for their hospital.

St. Joseph's Medical Center primarily serves residents of Stockton along with members of neighboring communities within San Joaquin County. The overall service area is comprised of 24 ZIP Codes. The population of San Joaquin County is approximately 745,000, while the City of Stockton is home to roughly 310,000 residents. A summary description of the community is below. Additional details can be found in the CHNA report online.

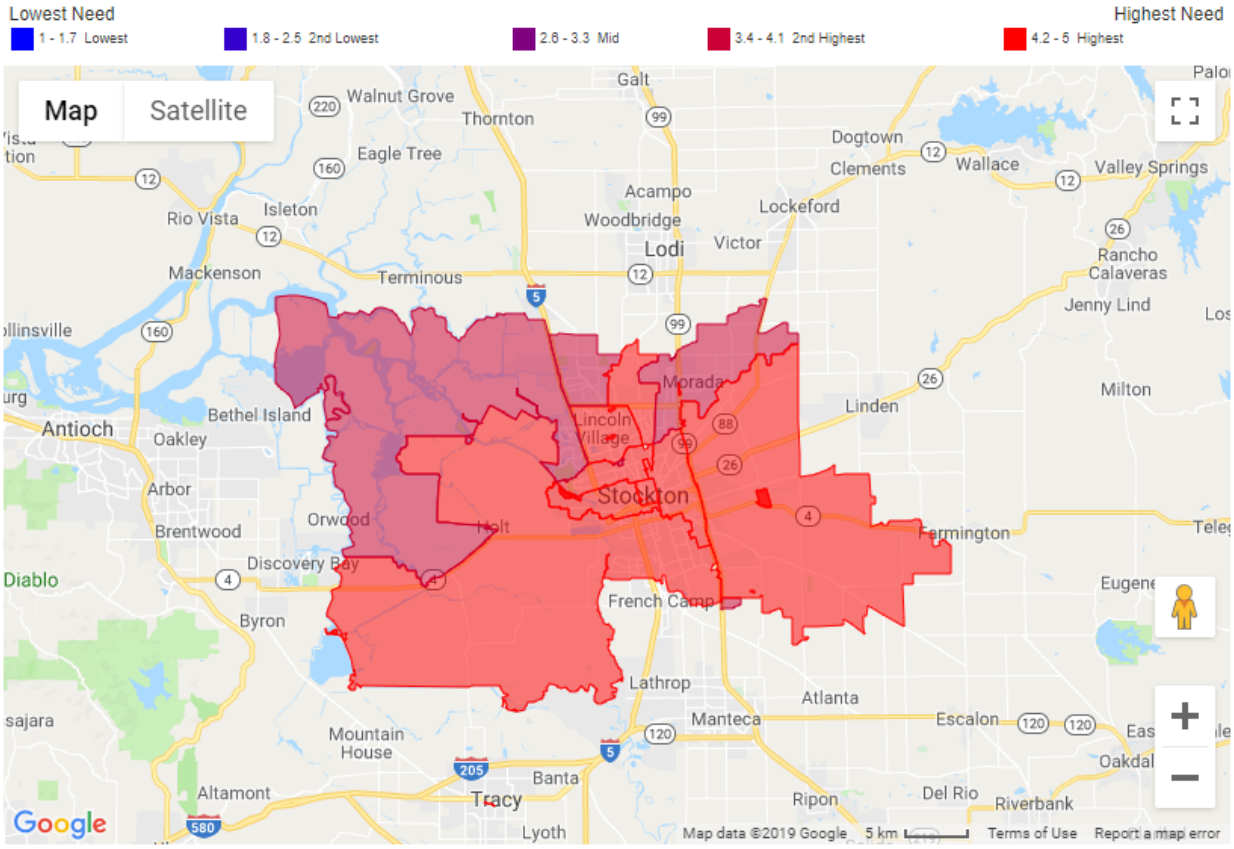
- St. Joseph's Medical Center lies in the midst of one of the most bountiful agricultural areas of the world while the population within the county experience food insecurity at rates that exceed California to levels as high as 18%. The county is celebrated for its diverse communities of Latinos and 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 and unemployment 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.

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. Scores for relevant zip codes are shown in the following Figure 1.

Figure 1. CNI score for each zip code in the city of Stockton as of September 2019.



Mean(zipcode): 4.4 / Mean(person): 4.4 CNI Score Median: 4.7 CNI Score Mode: 4.8

Zip Code	CNI Score	Population	City	County	State
95202	5	6877	Stockton	San Joaquin	California
95203	5	16832	Stockton	San Joaquin	California
95204	4.6	29055	Stockton	San Joaquin	California
95205	5	40708	Stockton	San Joaquin	California
95206	4.8	70588	Stockton	San Joaquin	California
95207	4.8	50072	Stockton	San Joaquin	California
95209	3.6	43212	Stockton	San Joaquin	California
95210	4.8	42247	Stockton	San Joaquin	California
95211	4	1538	Stockton	San Joaquin	California
95212	3.4	29604	Stockton	San Joaquin	California
95215	4.6	24497	Stockton	San Joaquin	California
95219	3.4	31267	Stockton	San Joaquin	California

Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its community health improvement planning process. These include, but are not limited, to conducting a Community Health Needs Assessment with community input at least every three years, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospital's community health implementation strategy and programs were identified in the most recent CHNA report, which was adopted in June 2019. The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at https://www.dignityhealth.org/central-california/locations/stjosephs-stockton/about-us/community-programs/community-health-needs-assesment, as well as at www.healthiersanjoaquin.org or upon request at the hospital's Community Health office.

Significant Health Needs

The community health needs assessment identified the following significant community health needs:

Highest Priority

- Mental Health: Deaths by suicide, drug overdose and alcohol poisoning combined are higher in San Joaquin County when compared to the state average. Primary data indicates there is a perception of limited access to providers and culturally competent services. Poor mental health was also linked to stigma, low incomes, substance abuse, and homelessness.
- Economic Security: San Joaquin County benchmarks poorly compared to the state on many economic security indicators and there are a significant number of ethnic/racial disparities within the county. Black and Latino populations are among those most impacted by poverty. Unemployment is also higher in the County relative to the state. Homelessness and housing instability, lack of employment, poor recovery post-recession, transportation access and substance abuse are connected with economic security and were mentioned as important issues by key informants and in the focus groups.
- Obesity/Healthy Eating and Active Living (HEAL)/Diabetes: Obesity rates and diabetes prevalence were higher in San Joaquin County as compared to the state. Physical inactivity is higher among youth and adults in San Joaquin County compared to the state, and disparities are higher for Latino and Black youth in particular. Poverty, lack of access to healthy food and safe places for physical activity, and easy access to unhealthy foods were frequently mentioned as barriers in primary data and confirmed by secondary data.

Medium Priority

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

Lower Priority

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

Significant Needs the Hospital Does Not Intend to Address

The hospital intends to take actions to address the majority 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. Below are the two out of the nine identified needs that the hospital will not be addressing.

Asthma: The hospital has chosen to not address this identified need at this time so that resources can be directed towards higher priority needs. In addition, the University of the Pacific's School of Pharmacy offers personalized education for both pediatric and adult patients via their Asthma clinic which is open to all members of the San Joaquin community.

Climate and Health: Air quality is of significant importance in the overall health and quality of life of residents, however the topic is not the hospital's area of expertise. St. Joseph's Medical Center will not be addressing this identified need and will defer to the San Joaquin Valley Air Pollution Control District to develop the needed strategies to address the community's concerns.

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

St. Joseph's Medical Center is dedicated to improving community health and delivering community benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

The process used to identify and design the programs, initiatives, and collaborative efforts in this report has been based on the thoughtful evaluation of the CHNA findings, the recommended actions set forth in the San Joaquin County Community Health Improvement Plan (CHIP), and the existing community benefit investments with proven success.

- Participants in the strategic planning process included community health department leadership and staff, as well as an advisory team comprised of representatives from hospital administration, county public health services, CHNA and CHIP stakeholders, and community members.

- Community input was obtained throughout the CHNA and CHIP processes and all feedback was considered in the development of this report. Additionally, local residents participated in the advisory team and were key contributors to the strategy developed.
- Programs and initiatives selected to address identified needs were based on the following criteria:
  - Existing program resulting in impactful outcomes
  - Evidence-based or promising practice
  - Possibility in addressing health disparities and the social determinants of health
  - Probability of impacting health equity and cultural disparities
  - Alignment with current county-wide collaborative efforts

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: Mental Health

Strategy or Program Name	Summary Description
Community Health Programs & Initiatives	In partnership with St. Joseph's Behavioral Health Center and in collaboration with other mental health experts and service providers, the hospital's Community Health department will deploy several programs to address community needs. Key approaches include, but are not limited to: • Friends of Seniors & Friends of Seniors Links Project • Community Health Social Worker • Faith Community Health Partnership
Outreach & Education - Community Health Social Worker	A new position to the community health department as of August 2019. This person will be responsible for providing outreach and education regarding mental health and social topics such as stress, depression, anxiety and overcoming trauma to serve the needs of at risk community members, including youth and those with chronic diseases.

Community Grants Program	Through a formal process, grants are administered annually to non-profit organizations that best demonstrate their ability to impact community health needs as they pertain to the most recent needs assessment. The following programs awarded funding in 2019, are addressing mental health: • ACEing Parenting is a project that encourages physicians to engage the parents of minors in a discussion about Adverse Childhood Experiences (ACEs) and prompting the completion of a questionnaire to determine the Resiliency Score of the parent. • Families Connect Project links residents of high disparity neighborhoods in South Stockton to services in order to reduce stress and the effects of trauma.

Anticipated Impact: Overall, these strategies will focus on prevention and early intervention of identifying and responding to mental health issues. There are additional programs and strategies listed in other areas of this report that are also anticipated to impact mental and behavioral health needs.

Planned Collaboration: Cross-sector collaboration is planned for all of the programs listed in order to ensure efficiency of services, leveraging of resources, avoidance of duplication, and to ensure sustainability. The short list of key partners include: San Joaquin County Child Abuse Prevention Council, San Joaquin County Public Health, San Joaquin General Hospital, Reinvent South Stockton Coalition, Trustbuilder organizations, Public Health Advocates, Churches, and local community volunteers.

Health Need: Economic Security

Strategy or Program Name	Summary Description
Connected Community Network (CCN)	This county-wide network of stakeholders, navigation and convening partners, along with community based organizations will create a fully integrated referral system. The system will increase community member connections to various medical and social services.
San Joaquin County Continuum of Care (SJCoC)	Community Health staff participate actively in the SJCoC in the following capacities; general membership, Education and Membership Committee, the Strategic Planning Committee, as well as the Coordinated Entry System Committee to develop solutions to end homelessness.
San Joaquin County Whole Person Care (WPC)	As a partner in this countywide collaborative pilot, the hospital identifies and refers homeless patients to WPC in an effort to secure stable housing and income for individuals experiencing or at-risk of homelessness.
Gospel Center Rescue Mission Recuperative Care	Safe hospital discharge for those experiencing homelessness with medical conditions that could worsen if returned to the streets. Case management services help to ensure compliance with discharge plan and links individuals to resources for housing, employment, and other services to help them become self-sufficient.

Community Grants Program	• Child Care Mobile Farmer's Market: Delivery of fresh produce (fruits & vegetables) free of charge to five large child care facilities within Stockton to be used for meals and snacks. This program stretches the food budget and ensures proper nutrition for children and their families • Early Infant Literacy Project: Enrolls 800 newborns and toddlers to age three in Dolly Parton's Imagination Library. This upstream approach to academic and economic success will increase early literacy.

Anticipated Impact: Outcomes will include referrals and connections to a multitude of community based programs such as; shelter/housing assistance, residential substance abuse treatment programs, life skills and work readiness programs. Programs funded through community grants are anticipated to prevent food insecurity and increase education regarding healthy eating for low income families and economic increase youth academic performance.

Planned Collaboration: San Joaquin County 211, United Way of San Joaquin County, along with several other stakeholders are instrumental partners in for the CCN, as well as in the SJCoc and the WPC program. Partners in the Community Grants Program include; Emergency Food Bank, Family Resource and Referral, First 5 of California, Cal Fresh, Read to Me Stockton, Books for Babes, Stockton Unified School District and the San Joaquin County Office of Education.

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

Strategy or Program Name	Summary Description
St. Joseph's Community Health Department Education Programs	• Diabetes Education and Empowerment Program (DEEP): 2 hour/week, 6 week program focusing on healthy living and diabetes prevention and management. • Diabetes Navigator: Resource and referral service for patients and community members seeking health education and support. • Certified Diabetes Educator Consultations: Free one-on-one, personalized diabetes education for populations who face significant barriers to better health. • Sweet Journey 101: A highly interactive diabetes basics workshop to encourage individuals to pursue additional classes and/or diabetes support services. • Sugar Fix Support Group: Monthly diabetes support group offering multi-disciplinary professional presentations along with peer support. • Matters of Balance: This nine week workshop offers older adults with 2 hour weekly sessions that provide practical tips to overcome fears of falling.
San Joaquin Community Health Improvement Plan (CHIP)	As a core team and steering committee member, hospital staff will play a supportive and active role in advancing the CHIP goal of helping people of all ages and abilities get more physically active through programs that meet their language and culture needs. The goal of the CHIP is to increase

	physical activity in residents through the utilization of community parks. More information regarding the CHIP can be found at www.healthiersanjoaquin.org

Anticipated Impact: Community members are expected to increase knowledge of diabetes, decrease A1C levels, increase consumption of fruits and vegetables, and increase physical activity.

Planned Collaboration: All community health programs can be, and often are, delivered in collaboration with various community based organizations. San Joaquin County Public Health Services supports the Matter of Balance program and the CHIP strategy will be deployed alongside various stakeholders, including city Parks and Recreation and other healthcare systems.

Health Need: Violence/Injury Prevention

Strategy or Program Name	Summary Description
Human Trafficking Education and Outreach	Through involvement in both the Human Trafficking Healthcare Workgroup and the San Joaquin County Human Trafficking Taskforce, the hospital seeks to increase awareness, response, and care and support of trafficked victims.
Outreach & Education - Community Health Social Worker	Please see description in Mental Health section. Through a comprehensive strategy, the social worker will implement programs to reduce cycles of violence within families and vulnerable communities.
San Joaquin Community Health Improvement Plan (CHIP)	Please see description in the above section. Through the community occupying of parks in priority neighborhoods, a reduction in neighborhood crime is an anticipated outcome.

Anticipated Impact: The above strategies are a multipronged approach to reducing violence and injury, and the anticipated impact for each are included in the respective summary description.

Planned Collaboration: The full list of collaborative partners for each program is described in the program digest section of this report.

Health Need: Access To Care

Strategy or Program Name	Summary Description
Certified Diabetes Educator (CDE) Consultations	CDE consultations are provided at no cost to individuals who would otherwise not have access to this specialty service. One on one

	consultations evaluate and address barriers to diabetes care and management.
San Joaquin County Whole Person Care (WPC)	In addition to increasing economic security, the WPC program helps to ensure medical compliance. The primary lead entities in this work are health care providers and mental health professionals who provide comprehensive care management for homeless individuals.
Graduate Medical Education (GME)	Dignity Health is committed increasing access to care through work force development and SJMC is a leader in growing future medical providers in San Joaquin County. The GME program started in 2018 with 15 residents and is set to expand to approximately 200 residents by 2025.
Free Medical and Dental Clinics	Financial support of St. Mary's Dining Room's health and dental clinics provides free medical services for the uninsured.
Community Grants Program	A grant to fund Community Health Connectors in Cambodian, Latino and African American communities will provide access to resources, increase opportunities for health education, and individualized case management for those with multiple chronic health conditions.
Financial Assistance Program	High-quality, affordable services are provided regardless of an individual's ability to pay, and the hospital's financial assistance offers discounted, interest free payments, or free services depending on the patient's financial circumstances.
Anticipated Impact: Overall, these programs will increase referrals and linkages to medical appointments and deliver equitable and culturally sensitive health care services for at risk individuals.	
Planned Collaboration: The full list of collaborative partners for each program is described in the program digest section of this report.	

Health Need: Substance Abuse/Tobacco

Strategy or Program Name	Summary Description
CA Bridge Program Opioid Grant	Provide medication assisted treatment with buprenorphine to everyone possible struggling with opioid use disorder. Provide education to both the community and other healthcare providers regarding opioid use disorder and treatment options such as buprenorphine. Participate in San Joaquin County Opioid Safety Coalition.
Anticipated Impact: Decrease in opioid overdose deaths, increase prescriptions of Buprenorphine	
Planned Collaboration: Emergency department physicians, Substance Use Navigator, Public Health Institute, first responders, and members of the San Joaquin County Opioid Safety Coalition.	

Health Need: Oral Health	
Strategy or Program Name	**Summary Description**
Free Dental Clinic	Financial support for St. Mary's Dining Room dental clinic provides free oral health care for the uninsured.
Anticipated Impact: Direct oral health services for uninsured individuals in need.	
Planned Collaboration: This community benefit investment to St. Mary's Dining Room provides the necessary safety net of services to ensure equitable care for the most vulnerable in the community.	

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.

Outreach & Education- Community Health Social Worker	
Significant Health Needs Addressed	✓ Mental Health ✓ Violence/Injury Prevention
Program Description	This person will be responsible for providing outreach and education regarding mental health and social topics such as stress, depression, anxiety and overcoming trauma to serve the needs of at risk community members, including youth and those with chronic diseases.
Community Benefit Category	A1 Community Health Education
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	The overall program goal is early intervention and prevention of psychosocial issues in youth, as well as educating and bringing awareness of trauma informed care and mental health first aid among service providers and parents.

Measurable Objective(s) with Indicator(s)	Measurable objectives will be developed and based on the interventions implemented, and yet to be determined.
Intervention Actions for Achieving Goal	The first step was accomplished August 2019 with the hiring of a Master's level Social Worker, MSW. Next step will include strategic planning to deploy services/interventions in areas of greatest needs.
Planned Collaboration	The collaboration will evolve, but initial partners considered include; Stockton Unified School District, law enforcement, City and County officials, and any community based organizations interested in providing their staff with trauma informed care training.

Community Grants Program

Significant Health Needs Addressed	✓ Mental Health ✓ Economic Security ✓ Obesity/Healthy Eating Active Living (HEAL)/Diabetes ✓ Violence/Injury Prevention ✓ Access to Care ✓ Substance Abuse/Tobacco ✓ Oral Health
Program Description	This formal annual grants process awards funds to projects that demonstrate ability to greatly impact many of the identified community health needs. Funded projects may change annually based on prior grantee performance, the proposed scope of work, or the amount of funding available. 2019 funded projects include: • ACEing Parenting: San Joaquin County Child Abuse Prevention Council in partnership with San Joaquin Public Health & San Joaquin General Hospital are encouraging physicians to engage the parents of minors in a discussion about Adverse Childhood Experiences (ACEs) and prompting the completion of a questionnaire to determine the Resiliency Score of the parent. Outcomes will include the increase in interventions to address trauma, treat identified behavioral health issues, and reduce the cycle of abuse. • Families Connect Project: Reinvent South Stockton California in partnership with Reinvent South Stockton Coalition, San Joaquin County Public Health, and the Trustbuilder Organization will connect South Stockton and Midtown Magnolia residents to services in order to reduce stresses and trauma. Success metrics will include increased attendance at work/school, and improved feeling of support and safety. • Child Care Mobile Farmer's Market: Emergency Food Bank in partnership with Family Resource & Referral Center, First 5 of San Joaquin & University of California, and Cal Fresh Nutrition Education will deliver fresh produce (fruits & vegetables) free of charge to 15 child care facilities within Stockton to be used for meals and snacks. This

	program will stretch the households' food budget and ensure proper nutrition for children. • Early Infant Literacy Project: Read to Me, Stockton! in partnership with Books for Babes, Stockton Unified School District & S. J. County Office of Education will enroll 800 newborns and toddlers to age three in Dolly Parton's Imagination Library. This upstream approach to academic and economic success will increase early literacy. • Community Health Connectors: Asian Pacific Self-development & Residential Association (APSARA) in partnership with Catholic Charities & Community Partnership for Families will provide access to resources, increase opportunities for health education and provide case management for those with multiple chronic health conditions. Data will be collected to measure the changes and improvement in personal health care behaviors, as well as improved linkages to health care providers to deliver services.
Community Benefit Category	E2 Grants
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Each grant must plan to address a minimum of one priority health need from the CHNA, and goals vary on the project.
Measurable Objective(s) with Indicator(s)	All grantees are expected to deliver both quantitative and qualitative results. Objectives and indicators dependent on the scope of work and will be reported in future implementation plan updates.
Intervention Actions for Achieving Goal	This grants program is overseen by an advisory committee comprised of hospital leadership, public health, and community members. This group provides accountability and support for program success.
Planned Collaboration	Collaboration is a requirement for grant funding. Each grantee partners with a minimum of one agency to deliver services.

Friends of Seniors & Links Project

Significant Health Needs Addressed	✓ Mental Health ✓ Economic Security ✓ Access to Care
Program Description	This program provides friendly visiting, transportation assistance, and resource and referral services to address basic needs for home bound seniors. The Links Project is a pilot scheduled to start in Fall 2019, and will encourage seniors to utilize technology tools and social media to increase their independent living and reduce their feelings of stress and isolation.

Community Benefit Category	A3 Health Care Support Services
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Increase access to care and food security. Increase independence and safety in place of residence and reduce feelings of isolation and loneliness.
Measurable Objective(s) with Indicator(s)	Outputs will include; number and type of rides provided, hours of friendly visiting, number of seniors using technology to meet their basic needs. Outcomes collected via annual survey; rating of volunteer qualities along with client rating of perceived levels of stress, loneliness/isolation, safety/well-being, confidence and independence.
Intervention Actions for Achieving Goal	The annual survey evaluates if the program is meeting intended goals, and regular program oversight and interaction with program volunteers in ensures program effectiveness.
Planned Collaboration	This program and the pilot rely greatly on a strong partnership with dedicated and compassionate community volunteers. Outreach for volunteer recruitment occurs regularly with the support of San Joaquin Delta College, University of the Pacific, VolunteerMatch.com, and community centers, just to name a few.

Diabetes Navigation and Education

Significant Health Needs Addressed	✓ Obesity/Healthy Eating Active Living (HEAL)/Diabetes ✓ Access to Care
Program Description	The following diabetes education programs are available to the community at no cost: • Diabetes Navigator: Resource and referral service for patients and community members seeking health education and support. • Diabetes Education Empowerment Program (DEEP): Comprehensive series of classes targeting individuals with diabetes and pre-diabetes. - 2 hours per week, 6 weeks program. • Sweet Journey 101: A highly interactive diabetes basics workshop to encourage individuals to pursue additional classes and/or diabetes support services. 2 hour workshop, available monthly. • Sugar Fix: Led by a RN, Certified Diabetes Educator, this monthly diabetes support group offers multi-disciplinary professional presentations along with peer support.

	• Certified Diabetes Educator (CDE) Consultations: Free one-on-one, personalized diabetes education for populations who face significant barriers to better health.
Community Benefit Category	A1 Community Health Education
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	The overall program goal is to increase referrals to connect individuals to health education to better manage diabetes, and ultimately improve upon other chronic diseases as well.
Measurable Objective(s) with Indicator(s)	# of individuals served, # of individuals that completed education, improved level of confidence with managing diabetes, increase understanding of how to take medication, increase minutes of activity per week, decrease consumption of sugary beverages, improved A1c levels.
Intervention Actions for Achieving Goal	All programs survey participants before and after education to determine the increase of knowledge and evaluate program impact.
Planned Collaboration	CDE consultations are delivered in the community in partnership with clinics who serve high-risk populations; St. Mary's Dining Room, Asian Pacific Self-development & Residential Association (APSARA), and Fremont Clinic. All other classes/workshops are open to be delivered in the community and often are provided in community centers, libraries, and community based organizations upon request.

Connected Community Network

Significant Health Needs Addressed	✓ Mental Health ✓ Economic Security ✓ Obesity/Healthy Eating Active Living (HEAL)/Diabetes ✓ Violence/Injury Prevention ✓ Access to Care ✓ Substance Abuse/Tobacco ✓ Asthma ✓ Oral Health ✓ Climate and Health
Program Description	This county-wide network of stakeholders, navigation and convening partners, along with community based organizations will create a fully integrated repository of resources and referrals through a shared technology platform. This strategy has the potential of addressing all CHNA identified needs among others.

Community Benefit Category	A1 Community Health Education
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Anticipated network launch is scheduled for January, 2020.
Measurable Objective(s) with Indicator(s)	Full spectrum of measurable outcomes are to be determined through the collaborative implementation phase of the network scheduled to start October 1, 2019.
Intervention Actions for Achieving Goal	Regularly scheduled convening of network partners, along with network integrity, accountability and oversight via technology partner.
Planned Collaboration	Full list of collaborative partners is yet to be determined, but key agencies include 211 of San Joaquin, Family Resource and Referral Center, and United Way of San Joaquin and United Way Worldwide.

Recuperative Care at Gospel Center Rescue Mission

Significant Health Needs Addressed	✓ Mental Health ✓ Economic Security ✓ Obesity/Healthy Eating Active Living (HEAL)/Diabetes ✓ Violence/Injury Prevention ✓ Access to Care ✓ Substance Abuse/Tobacco ✓ Oral Health
Program Description	Safe hospital discharge for those experiencing homelessness with medical conditions that could worsen if returned to the streets. Case management services help to ensure compliance with discharge plan.
Community Benefit Category	E2 Grants
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Provide immediate shelter for safe recovery post hospitalization, provide resources, referrals, and connections to ongoing physical, oral and mental health treatment, permanent housing, residential substance abuse treatment, life skills and work readiness programs. Reduce emergency room visits and hospital admissions through proactive management of health via a medical home.
Measurable Objective(s) with Indicator(s)	# of recuperative care referrals, # of individuals served, % of program participants that are housed post recuperative care, % of individuals

	connected to a primary care, % of hospital readmissions pre/post program
Intervention Actions for Achieving Goal	Continued support of recuperative care via both in-kind and financial investments to ensure program services and expand capacity to meet needs.
Planned Collaboration	Hospital Care Coordination and Social Work staff partner closely with Gospel Center Rescue Mission to ensure appropriate program referrals.

Matters of Balance

Significant Health Needs Addressed	✓ Obesity/Healthy Eating Active Living (HEAL)/Diabetes ✓ Violence/Injury Prevention
Program Description	This nine week workshop, done in locations throughout the community, offers older adults 2 hour weekly sessions that provide practical tips to overcome fears of falling and increase strength, agility, stability, and physical activity.
Community Benefit Category	A1 Community Health Education
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Reduce fears of falling, reduce falls, increase activity levels and physical strength
Measurable Objective(s) with Indicator(s)	# of participants, # of individuals who have fallen pre and post program, # of individuals who completed safety modifications in the home (i.e. grab bars, and securing loose rugs)
Intervention Actions for Achieving Goal	Regular and strategic outreach to ensure community engagement and class participation will help to achieve goals.
Planned Collaboration	This program is in collaboration with San Joaquin County Public Health Services, and community based organizations interested in being hosts of this program.

San Joaquin Community Health Improvement Plan (CHIP)

Significant Health Needs Addressed	✓ Obesity/Healthy Eating Active Living (HEAL)/Diabetes ✓ Violence/Injury Prevention

Program Description	As a core team and steering committee member, St. Joseph's Medical Center will play a supportive and active role in advancing the CHIP goal of helping people of all ages and abilities get more physically active through programs that meet their language and culture needs.
Community Benefit Category	TBD based on implementation strategies and the type of investments that need to be deployed. (i.e. in-kind, financial, etc.)

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	Develop parks so that they are utilized by community and contribute towards reducing neighborhood crime and violence, vagrancy, and increasing physical activity of residents.
Measurable Objective(s) with Indicator(s)	• Increased enforcement of county codes/policies that push funding toward environmental/programmatic improvements to support safe routes to parks/active transportation in the priority neighborhoods. • Increased access to places/opportunities for physical activity in the Priority Neighborhoods. • Increased Priority Neighborhood resident awareness of available parks/programming that promotes physical activity.
Intervention Actions for Achieving Goal	San Joaquin Public Health will lead in the strategy and implementation of the CHIP, and St. Joseph's Medical Center Community Health Staff will remain as active stakeholders.
Planned Collaboration	The CHIP will advance through the collaboration of the following primary stakeholders, alongside many other public, private and governmental agencies. • Adventist Health, Community Medical Centers, Dameron Hospital, Dignity Health, First 5 of San Joaquin, Health Net, Health Plan of San Joaquin, Kaiser Permanente, and San Joaquin County Public Health, and Sutter Health.

Graduate Medical Education (GME)

Significant Health Needs Addressed	✓ Mental Health ✓ Obesity/Healthy Eating Active Living (HEAL)/Diabetes ✓ Violence/Injury Prevention ✓ Access to Care ✓ Substance Abuse/Tobacco

Program Description	Dignity Health is committed to workforce development, and SJMC is a leader in growing future medical providers in San Joaquin County. The GME program started in 2018 and below is a summary of the implemented and planned expansion of the program: • Family Practice: 6 new residents each year x3 years (started 6/2018) • Emergency Medicine: 9 new residents each year x3 years (started 6/2018) • Internal Medicine: 10 new residents each year x3 years (to start, 6/2020) • Obstetrics/Gynecology: 4 residents each year x4 years (to start 6/2021) • Psychiatry: 7 new residents each year x4 years (to start 6/2021-possibly 6/2020) • Anesthesia: 4 new residents each year x4 years (to start 6/2021)
Community Benefit Category	B1 – Physicians/Medical Students

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	The overall anticipated outcome is to increase the number of medical providers trained and practicing in San Joaquin County. Program specific goals, objectives and impact measures will also be reported as research projects and community based services are implemented.
Measurable Objective(s) with Indicator(s)	# of medical providers trained, # of patients served, # new residency programs. Quantifiable metrics to be determined based on the community health program strategy developed for the residents.
Intervention Actions for Achieving Goal	Residents will participate in a required mentoring program designed to meet their individual needs. As part of this program they will work directly with experienced physicians who are caring for underserved and diverse populations. These assigned mentor physicians will act as role models for the residents and display the qualities of physicians with expertise of serving diverse populations, all in an effort to inspire residents to continue caring for local residents.
Planned Collaboration	Community Medical Centers, Touro California, Oakland Children's Hospital, San Joaquin County Hospital, Alpine Orthopedic, Center for Sight, Central Valley Eye, Gill Group, Kaiser Permanente Otorhinolaryngology Specialty.

St. Mary's Free Medical and Dental Clinics

Significant Health Needs Addressed	✓ Mental Health ✓ Obesity/Healthy Eating Active Living (HEAL)/Diabetes

	✓ Access to Care ✓ Asthma ✓ Oral Health
Program Description	Financial support of St. Mary's Dining Room's health and dental clinics to provide free care for the uninsured as well as for those experiencing homelessness.
Community Benefit Category	E2 Grants
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Ensure that those with no or limited access to medical and oral healthcare have a place to receive services.
Measurable Objective(s) with Indicator(s)	# of persons served, # and types of services rendered at both the medical and dental clinics
Intervention Actions for Achieving Goal	Quarterly reporting from St. Mary's to Community Benefit staff to ensure disbursement of funds based on scope of work.
Planned Collaboration	This financing support from St. Joseph's Medical Center directly funds the free clinics operated by St. Mary's Dining Room.

Bridge Program	
Significant Health Needs Addressed	✓ Mental Health ✓ Economic Security ✓ Violence/Injury Prevention ✓ Access to Care ✓ Substance Abuse/Tobacco
Program Description	Provide medication assisted treatment with buprenorphine to everyone possibly struggling with opioid use disorder. Provide education to both the community and other healthcare providers regarding opioid use disorder and treatment options such as buprenorphine. Participate in San Joaquin County Opioid Safety Coalition
Community Benefit Category	E2 Grants
Planned Actions for 2019 - 2021	

Program Goal / Anticipated Impact	Decrease in opioid overdose deaths, increase prescriptions of Buprenorphine
Measurable Objective(s) with Indicator(s)	# of buprenorphine prescriptions, # of patients treated and/or referred for treatment, # of overdose deaths
Intervention Actions for Achieving Goal	Increased education to healthcare providers and community regarding Medication Assisted Treatment (MAT).
Planned Collaboration	Emergency department physicians, Substance Use Navigator, Public Health Institute, first responders, and members of the San Joaquin County Opioid Safety Coalition.

Human Trafficking Education and Outreach

Significant Health Needs Addressed	✓ Mental Health ✓ Economic Security ✓ Violence/Injury Prevention ✓ Access to Care ✓ Substance Abuse/Tobacco
Program Description	Through involvement in both the Human Trafficking Healthcare Workgroup and the San Joaquin County Human Trafficking Taskforce, SJMC seeks to increase awareness, response, and care and support of trafficked victims.
Community Benefit Category	A5 – Initiative - Human Trafficking Community Response

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	Increase community awareness of Human Trafficking, increase implementation of protocols to identify and respond to victims in health care settings.
Measurable Objective(s) with Indicator(s)	Complete list of 2019 - 2021 metrics to be determined, but will consist of: • Completion of online access of documents/templates of Human Trafficking Healthcare Toolkits that provide policy, procedure and training protocols, along with resources. • # of health care organizations that request and implement victim response protocols.
Intervention Actions for Achieving Goal	Development of a policies and procedures template for use at healthcare facilities, as well as universal PowerPoint template for use in both acute and ambulatory healthcare settings.

Planned Collaboration	Continued collaboration with the over 50 organizations participating in the SJC Human Trafficking Taskforce.

San Joaquin County Whole Person Care (WPC)

Significant Health Needs Addressed	✓ Mental Health ✓ Economic Security ✓ Obesity/Healthy Eating Active Living (HEAL)/Diabetes ✓ Violence/Injury Prevention ✓ Access to Care ✓ Substance Abuse/Tobacco
Program Description	As a partner in this countywide collaborative pilot, hospital social work and care coordination staff identifies and refers homeless patients to WPC in an effort to secure stable housing and income, and improve health for individuals experiencing or at-risk of homelessness.
Community Benefit Category	A1 Community Health Education

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	Improve the lives of individuals experiencing homelessness through comprehensive case management and connection to resources.
Measurable Objective(s) with Indicator(s)	# of individuals enrolled and engaged in WPC, # of emergency visits and hospital admissions, % of WPC enrollees referred and received housing
Intervention Actions for Achieving Goal	Active utilization of care management platform, Act.MD, to ensure tracking of care plan.
Planned Collaboration	WPC is possible through the participation of the following agencies; Central Valley Low Income Housing, Community Medical Centers, Correctional Health Services, Gospel Center Rescue Mission, Health Net, Health Plan of San Joaquin, San Joaquin Community Health Information Exchange, San Joaquin County Clinics, San Joaquin County Behavioral Health Services, San Joaquin County Health Care Services Agency, San Joaquin County Public Health Services, San Joaquin County Substance Abuse Services, and San Joaquin General Hospital.

Hospital Board and Committee Rosters

Port City Operating Company, LLC Board of Managers

Richard Carvolth, MD	Chief Physician Executive, Dignity Health
Debra Cunningham	SVP, Strategy, Kaiser Permanente
Tom Hanenburg	SVP, Hospital & Health Plan Operations, Kaiser Permanente
Corwin Harper	SVP Central Valley Service Area, Kaiser Permanente
John Petersdorf	SVP Operational Effectiveness, Dignity Health
Jon VanBoening	President, Dignity Health Central California Division
Kevin Walters	CSO/SAO Central California Division, Dignity Health

Community Health Department Advisory Committee

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

Integrated Quality Council

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