St. Joseph's Medical Center and St. Joseph's Behavioral Health Center

2022 Community Health Implementation Strategy

Adopted October 2022

Dignity Health

St. Joseph's Behavioral Health Center
St. Joseph's Medical Center

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At-a-Glance Summary

Community Served

St. Joseph's Medical Center (SJMC) and St. Joseph's Behavioral Health Center (SJBHC), in collaboration with other community stakeholders, chose San Joaquin County as the primary service area for the Community Health Needs Assessment (CHNA). However both hospitals primarily serve residents of Stockton along with members of neighboring communities within San Joaquin County. Overall the primary hospitals' service area consists of 24 ZIP codes, and based on the top 75-80% of patient discharges from FY20 (July 1, 2019 - June 30, 2020) the patients served were from the following specific zip codes; 95203, 95204, 95205, 95206, 95207, 95209, 95210 and 95215.

Significant Community Health Needs Being Addressed

The significant community health needs the hospitals are helping to address, and that form the basis of this document, were identified in the hospitals' 2022 Community Health Needs Assessment (CHNA). Needs being addressed include:

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

Strategies and Programs to Address Needs

The hospitals intend to take several actions and to dedicate resources to these needs, including:

Mental Health/Behavioral Health Including Substance Use

St. Joseph's Medical Center (SJMC):

- Community Health Social Worker staffed to advance mental health programming.
- Launch of new programs: Youth Overcoming Life's Obstacles (YOLO) group (ages 14-17), Mental Health First Aid training, Trauma Informed Systems Training through embedded local trainers and local coaches.
- Established psychiatry residency in partnership with Touro University.
- Substance Use Navigator funding acquired and position staffed in the ED.

St. Joseph's Behavioral Health Center (SJBHC):

- Continued 24/7/365 Behavioral Health Evaluations countywide.
- Continuing Care group that is free to the community as a step down program for those recovering from substance use/abuse.

Access to Care

SJMC:

- Expansion of Graduate Medical Education.
- Continued FOCUS programming to fully integrate routine opt-out Hep C, HIV, and Syphilis screening in the ED and ensure patient linkages to care through navigation services.

- Continued the Homecoming Program in partnership with Catholic Charities to provide a successful post hospital recovery through comprehensive case management, addressing both health and health related social needs. (This program supports various CHNA needs including; chronic disease/HEAL, family and social support, and transportation.)

SJBHC:

- Expansion of Psychiatry residency and workforce development of nursing and social workers

Income and Employment

SJMC:

- Implementation of the Connected Community Network (CCN) to streamline community resource connections and communications among social service providers.
- Launch of Community Health Advocate pilot to identify health related social needs of patients in the SJMC Emergency Dept and refer them to community resources(this program support many other health needs as well)
- Implementation of the Pathways Community HUB, an evidence based, pay for outcomes model, that supports the valuable role of Community Health Workers.

Housing

SJMC:

- Increased investments through a Homeless Health Initiative (HHI) fund which expanded mobile street outreach in partnership with the Salvation Army of Stockton, increased permanent housing solutions in collaboration with STAND Affordable Housing and San Joaquin County Whole Person Care, and comprehensive case management services for emergency department patients post discharge.
- Continued collaboration with the Gospel Center Rescue Mission to ensure safe patient discharges through the Recuperative Care program.
- Active involvement with the San Joaquin County Continuum of Care (CoC) to collectively find solutions to address homelessness.

Chronic Disease/Healthy Eating & Active Living (HEAL)

SJMC:

- Investments to support the Community Health Improvement Plan (CHIP) including improving park beautification & increasing park activation to address community safety, health and wellness in CHNA priority neighborhoods.
- Implementation of multiple diabetes education programs, including Diabetes Navigation services, Power Hour, Diabetes Empowerment Education Program (DEEP), Certified Diabetes Care & Education Specialist (CDCES) Consultations, the Sugar Fix Support Group, & psycho-social assessments and resource referrals for patients experiencing social barriers to diabetes care.
- The annual Community Grants Program supports the CHNA needs through a competitive application process.

SJBHC:

- Community Grants Program (joint investments in partnership with SJMC)

Community Safety

SJMC:

- Investments to improve park beautification & increase park activation to address community safety, health and wellness in CHNA priority neighborhoods
- Active participation in the San Joaquin HumanTrafficking Task Force to bring awareness of, education and support to victims of humantrafficking and leadership in the Healthcare Workgroup to support response protocols within other healthcare facilities.

Family and Social Support

SJMC:

- Connected Community Network – improve referral linkages & enhance communication among social service partners.
- Implementation of the Pathways Community HUB,mitigates health related social risk factors, through the assessment of closure of 21 specific "pathways"..
- Community Health Advocate program, offering social needs screening and referrals to emergency department patients to proactively mitigate risks that increase poor health outcomes if left unaddressed.
- Continued the Lifeline home monitoring services in an effort to improve independent living and safety for older adults and individuals with disabilities.

SJBHC:

- Relaunch of low cost/open to the community DBT 101 to support families with a loved one in treatment.

Education

SJMC:

- Expanded the Connected Community Network into the education sector by onboarding the San Joaquin County Office of Education to improve educational attainment by addressing unmet social needs.
- Established a relationship with local universities to support masters level social work internships.

SJBHC:

- Established a relationship with local universities to support masters level social work internships.

Transportation

SJMC:

- Connected Community Network – improve referral linkages & enhance communication among social service partners
- Homecoming Project in partnership with Catholic Charities to provide a successful post hospital recovery through comprehensive case management, addressing both health and health related social needs.

SJBHC:

- Transportation assistance for patients in need

Anticipated Impact

Through the various strategies and programs, SJMC and SJBHC seek to positively impact the lives of those served and below is a high level summary of the anticipated impact per health need.

Mental Health/Behavioral Health Including Substance Use:
Plans are to increase access to mental health and substance use treatment and supportive services, as well as address barriers such as financial insecurity, lack of insurance, transportation, social stigma, language and cultural competencies.

Access to Care:
Increase access to medical, dental and specialty care and address barriers such as lack of providers, cost of services, inadequate insurance coverage through patient education and navigation to establish linkages to care and disease prevention.

Income and Employment:
Expand the provision of social services and supportive services to assist individuals with the ability to maintain housing, provide their families with healthy foods and access needed medical and community resources through health related social needs screenings.

Housing:
Increase collaboration to expand stable and affordable housing solutions for low-income residents who struggle to find affordable housing, as well as for people experiencing homelessness including potential solutions such as;

- Expanding social determinants of health screening across community health programs
- Establishing a low barrier, higher acuity medical respite facility
- Contracting with skilled nursing facilities to support unsheltered patients with complex needs, including behavioral health
- Implementing interim supportive housing options
- Expand referrals to sober living environments through Medication-Assisted Treatment grant services
- Proactively assess housing insecurity through social needs screening and increase referrals to housing and economic security resources

Chronic Disease/Healthy Eating & Active Living (HEAL):
Continue with the implementation, expansion, and process improvement of existing strategies in order to increase outreach, community engagement, and participant participation in diabetes education and prevention programs, fall prevention, and CHIP activities.

Community Safety:
Increase the safety of public spaces that are intended for physical activity by supporting CHIP activities, and expand awareness of humantrafficking through participation of the San Joaquin County Humantrafficking Task Force.

Family and Social Support:

	Expand supportive services for residents with disabilities, limited family support, and/or limited English proficiency to sustain healthy communities via large support networks. **Education:** Expand collaboration with charter schools, high schools, colleges and universities to grow existing internship opportunities and increase internship opportunities for students and ultimately improve community health and reduce cycles of poverty. **Transportation:** Improve transportation assistance for those lacking resources by identifying unmet needs, assessing existing services, and addressing any identified gaps in resource capacity.
Planned Collaboration 	Dignity Health prides itself in being an innovative and strategic partner to break silos and advance community health. Collaboration with community-based non-profit organizations, government leadership, as well as public and private stakeholders is planned and highlighted in its respective sections below.

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 Hospitals and the Community Served

About Our Hospitals

Dignity Health St. Joseph's Medical Center (SJMC) and St. Joseph's Behavioral Health Center (SJBHC) are a part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 1,000 care sites in 21 states coast to coast, serving 20 million patients in big cities and small towns across America. Both hospitals take pride in serving the residents of San Joaquin County and are recognized champions for health. Below are a few notable achievements, demonstrating excellence and commitment to the community.

SJMC Highlights:

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

St. Joseph's Behavioral Health Center established services in 1974 as a patient care unit at St. Joseph's Medical Center (SJMC) in Stockton. In 1988, the program expanded operations to the current location, 2510 North California Street. SJBHC is a 35 bed licensed not-for-profit psychiatric hospital serving Central California, with 154 employees and 18 medical staff members. Inpatient and partial hospitalization services are provided to adults, 18 years and older and outpatient services are provided for adults, adolescents and children older than 5 years of age.

Our Mission

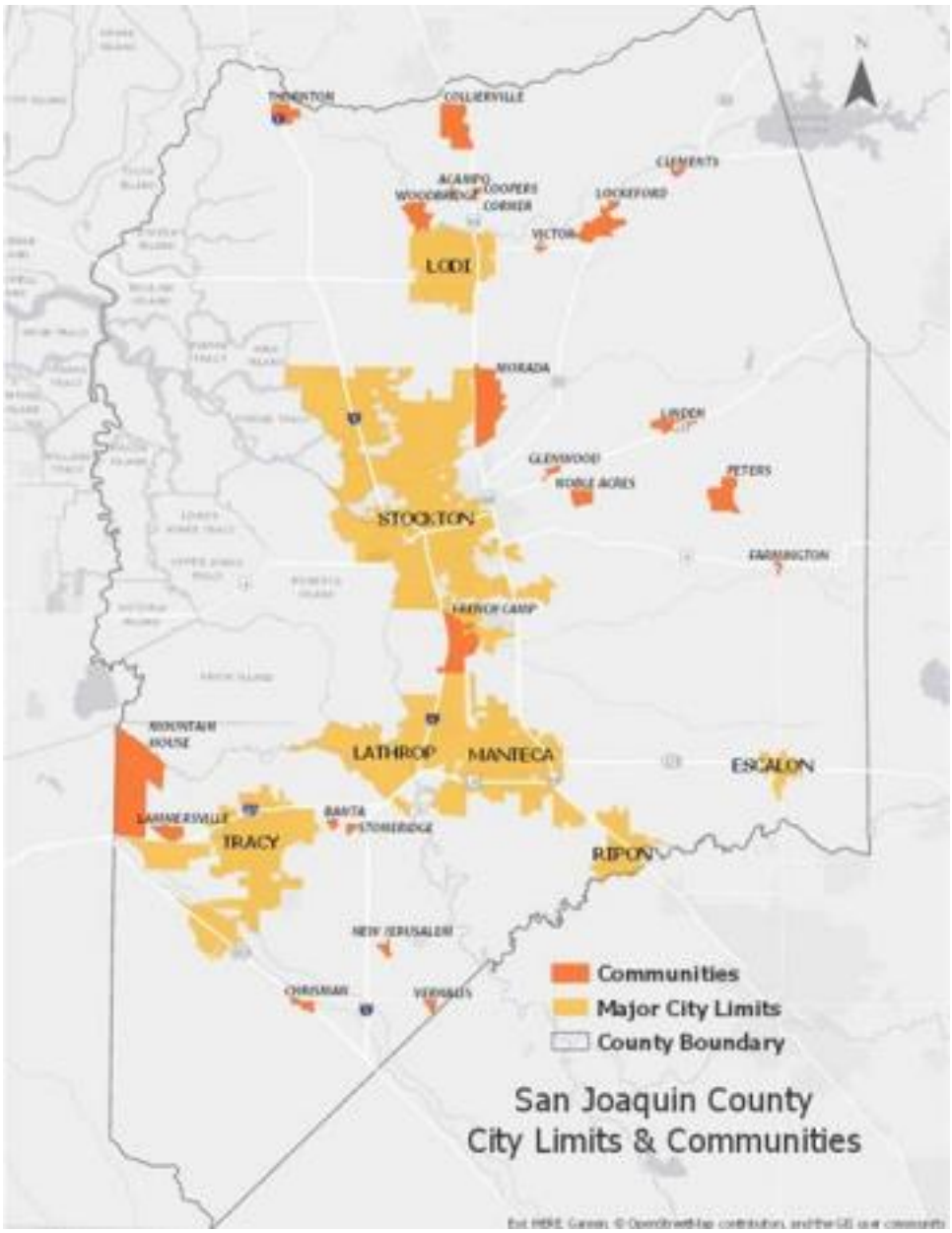
The hospitals' dedication to assessing significant community health needs and helping to address them in conjunction with the community is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Financial Assistance for Medically Necessary Care

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

Description of the Community Served

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



San Joaquin County, in the Central Valley of California, is roughly 60 miles east of San Francisco and 35 miles south of Sacramento, with a total population of 742,603 (2019). Historically, agriculture has been a strong driver of our economy and many migrants and immigrants have settled here to work in the fields and help with agricultural processing or shipping. The County is mostly rural, with one large urban core (Stockton) and seven smaller cities, as well as many ranching and farming communities scattered across the County.

San Joaquin County is home to a high concentration of residents at elevated risk for COVID-19 and who have experienced enormous impacts from the pandemic. A quarter of residents are foreign-born. Overall, 14.5% of residents live in poverty. Residents aged 65 years and

older have a poverty rate of 9.9%. The educational attainment of San Joaquin County residents is much lower than California residents. Only 18.8% of County residents aged 25 and older have a bachelor's degree or higher, compared to 33.9% of Californians aged 25 and older that have a bachelor's degree or higher.

Community Assessment and Significant Needs

The health issues that form the basis of the hospitals' community health implementation strategy and programs were identified in the most recent CHNA report, which was adopted in May 2022.

The CHNA contains several key elements, including:

- Description of the assessed community served by the hospitals;
- 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 on the hospitals' website or upon request from the respective hospital, using the contact information in the At-a-Glance Summary.

Significant Health Needs

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

Significant Health Need	Description	SJMC Intends to Address?	SJBHC Intends to Address?
Mental Health/Behavioral Health Including Substance Use	Mental health affects physical wellbeing, job performance, and community activities.	•	•
Access to Care	Quality healthcare is important for health and is essential for maintaining a higher quality of life.	•	•
Income and Employment	Barriers such as low income, high unemployment, and pervasive poverty can exacerbate poor health outcomes.	•	•
Housing	Stable, affordable housing is strongly associated with health, well-being, educational achievement, and economic success.	•	•
Chronic Disease/Healthy Eating and Living (HEAL)	Those who have limited access to healthy foods have a higher risk of developing a chronic disease, such as obesity and heart disease. Along with a healthy diet, physical activity is key to preventing and reducing complications from chronic diseases.	•	•
Community Safety	Safe communities promote community cohesion and economic development, and provide more opportunities to be active and improve mental health while reducing	•	•

Significant Health Need	Description	SJMC Intends to Address?	SJBHC Intends to Address?
	untimely deaths and serious injuries.		
Family and Social Support	The presence or absence of a strong social support network affects all aspects of life, including physical and mental wellbeing.	•	•
Education	The link between education and health is well known – those with higher levels of education are more likely to be healthier and live longer.	•	•
Transportation	Without reliable and safe transportation, individuals struggle to meet basic needs such as earning an income, accessing health care, and securing food.	•	•

2022 Implementation Strategy

This section presents strategies and program activities that the hospitals intend to deliver, fund, or collaborate with others on to address significant community health needs over the next three years, including resources for and anticipated impacts of these activities.

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

Creating the Implementation Strategy

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

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

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

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

Community Health Strategic Objectives

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

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

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

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

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

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

Strategies and Program Activities by Health Need

Health Need: Mental Health/Behavioral Health Including Substance Use					
Anticipated Impact (Goal)	• Increase access to mental health & substance use treatment/services. • Address barriers such as cost, lack of insurance, transportation, language/cultural competency, social stigma.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
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 grants program is a strategy to fund innovative, collaborative services to address the needs identified in the CHNA and awarded partners are required to report outputs and outcomes of services.	●	●	●	●
Community Mental Health Programming	In collaboration with other mental health experts and service providers, SJMC and SJBHC will deploy and/or support several programs/initiatives to address Mental Health/Behavioral Health Including Substance Use, including but not limited to: • 24/7, 365 behavioral health evaluations • Substance Use Navigation • Medication Assisted Treatment • SJC Mental Health Consortium - Membership in this group supports the sharing of mental health resources and best practices.	●	●	●	●

Health Need: Mental Health/Behavioral Health Including Substance Use					
	• Youth Overcoming Life's Obstacles (YOLO) Group to address anxiety and depression in youth. • Mental Health First Aid: A certificated training to help adults and teens working with the community, to identify and respond to signs of addictions and mental illnesses. • Trauma Informed Training				
Friends of Seniors Links	This program supports the reduction of isolation and depression in older adults through intergenerational volunteers who provide friendly visiting, community resource/referrals, and opportunities for social activities.	●	●	●	●
GME Psychiatry Residency	Dignity Health is committed to increasing access to care through workforce development and SJMC is a leader in growing future medical providers in San Joaquin County. In partnership with Touro University, the GME program started in 2018 with 15 residents and is set to expand to approximately 200 residents by 2025. • Psychiatry: 7 new residents each year x4 years (started 06/2021)	●	●	●	●
Connected Community Network (CNN)	This network was created to provide the general population with access to resources and programs offered through various community based organizations (CBOs) and is an initiative to address the complex needs of hospital patients and the broader community. Many CBOs provide vital services that help people address a variety of needs, including but not limited to: affordable housing; maternal, infant, and child health; chronic disease management programs, healthy food, and mental health and substance abuse counseling.	●	●	●	●

Health Need: Mental Health/Behavioral Health Including Substance Use					
Community Health Advocate (CHA) Program	Launched in October of 2021 in partnership with Community Partnership for Families of San Joaquin (CPFSJ), the CHA is a strategy to address multiple identified unmet needs through a universal screening of the social determinants of health for patients in the hospital emergency department. The CCN technology is utilized to provide a ten question screening spanning seven social domains and is used to make community referrals. All of the CHNA health needs are assessed in the screening. The following question is included in the screening to help identify and address feelings of isolation: *How often do you feel lonely or isolated from those around you? (Never, Rarely, Sometimes, Fairly often, Very often)*	●	●	●	●
SJC Trauma Initiative	A collaborative group of over 70 members, representing 41 organizations throughout the county focusing on addressing trauma and promoting equity through the development of a Trauma Informed Care train-the-trainer training model for sustainability. This initiative focuses on addressing diversity, inclusion and cultural humility for both medical staff and providers, as well as social service providers.	●	●	●	●
CA Bridge Program Opioid Grant	Provide medication assisted treatment with Buprenorphine to those struggling with opioid use disorder. Provide education to both the community and other healthcare providers regarding opioid use disorder and treatment options such as buprenorphine. Participate in the San Joaquin County Opioid Safety Coalition.	●	●	●	●

Health Need: Mental Health/Behavioral Health Including Substance Use	
Planned Resources	The hospital will provide both funding and in-kind funds for staff, community health educators, philanthropic cash grants, outreach communications, supplies, and program management support for these initiatives.
Planned Collaborators	Cross-sector collaboration is planned for all of the programs listed in order to ensure efficiency of services, leveraging of resources, avoidance of duplication, and to ensure sustainability. In addition to those partners listed above, additional key partners include: Reinvent South Stockton Coalition, United Way of San Joaquin, San Joaquin County Behavioral Health Services, along with the growing number of CCN and SJC Trauma Initiative partners.

Health Need: Access to Care					
Anticipated Impact (Goal)	• Increase access to medical/dental/speciality care. • Address barriers such as lack of providers, cost of services, co-pays, inadequate insurance coverage, etc.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
San Joaquin County Whole Person Care (WPC)	Continuing the strong collaboration with the WPC team to ensure a smooth transition of care for individuals experiencing homelessness and increase the linkages to the Cal-AIM Enhanced Care Management and Community Supports for those who qualify.	●	●	●	●
St. Joseph's Community Health Department Education Programs	Diabetes Navigator: Resource and referral service for patients and community members seeking health education and support.	●	●	●	●

Health Need: Access to Care					
Community Grants Program	Through a formal process, grants are administered annually to non-profit organizations that best demonstrate their ability to impact community health needs as they pertain to the most recent needs assessment. The grants program is a strategy to fund innovative, collaborative services to address the needs identified in the CHNA and awarded partners are required to report outputs and outcomes of services.	●	●	●	●
Graduate Medical Education (GME)	Dignity Health is committed to increasing access to care through workforce development and SJMC is a leader in growing future medical providers in San Joaquin County. In partnership with Touro University, the GME program started in 2018 with 15 residents and is set to expand to approximately 200 residents by 2025.	●	●	●	●
Free Medical and Dental Clinics	This community benefit investment provides financial support of St. Mary's Dining Room's health and dental clinics that provides free medical and dental services for the uninsured.	●	●	●	●
Frontlines of Communities in the United States (FOCUS)	Supports CDC recommendations for universal screening of HIV, Hepatitis C and Syphilis. Patient Navigators support linkage to care of individuals found positive from testing. Works with partners, such as San Joaquin County Public Health Services, Gilead Sciences, California Department of Public Health and other FOCUS funded partners, to develop and share replicable model programs that embody best practices in HIV and HCV screening and linkage to care. As of FY22 Syphilis screening was added in.	●	●	●	●

Health Need: Access to Care					
Homecoming Program	In partnership with Catholic Charities, this program provides comprehensive community case management for up to six-weeks post discharge for SJMC patients identified with limited family support and resources.	●	●	●	●
Financial Assistance Program	High-quality, affordable services are provided regardless of an individual's ability to pay, and the hospital's financial assistance offers discounted, interest free payments, or free services depending on the patient's financial circumstances.	●	●	●	●
Planned Resources	Both hospitals will provide both funding and in-kind funds for staff, community health educators, philanthropic cash grants, outreach communications, supplies, and program management support for these initiatives.				
Planned Collaborators	Program partners are noted in the respective program summaries above.				

Health Need: Income & Employment					
Anticipated Impact (Goal)	Aid residents' ability to maintain housing, provide their families with healthy foods, and access medical care.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Connected Community Network (CNN)	Please reference the Mental Health Need section above for the program description.	●	●	●	●

Health Need: Income & Employment					
Community Health Advocate (CHA) Program	Please note the full program description in the Mental Health need section above. The following questions are included in the screening to proactively identify and address financial issues: *In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?* *Yes / No / Already shut off* *In the past 12 months, how often did you skip medications to save money?* *Never / Rarely / Sometimes / Fairly often / Very often* *How often does this describe you? I don't have enough money to pay my bills:* *Never / Rarely / Sometimes / Fairly often / Very often*	●	●	●	●
Pathways Community Hub (PCH)	The PCH is an integrated model that utilizes a localized, outcomes-based approach that connects individuals to Community Health Workers (CHWs) who assess and help resolve identified, modifiable risk factors that could lead to poor health outcomes if left unaddressed. Dedicated Community Health staff from St. Joseph's Medical Center is leading the implementation of a certified PCH in San Joaquin County, alongside other community stakeholders to build a sustainable CHW workforce to address the social determinants of health impacting the community. The growing list of partners include: San Joaquin Community Foundation, United Way of San Joaquin, Health Plan of San Joaquin, HealthNet, Reinvent South Stockton Coalition, California Health Care Foundation, Abbott Fund, Public Health Institute, Center to Advance Community Health and Equity, San Joaquin	●	●	●	●

Health Need: Income & Employment					
	Public Health Services, and others.				
Partner Collaboration	SJBHC will expand collaboration with a local staffing agency to help individuals seek employment after discharging from outpatient behavioral health care.	●	●	●	●
Planned Resources	Hospitals will provide both funding and in-kind funds for staff, community health educators, philanthropic cash grants, outreach communications, supplies, and program management support for these initiatives.				
Planned Collaborators	Program partners are noted in the respective program summaries above.				

Health Need: Housing					
Anticipated Impact (Goal)	Reduce challenges such as rent affordability, crowded households, etc. that can increase mental health difficulties & domestic violence.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Homeless Health Initiative	● STAND and Project Homekey – $1.8 million – 7 units shared scattered site permanent housing for at least 16 previously housing ready Whole Person Care clients and a $722,650 contribution to support Town Center Studios (39 units, housing up to 41 previously homeless individuals)	●	●	●	●

Health Need: Housing					
Gospel Center Rescue Mission Recuperative Care (GCRM)	Safe hospital discharge for those experiencing homelessness with medical conditions that could worsen if returned to the streets. Case management services help to ensure compliance with discharge plans and link individuals to resources for housing, employment, and other services to help them become self-sufficient. GCRM also converted some of their housing to specifically take homeless COVID positive patients that were able to be discharged from the hospital.	●	●	●	●
San Joaquin County Continuum of Care (SJCoC)	Community Health staff participate actively in the SJCoC in the following capacities; general membership, Education and Membership Committee, the Strategic Planning Committee, as well as the Coordinated Entry System Committee to develop solutions to end homelessness.	●	●	●	●
San Joaquin County Whole Person Care (WPC)	As a partner in this countywide collaborative project, the hospital identifies and refers homeless patients to WPC in an effort to secure stable housing and income for individuals experiencing or at-risk of homelessness. With the implementation of Cal-AIM and Community Supports, collaboration has expanded to ensure smooth transitions of care for unhoused patients.	●	●	●	●
Community Health Advocate (CHA) Program	The following question is included in the screening to help identify and address housing insecurity: *What is your current living situation today?* *I have a steady place to live* *I have a steady place but am worried about it in the future* *I do not have a steady place to live*	●	●	●	●
Interim Supportive Housing Project	In collaboration with Health Plan of San Joaquin, Dignity Moves, the City of Stockton, San Joaquin County Healthcare Services,	●	●	●	●

Health Need: Housing					
	CommonSpirit Health, St. Mary's Dining Hall, and others, SJMC is exploring the development of a low barrier medical respite and transitional housing project to help address some identified resource gaps existing in San Joaquin County.				
Planned Resources	The hospital will provide both funding and in-kind funds for staff, community health educators, philanthropic cash grants, outreach communications, supplies, and program management support for these initiatives.				
Planned Collaborators	Program partners are noted in the respective program summaries above.				

Health Need: Chronic Disease/Healthy Eating, Active Living (HEAL)					
Anticipated Impact (Goal)	Increase access to healthy food & safe places for physical activity.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
St. Joseph's Community Health Department Education Programs	• Power Hour:1 hour, monthly presentations focused on increasing individuals' diabetes self-management skills. Topics cover the American Association of Diabetes Educators, AADE7™ Self-Care Behaviors. (launch July 2022)	•	•	•	•

Health Need: Chronic Disease/Healthy Eating, Active Living (HEAL)					
	• Certified Diabetes Care and Education Specialist (CDCES) consultations are provided at no cost to individuals who would otherwise not have access to this specialty service. One on one consultations evaluate and address barriers to diabetes care and management. • Diabetes Education and Empowerment Program (DEEP): 2 hour/week, 6 week program focusing on healthy living and diabetes prevention and management. • Diabetes Navigator: Resource and referral service for patients and community members seeking health education and support. • Matters of Balance: This nine week workshop offers older adults 2 hour weekly sessions that provide practical tips to overcome fears of falling. • Sugar Fix Support Group: Monthly diabetes peer-to-peer support group co-facilitated by a Certified Diabetes Care and Education Specialist and Community Health Social Worker.				
San Joaquin Community Health Improvement Plan (CHIP)	As a core team and steering committee member, hospital staff played a supportive and active role in advancing the CHIP goal of helping people of all ages and abilities get more physically active through programs that meet their language and culture needs. The goal of the CHIP is to increase physical activity in residents through the utilization of community parks. More information regarding the CHIP can be found at www.healthiersanjoaquin.org.	•	•	•	•
Community Grants Program	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 grants program is a strategy to fund innovative,	•	•	•	•

Health Need: Chronic Disease/Healthy Eating, Active Living (HEAL)					
	collaborative services to address the needs identified in the CHNA and awarded partners are required to report outputs and outcomes of services.				
Community Health Advocate (CHA) Program	The following question is included in the screening to help identify and address food insecurity: *In the last 12 months, the food that you bought just didn't last, and you didn't have money to get more.* *Never true / Sometimes true / Often true*	●	●	●	●
Planned Resources	The hospital will provide both funding and in-kind funds for staff, community health educators, philanthropic cash grants, outreach communications, supplies, and program management support for these initiatives.				
Planned Collaborators	In addition to the partners noted above, the Matter of Balance program is in collaboration with the University of the Pacific (UOP) Health Sciences program, and social work interns from UOP support the psychosocial assessments and community referrals through Diabetes Navigation. The CHIP strategy will be deployed alongside various stakeholders, including city Parks and Recreation, Reinvent South Stockton Coalition, the Trust for Public Land and other healthcare systems and community partners.				

Health Need: Community Safety					
Anticipated Impact (Goal)	Increase safety of public spaces that are intended for physical activity. Improve the relationship between law enforcement & the community, especially people of color and those experiencing homelessness.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment &	Clinical - Community	Capacity for Equitable	Innovation & Impact

Health Need: Community Safety					
		Integration	Linkages	Communities	
Human Trafficking Education and Outreach	Through involvement in both the Human Trafficking Healthcare Workgroup and the San Joaquin County Human Trafficking Taskforce, the hospital seeks to increase awareness, response, and care and support of trafficked victims beyond its internal protocols and staff training.	●	●	●	●
Community Mental Health Programming	Please see the description in the Mental Health section. Through a comprehensive strategy, a community health social worker is implementing programs to reduce cycles of violence within families and vulnerable communities.	●	●	●	●
San Joaquin Community Health Improvement Plan (CHIP)	Please see the description in the above section. Through the increased utilization of parks in priority neighborhoods, a reduction in neighborhood crime is an anticipated outcome.	●	●	●	●
Planned Resources	The hospital will provide both funding and in-kind funds for staff, community health educators, philanthropic cash grants, outreach communications, supplies, and program management support for these initiatives.				
Planned Collaborators	Program partners are noted in the respective summaries above.				

Health Need: Family & Social Support	
Anticipated Impact	Create & sustain healthy communities via large support networks.

Health Need: Family & Social Support					
(Goal)					
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Connected Community Network (CNN)	This network was created to provide the general population with access to resources and programs offered through various community based organizations (CBOs) and is an initiative to address the complex needs of hospital patients and the broader community . Many CBOs provide vital services that help people address a variety of needs, including but not limited to: affordable housing; maternal, infant, and child health; chronic disease management programs, healthy food, and mental health and substance abuse counseling.	●	●	●	●
Pathways Community Hub (PCH)	The PCH is an integrated model that utilizes a localized, outcomes-based approach that connects individuals to Community Health Workers (CHWs) who assess and help resolve identified, modifiable risk factors that could lead to poor health outcomes if left unaddressed. The core planning team implementing PCH, selected Black maternal health as an initial priority group for the initial phase of the work.	●	●	●	●
Community Health Advocate (CHA) Program	The following screening questions help to identify family and social support, or lack thereof, in an effort to proactively meet needs: *How often does anyone, including family and friends, threaten to harm or physically hurt you?* *Never* *Rarely* *Sometimes - ❒ threaten to harm and/or ❒ physically hurt*	●	●	●	●

Health Need: Family & Social Support					
	Fairly often - ❒ threaten to harm and/or ❒ physically hurt *Very often - ❒ threaten to harm and/or ❒ physically hurt* *Do problems getting child care make it difficult for you to work or study?* *(N/A - I do not have children, Never, Rarely, Sometimes, Fairly often, Very often)*				
Lifeline	Home monitoring services to improve independent living and safety for older adults and individuals with disabilities.	●	●	●	●
Dialectical Behavior Therapy (DBT) 101	SJBHC will relaunch these low-cost classes to help support families with a loved one in treatment. This will be open to the public.	●	●	●	●
Partner Collaboration	Explore collaboration with the San Joaquin County Department of Aging to expand Family Caregiver Support programming.	●	●	●	●
Planned Resources	The hospital will provide both funding and in-kind funds for staff, community health educators, philanthropic cash grants, outreach communications, supplies, and program management support for these initiatives.				
Planned Collaborators	Program partners are noted in the respective summaries above.				

Health Need: Education	
Anticipated Impact (Goal)	Address systemic barriers related to education to improve community health & lift families out of poverty.

Health Need: Education					
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Connected Community Network (CNN)	This network was created to provide the general population with access to resources and programs offered through various community based organizations (CBOs) and is an initiative to address the complex needs of hospital patients and the broader community . Many CBOs provide vital services that help people address a variety of needs, including but not limited to: affordable housing; maternal, infant, and child health; chronic disease management programs, healthy food, and mental health and substance abuse counseling.	●	●	●	●
Graduate Medical Education (GME)	Dignity Health is committed to workforce development, and SJMC is a leader in growing future medical providers in San Joaquin County. The GME program started in 2018 and below is a summary of the implemented and planned expansion of the program: ● Family Medicine: 6 new residents each year x3 years (started 06/2018). Increased to 10 residents per year as of 06/2022 ● Emergency Medicine: 9 new residents each year x3 years (started 06/2018). Increased to 12 residents per year as of 06/2022 ● Internal Medicine: 10 new residents each year x3 years (started 06/2020) ● Transitional Year: 10 new residents each year 1 year (started 06/2020). Increased to 16 residents per year as of 06/2022	●	●	●	●

Health Need: Education					
	• Anesthesia: 6 new residents each year x4 years (started 06/2021) • Psychiatry: 7 new residents each year x4 years (started 06/2021) • Urology: 2 new residents each year x5 years (started 06/2022) • Neurology: 4 new residents each year x4 years (started 06/2022) • Orthopedic Surgery: 3 new residents each year x5 years (to start 06/2023)				
Planned Resources	The hospital will provide both funding and in-kind funds for staff, community health educators, philanthropic cash grants, outreach communications, supplies, and program management support for these initiatives.				
Planned Collaborators	Program partners are noted in the respective summaries above.				

Health Need: Transportation					
Anticipated Impact (Goal)	Address barriers related to transportation and increase active transportation (biking or walking as opposed to commuting alone by car)				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact

Health Need: Transportation					
Substance Abuse and Mental Health Services Administration (SAMHSA)	A SJBHC Grant to provide expanded services designed to meet the needs of adults who are uninsured or underinsured with a history of opioid or stimulant use dependency. Medication Assisted Therapy (MAT) provides medication and psychosocial support including Recovery Support Services (RSS) to adults in the community and to individuals preparing to exit correctional facilities. This grant will also provide transportation assistance for those in need.	●	●	●	●
Transportation	SJBHC will continue to provide transportation for patients without any other means to get home.	●	●	●	●
Community Health Advocate (CHA) Program	The following question is included in the screening to help identify and support transportation barriers: *In the past 12 months, how often did you go without health care because you didn't have a way to get there? (include the frequency this happens in the answer choices)* *Never / Rarely / Sometimes / Fairly often / Frequently*	●	●	●	●
Community Grants	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 grants program is a strategy to fund innovative, collaborative services to address the needs identified in the CHNA and awarded partners are required to report outputs and outcomes of services.	●	●	●	●
Planned Resources	The hospital will provide both funding and in-kind funds for staff, community health educators, philanthropic cash grants, outreach communications, supplies, and program management support for these initiatives.				
	Program partners are noted in the respective summaries above.				

Health Need: Transportation	
Planned Collaborators	