



St. Joseph's Behavioral Health Center
A member of CHW



St. Joseph's Behavioral Health Center

Community Benefit Report 2011
Community Benefit Plan 2012

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EXECUTIVE SUMMARY

FACILITY DESCRIPTION

St. Joseph's Behavioral Health (SJBHC) is a 35 bed licensed not-for-profit psychiatric hospital serving Central California. The primary service area is Stockton, pop. 292,133 (2010) with a secondary service area of San Joaquin County, population of 694,293 (2010). SJBHC also serves as a referral for tertiary care for surrounding counties, which include Alpine, Amador, Calaveras, Mariposa, Stanislaus and Tuolumne Counties. The hospital has been providing specialized psychiatric and chemical recovery services for over 30 years and since 1996, SJBHC has been a part of Catholic Healthcare West (CHW) a system of 40 hospitals that is one of the largest in the United States.

St. Joseph's Behavioral Health Center offers a variety of inpatient, partial and outpatient services as well as support groups. Specialized Geropsychiatric services meet the needs of the elderly population. Inpatient and partial hospitalization services are provided to adults 18 years and older. Outpatient services are provided for adults, adolescents and children above the age of five years old. St. Joseph's Behavioral Health Center has board certified psychiatrists, physicians and experienced licensed professionals to address the needs of the patients.

The hospital is located at 2510 North California Street, Stockton, CA 95204. The hospital employs 117 staff members.

Based on the 2008 Community Needs Index, the Community Health and Advocacy Board, the Community Board and hospital administration have set the Community Benefit Priorities as the following:

- Free 24 hour Behavioral Evaluations and referrals to address individuals at risk for suicide and other high risk behaviors
- Sponsored Support Groups, Aftercare and Trainings to address drug and alcohol prevention and behavioral health

In FY2011, St. Joseph's Behavioral Health Center's contribution to the community through programs and services, as well as for care provided was \$529,631.

MISSION STATEMENT

Our Mission

St. Joseph's Behavioral Health Center, Catholic Healthcare West and its sponsoring congregations are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

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

Our Vision

A growing and diversified health care ministry distinguished by excellent quality and committed to expanding access to those in need.

Our Values

St. Joseph's Behavioral Health Center and Catholic Healthcare West are committed to providing high-quality, affordable health care to the communities we serve. Above all else we value:

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

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

Justice – Advocating for social change and acting in ways that promote respect for all persons and demonstrate compassion for our sisters and brothers who are powerless.

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

Excellence – Exceeding expectations through teamwork and innovation.

ORGANIZATIONAL COMMITMENT

CHW policy integrates community benefit into the ongoing processes of planning, budgeting and reporting. System wide and at the local level, CHW explicitly uses its resources to benefit those who are economically disadvantaged and to promote health and healing in the community.

CHW Organizational Infrastructure:

- a) Senior Executive Leadership: The Executive Vice President of Sponsorship, Mission Integration and Philanthropy leads system wide community benefit initiatives, aligns system wide strategic objectives with community benefit and ensures that adequate resources are allocated to community benefit planning and programming system wide.
- b) Board of Directors: The CHW Board of Directors establishes key measures of system wide community benefit performance and receives regular reports on progress toward established goals.
- c) Staff: The CHW Vice President of Community Health, who reports to the Executive Vice President of Sponsorship, Mission Integration and Philanthropy, directs and oversees system wide community benefit initiatives. The CHW Director of Community Benefit is responsible for planning, developing, coordinating and overseeing community benefit initiatives, standards, programming and reporting.

Local Organizational Infrastructure:

- a) Executive Leadership: CHW Hospital Presidents ensure that their hospitals allocate adequate resources to assess, develop and implement community benefit initiatives that respond to the unmet health priorities selected in collaboration with their community partners.
- b) Community: The Hospital Board, or Board Committee, participates in the process of establishing program priorities based on community needs and assets, developing the hospital's community benefit plan and monitoring progress toward identified goals.
- c) Community Health and Advocacy Committee: Chair appointed by Community Board and membership includes representation of community-based organizations and other providers and reflects the ethnic diversity of the community.

St. Joseph's Behavioral Health Center's Organizational Commitment:

The President of St. Joseph's Behavioral Health Center is Mr. Paul Rains who has the overall responsibility for the Mission and Community Benefit Strategic Planning process. Adequate resources are allocated to carry out the Community Benefit Plan through the operations and capital budgeting process each fiscal year. As a small specialty behavioral services hospital SJBHC has integrated its Mission, Community Benefit planning and prioritization during the Strategic Planning process through alignment of its Integrated Quality Council, Medical Executive Committee & Community Board.

St. Joseph's Behavioral Health Center participates on the CHW San Joaquin–Sierra service area Community Board with Dr. David Robinson as a voting member. Don Sims, CD Program Manager is a member of the community health and advocacy committee. SJBHC has provided orientation programs on the mission, vision, values, and core processes for the Employees, Medical Staff and Volunteers. The mission statement has been distributed and discussed during staff meetings and has also been posted throughout the facility to integrate the mission, vision and values into our daily care of patients and rules of conduct in the treatment of each other.

COMMUNITY

The primary service area of St. Joseph's Behavioral Health Center (SJBHC) is Stockton and the secondary service area is San Joaquin County (pop. 694,293 (2010)). SJBHC also serves as a referral for tertiary care for surrounding counties, which includes Alpine, Amador, Calaveras, Mariposa, Stanislaus and Tuolumne Counties.

The key factors used to define our primary and secondary area are the geographic location sources of our patients, contractual agreements for services and service areas of excellence such as our Behavioral Evaluation Services Team (BEST).

County Demographics Overview (Primary source –California Department of Finance, Population Projections for California and It's Counties 2000-2050 as utilized in the San Joaquin County 2011 Community Health Status Report , San Joaquin County Public Health Services and the San Joaquin Community Health Assessment 2010-2011. Currently, Caucasians make up 40% of the County population while Hispanics make up 36%. By 2020 it is projected that Latinos will be a higher percentage than Caucasians. Over the next five years the percentage of Asians will increase to 16% and African Americans will remain at about 7% respectively. The population is also aging; seniors currently are 9% of the County's population, but by 2018 one in ten people (10%) will be age 65 or over. The County's diversity is reflected in the languages commonly used by residents as well; in 2009, 39% of residents over age five spoke a language other than English in their home. Of the total population, 26% spoke Spanish. These demographic changes will present challenges to the community in regard to health care access and delivery for a growing elderly population and for residents facing linguistic and cultural barriers to services.

Population: From 2004 to 2010 the population of San Joaquin County grew 10% as compared to California at 7% during the same time frame. The South County cities (Tracy, Manteca & Ripon) had the greatest population growth from 2004 to 2010.

Ethnicity: San Joaquin County is very diverse ethnically. In the year 2010 40% of residents were Caucasian while 36% were Latino and 16% was Asian. Stockton has the greatest ethnic diversity of San Joaquin County and also the majority of the county's Hispanic or Latino, African American and Asian of county populations.

Age of Population: The projection 2010 – 2020 for growth by age is comparable to California: 6-11 and 12-17 years is projected to remain constant, while the percentage for those ages 0-5 is projected to increase. The population ages 18 and over is estimated to decrease by 2020.

Educational Attainment: In 2009, within the population 25 years and older in San Joaquin County, only one in four residents had achieved a high school diploma, 25.5% had achieved Associate, Bachelor's and Graduate or professional degrees. However, 24% of the population had no high school diploma and of that number half had less than a 9th grad educational level. Educational attainment is an important indicator of future success not only with residents to better employment opportunities but access to health care.

Poverty: In San Joaquin County (2009) the percentage of persons of all ages living in poverty decreased slightly for all age groups to 16%. When looking at the percentage of households with incomes below 300% of the Federal Poverty Guidelines, the greatest concentration was in Stockton and Lodi; more than 40% of surveyed households had incomes below 300% of Federal Poverty Guidelines.

Household Income: While the median household income increase from \$41,282 in 2000 to \$54,882 in 2008 to \$63,100 in 2010; SJ County remains poorer than the median household income of \$71,000 in the state. As stated in the SJCPHS, 2010 Community Status Health Report. Greater than 40% of Hispanics and African American and 33% of Asians live in households with less than \$35,000.

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS

COMMUNITY HEALTH ASSESSMENT PROJECT OVERVIEW 2010-2011:

The San Joaquin County Community Health Assessment Collaborative (SJCCHAC) was first formed in 2004 in order to complete the Community Health Needs Assessment mandated by the State of California. The collaborative evolved from the 2001 Needs Assessment Group that was co-funded and composed of St. Joseph's Medical Center/St. Joseph's Behavioral Health Center, Dameron Hospital, Sutter Tracy Community Hospital, Kaiser Permanente and Health Plan of San Joaquin (Medi-Cal option HMO).

The 2011 report shares the purpose of the 2005 assessment, which was to produce a functional and comprehensive community health profile of San Joaquin County. The collaborative will use this community profile to inform and engage local stakeholders and community members to promote collaborative efforts based on data, community input and group consensus in order to improve the health of local residents.

Priority Goals:

- Engage local stakeholders;
- Generate knowledge and findings that could lead to collaborative action;
- Identify information and data that would be useful for policy and advocacy work;
- Establish “**A Call for Action**” for community members;
- Assess community needs and assets;
- Develop a community dissemination plan;
- Provide ongoing tracking and monitoring; and
- Develop end products that are user-friendly and audience appropriate.

Desired Outcomes of the Project:

- I. The San Joaquin County Community Health Assessment will highlight community or geographic specific information, including:
 - Quantitative secondary data for selected indicators reflecting the county's population.
 - Qualitative and quantitative primary and secondary data and information for the three areas of focus:
 - Access to Health Care
 - Chronic Disease
 - Children and Adolescents
 - Development/facilitation of community input process.
- II. Finalize and publish a Community Plan for distribution and/or presentation of the report during the spring of 2011.
- III. Produce an Executive Summary summarizing analyses, key findings, comparisons to state and national health trends and defining priorities for collaborative work.
- IV. Facilitate the development of a “Dashboard of Indicators” for:
 - Ongoing tracking and monitoring.
 - Evaluating project process, product and ongoing plans.

The Funding:

The San Joaquin County Community Health Assessment Collaborative jointly funded the project. Funding will be ongoing to support the goals developed. Some participating organizations contribute data and time related resources “in-kind”.

The SJCCHAC chose Applied Survey Research (ASR) to facilitate the 2011 Assessment. Primary data was gathered via telephone and face-to-face survey methodologies. ASR collected and analyzed secondary data which include community demographics.

Roles: SJMC/SJBHC Director of Community Health chairs the SJCCHAC and the Community Health Department staff provides support to the collaborative, such as meeting agendas and conference call coordination, communications with committee partners & ASR etc.

Methodology:

Quality of Life Indicators: The community assessment model relies on quality of life indicators as the primary measures to illustrate the status of a system or issue that might otherwise be too large and complex to understand. For the purposes of this project, the San Joaquin County Community Health Assessment Collaborative met in September 2004 and developed over fifty-five quality-of-life indicators. The group used special criteria to develop the quality of life indicators used for this project. These criteria stipulated that indicators need to be understandable to the general user and the public, respond quickly and noticeably to real changes, relevant for policy decisions and available annually. In 2009, all of the original indicators were reviewed for relevancy and additional indicators and sources were added.

Primary Data: Measures of community progress depend upon consistent, reliable and scientifically accurate sources of data. One of the types of data gathered for this project is primary (original) data. The primary data were obtained from a telephone survey and a face-to-face survey of San Joaquin County residents. There is much to be learned from people's perceptions of their community, especially when those perceptions contradict the empirical evidence about its conditions.

- Telephone Survey: In August 2010 Applied Survey Research conducted a telephone survey, in both English and Spanish, with over 430 randomly selected County residents. The intent of the survey was to measure the opinions, attitudes, desires and needs of a demographically representative sample of the County's residents.
- Telephone contacts were attempted with a random sample of residents 18 years or older in San Joaquin County. Surveys were completed with 431 respondents in the County, and each completed survey took an average of 12 minutes. In addition to landlines, in 2010, cell phone users were also contacted. The survey sample was pulled from wireless-only and wireless/land-line random digit dial prefixes in San Joaquin County. All cell phones were dialed manually to comply with Telephone Consumer Protection Act rules. Respondents were screened for geography, as cell phones are not necessarily located where the number came from originally. Data from the survey were "weighted" to better reflect the number of male and female respondents. Data weighting is a procedure that adjusts for discrepancies between demographic proportions within a sample and the population from which the sample was drawn.
- Face-to-Face Community Survey: In addition to the telephone surveying, in August 2010 trained community volunteers went into the community and distributed surveys to residents and selected groups and organizations throughout the County. Self-administered and face-to-face surveys were conducted. Face-to-face surveys enabled the project to reach those groups that may have been under-represented in the telephone survey including those who do not have a telephone, live in rural areas, may have disabilities, lower incomes and difficulty with their non-native language, including the Hmong community. A total of 1,950 face-to-face surveys were conducted.

Secondary Data: Secondary (pre-existing) data were collected from a variety of sources, including but not limited to: the U.S. Census; federal, state and local government agencies; academic institutions; economic development groups; health care institutions; and computerized sources through online databases and the Internet. Examples of sources used for data were:

- ✓ American Community Survey
- ✓ California Health Interview Survey
- ✓ California Healthy Kids Survey

San Joaquin County Community Health Assessment Collaborative (SJCCHAC) In-Kind Contributors: Dameron Hospital, Community Partnership for Families of San Joaquin, San Joaquin County Public Health Services, San

Joaquin County Office of Education, St. Joseph's Medical Center, St. Mary's Interfaith Community Services, First Five of San Joaquin, Community Medical Centers, University of the Pacific, Health Plan of San Joaquin, Kaiser Permanente, Sutter Tracy Community Hospital, Healthier Community Coalition of San Joaquin and Breast Feeding Coalition of San Joaquin.

Financial Contributors:

Breastfeeding Coalition of San Joaquin, Dameron Hospital, First Five San Joaquin, Healthier Community Coalition of San Joaquin, Health Plan of San Joaquin, Kaiser Permanente, San Joaquin County Office of Education, St. Joseph's Medical Center, Sutter Tracy Community Hospital.

About the Researcher:

Applied Survey Research (ASR) is a non-profit, social research firm dedicated to helping people build better communities by collecting meaningful data, facilitating information-based planning, and developing custom strategies. The firm was founded on the principle that community improvement, sustainability, and program success are closely tied to assessment of needs evaluation of community goals, and the development of appropriate responses.

PRIORITY SETTING:

Preliminary goals, set as a result of the 2010-2011 San Joaquin County Community Health Assessment (SJCCHAC), collaboratively with the Healthier Community Coalition are:

1. Access
 - ✓ Focus on Drug & Alcohol Usage, Preventive Health & Behavioral Health
2. Children and Adolescents
 - ✓ Drug and Alcohol Use & Preventative Health
 - ✓ Suicide Risk

The prior "Healthier San Joaquin County Community Assessment 2008" Executive Summary and full report is on a web site: <www.healthiersanjoaquin.org>, created by the SJCCHAC. The web site provides access to all the data indicators and survey findings from the assessment in addition to the reports. The results of the 2011 San Joaquin County Community Health Assessment will be presented to the community when completed and continue to be the starting point for any further resource allocation.

Key issues identified in the assessment were:

- Youth Suicide

According to the centers for disease control and prevention, suicide was the third leading cause of death among teenagers ages 15-19 in 2001. Because the death of a young person is usually only called a suicide if there is a suicide note, many health professionals believe suicides are underreported. Further, injuries are not tracked systematically unless they result in hospitalizations or death. Thus, these nonfatal self-inflicted injury hospital data only represent the most serious injuries among children. Suicidality, including intentional self-harm is indicative of serious mental health problems and may signal other traumatic life events such as depression, social isolation, discrimination and physical or substance abuse. Over the last decade in San Joaquin County, the number of youth suicides for ages 5-24 fluctuated between a low of 2 in 2005 and a high of 12 in 2004, with 7 in 2008.

- Health Insurance Coverage

Lack of medical insurance coverage is a significant barrier to accessing quality health services. Families and individuals without health insurance coverage often have unmet health needs, received fewer preventative services, experience delays in receiving appropriate care, and experience more hospitalizations that could have been prevented. Uninsured people are less likely to receive medical care, more likely to have poor health, and are more likely to die early. According to the California Health Interview Survey, 20% of San Joaquin County residents were uninsured in 2007, compared to 16% of residents across the state. In previous years, CHIS reported slightly higher rates of coverage throughout the county, ranging from 81% to 85%. Since 2001, neither California nor San Joaquin County met the 2010 Healthy People objective of

having 100% health insurance coverage for the population under the age of 65. In 2010, 81% of Healthier San Joaquin County telephone survey respondents reported having health insurance coverage. Of survey respondents with health insurance, 96% of telephone and 88% of face-to-face survey respondents indicated that their insurance covered at least a portion of their medical prescriptions. 94% of telephone survey respondents and 76% of face-to-face respondents also indicated that their insurance covered preventative care and annual exams.

- Youth Tobacco, Alcohol and Drug Usage

Smoking and secondary smoke have serious health consequences for people of all ages. However, tobacco use by young people is particularly problematic as earlier use is correlated with higher use later in life. Between 10% and 14% of high school students reported using tobacco in the past 30 days. Similarly, the National Center on Addiction and Substance Abuse indicates that teens who experiment with alcohol are “virtually certain” to continue using alcohol in the future. 24 to 35% of high school students reported drinking alcohol in the past 30 days. Older students reported drinking at higher percentages (34 - 35%) than younger students (24 - 26%). Approximately 75,000 deaths per year, in the US, are associated with alcohol use.

Data Sources utilized by SJMC/SJBHC community health to complement the community needs assessment are:

- Community Needs Index (CNI) (See Appendix)

This data along with input from the community are utilized in the development of community benefit goals as part of the strategic plan.

COMMUNITY BENEFIT PLANNING PROCESS

LEADERSHIP (Community Board) & COMMUNITY BENEFIT PLANNING PROCESS

Strategic Plan, Fiscal Year 2011-2013

The President, management and the Director of Strategy & Business Planning led the process to update the Fiscal Year 2011-2013 Strategic Plan. The Community Board and the Community Health Committee, middle management, members of the medical staff and its leadership, employees, and community members participated and provided input. Community stakeholder involvement is obtained from community and program advisory groups, members of the board committees, which include many representatives from community-based organizations, faith communities, public officials, private business, and other providers. Inclusive in the strategic planning process is the commitment to community benefit.

St. Joseph's Behavioral Health Center F 2011-2013 Strategic Plan is built upon the framework of the CHW System Strategic Plan. Horizon 2020, and represents an organizational road map to fulfilling our mission over the next three years. Central to the plan is a commitment to excellent quality and expanded access through three strategic foci: Growth, Innovation and Leadership.

Representation reflecting the ethnic composition of our community is evaluated in determining committee membership. Also considered are the key community organizations working to improve health, i.e., (See committee membership in the Appendix)

Roles & Responsibilities of the committee for Community Health & Advocacy include:

1. Participation in community benefit planning and oversight by:
 - Evaluation and provision of input for community benefit program elements, outcomes, goals and priorities.
 - Review and approval of the annual report for submission to the St. Joseph's Community Board.
2. Report of community benefit priorities and programs to the St. Joseph's Community Board
3. Review of the Community Needs Assessment and resulting priority-setting process.
4. Support of environmental concerns.
5. Advocacy of issues which impact the health of our community through the utilization of an advocacy process that addresses the social, political and economic structures that affect individuals and the community as follows:

- Committee members contact the Director of Community Health in regard to topics/speakers of interest for inclusion on committee agendas.
- The member or speaker provides information for inclusion in the committee meeting packet so that committee members have information prior to the meeting.
- The topic is discussed at a subsequent committee meeting.
- If action is required, committee members develop recommendations to forward to the St. Joseph's Community Board for approval

The Director of Community Health has the responsibility of collaborating with others in the community representing SJMC/SJBHC. Other responsibilities are to plan, organize, develop, evaluate and manage the Community Health Services and strategies approved by Senior Management and the Community Board. The Community Health Director and community benefit departments are integrated into the ongoing process of planning, budgeting and reporting. The Director of Community Health participates in Management level decision-making and has a designated time at monthly meetings to inform organization, middle and senior management about community benefit priorities and services. The Community Health Director is a member and reports to the Community Health and Advocacy Committee of Community Board.

The San Joaquin County Community Health Assessment which has been updated in C.Y. 2010, the Community Needs Index (CNI) and utilization data for Ambulatory Sensitive Conditions (ASC) findings are some of the data sources utilized in developing priorities. Input and advice from the Community Health & Advocacy Committee of the Community Board and community collaboratives such as the Healthier Community Coalition (HCC) is sought and included in the development of goals and priorities. Also considered are the strengths and resources of SJBHC and the assets of the community.

Other responsibilities of the Community Health Director and staff:

- Prepares the hospital's community benefit plan and monitors the progress of plan's goals and objectives
- Collates the budgets (operating and capital), oversees and evaluates the hospital's community benefit services/programs
- Oversees the collection, input and reporting of data for the hospital's community benefit services/programs CBISA (through Lyon Software) report
- Works with Communications to design and disseminate information regarding the hospital's community benefit services/programs to board members, legislators and the community at large
- Works with CHW Policy Advocacy Liaisons to coordinate advocacy efforts that impact the health and quality of life of the community

The priorities and goals for the Community Benefit Plan are based on defined needs as determined by the tri-annual community health assessment, collaboration with community stakeholders, CNI & ASC data, and other data or research sources. The strengths, capacity and resources of the community and our organization are also evaluated in the planning process. The planning, finance and community benefit departments collaborate to ensure evaluation of outcomes of community benefit programs.

Community-based Partnerships are a critical component of the plan development. The community is included in planning, participating in the community health assessment, in defining the priorities and goals and the evaluation process. Collaborators include the County Public Health Services, the school systems, faith-based organizations, local employees and other non-profit health and social services agencies. Frequently, an Advisory Committee composed of community stakeholders is utilized to develop and evaluate each of the community health programs. Composition of the Advisory Committees is determined by the goals and purpose of the specific program.

Comprehensive Review of Community Benefit Programs:

The five core principles integrated into program planning, implementation operations & evaluation are:

- **Emphasis on Disproportionate Unmet Health-related Needs**
All services, activities and donations to be counted as community benefits will include outreach and design elements that insure access for communities with disproportionate unmet health-related needs (DUHN).

- **Emphasis on Primary Prevention**
Collaborate with the community on program activities that address the underlying causes of persistent health problems as part of a comprehensive strategy to improve the health status and quality of life in our communities. The term primary prevention refers to three types of activities: Health promotion, disease prevention, and health protection. Secondary prevention measures, referring to early detection and prompt treatment of disease and tertiary prevention measures that help to limit disability where disease has already occurred, are also considered in this core principle.
- **Building a Seamless Continuum of Care**
This principle calls for developing operational linkages between CHW clinical services and community health improvement activities to ensure the resources investments will yield measurable positive impact on community health status and quality of life.
- **Building Community Capacity**
Focuses on the strategic targeting of resources to mobilize and build the capacity of existing community assets.
- **Emphasis on Collaborative Governance**
Emphasizing a collaborative approach to the governance and management of community benefit activities that involves community members and provides a platform for shared action and advocacy to address systemic problems such as access to health care

A comprehensive review was conducted in FY 2010 to help assess principal community benefit programs, and to design and identify enhancement strategies to increase their alignment with the Five Core Principles. The community health staff utilized a peer review process in evaluating each program. The final draft of each program template was subsequently reviewed by the Community Health and Advisory Committee and the Community Board for input and finalization. The program Coordinator/Supervisor incorporated their strategies in their program goals for FY 2011 and a progress report for each is included in the program report section for SJMC/SJBHC.

Definitions:

Community Benefit: A community benefit is clinical or non-clinical program or activity that provides treatment and/or promotes health and healing that is:

- Responsive to identified health priorities determined in collaboration with community stakeholders;
- Focused on persons who are poor, disenfranchised or located in an area with disproportionate unmet health needs;
- Integrated into the facility's strategic planning and budgeting process; and
- Planned and implemented with program objectives and measurable outcomes that are beneficial to community stakeholders.

Community is defined as a hospital's immediate geographical area as well as neighboring areas and populations with disproportionate unmet health-related needs.

Disproportionate Unmet Health-Related Needs – seek to accommodate the needs of communities/neighborhoods with socio-economic barriers that increase resident vulnerability to poorer health/health disparities

SJMC/SJBHC Community Health strives to be recognized as a leader in the community for collaboration and action to improve access to care for un-insured, underinsured and other populations with barriers to healthcare. SJMC/SJBHC Community Health staff led the San Joaquin County Community Health Needs Assessment (SCCHAC) for 2010 C.Y, completed in 2011. The Community Health Director has been Chair of the Healthier Community Coalition (HCC) which is the primary collaborative representing hospitals, public health, school district health services and other CBO's providing healthcare in the county. The HCC sets priorities for community/public health improvement based on the needs assessment process and consensus building.

In addition to the 2011 Community Needs Assessment findings, data from the Community Needs Index (CNI) and CHW findings on Ambulatory Care Sensitive Conditions are considered in the development of the Community Benefit Plan.

The priorities and community benefit programs of St. Joseph's Behavioral Health Center are:

- Free 24 hour Behavioral Evaluations and referrals to address individuals at risk for suicide
- Sponsored Support Groups, Aftercare and Trainings to address drug and alcohol prevention and behavioral health

PLANNING FOR THE UNINSURED/ UNDERINSURED POPULATION

Charity Care, Patient Assistance Policy: (See Appendix)

Consistent with the Mission, CHW maintains a special commitment to caring for the economically disadvantaged. CHW and its facilities demonstrate this commitment both through the direct provision of Charity Care, but also through the Community Benefit Programs. CHW Board of Directors updated the system-wide policy. SJBHC has adopted the policy with facility-specific procedures. The policy also instructs Patient Care Financial Services representatives/or vendors who assist self-pay accounts to provide government-funded insurance program enrollment assistance. The numbers of persons assisted are reported via the Community Benefit Reports (CBISA) in the Monthly Operations Report (MOR). Signage informing the public about Patient Care Assistance and its availability is posted at all intake areas of the hospital in English and Spanish, i.e. admitting. The program and policy are shared with community leaders and collaboratives that work to increase health services in DUHN and high CNI areas of the community.

PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

BEHAVIORAL EVALUATION SERVICES

DESCRIPTION

SJBHC provides free Behavioral Evaluation assessments 24-hours daily and 365 days per year to anyone in the community. These services are provided regardless of the individual's ability to pay or eligibility for care at our facility.

IDENTIFIED NEED & POPULATION SERVED

There are limited resources available to residents of San Joaquin and surrounding counties to assess their health needs on a 24-hour basis. SJBHC's behavioral evaluation service team (BEST) provides the most rapid response to individuals in crisis. This responds to the identified needs of suicidal individuals and individuals at risk.

OBJECTIVES

1. To provide a behavioral evaluation of individual needs related to Mental Health or Substance Use issues upon request 100% of the time.
2. To promote continuity of care and integrate mental health issues into general health treatment for those not admitted to either inpatient or partial hospitalization care, contact the primary care physician and/or allied health professional 100% of the time upon written release by the individual. The concerns expressed during the evaluation will also be included in this communication.

EVALUATION

A record will be maintained of all patients assessed. Patients who are not admitted will be asked to sign a release of the information so that SJBHC can contact their primary care physician to review follow up recommendations. There are approximately 1,500 of these free community behavioral evaluations done annually.

FUTURE PLANS

This service will continue to be provided to anyone who is in need of an evaluation on a 24-hour basis, 365 days a year.

SPONSORED SUPPORT GROUPS, AFTERCARE and TRAININGS

DESCRIPTION

Aftercare Programs for Mental Health and Substance Use graduates is provided, as a support group, on a weekly basis with various presentations from the medical and clinical staff. The hospital sponsors meeting space for community led support groups such as Alcoholics, Narcotics and Crystal Methamphetamine Anonymous and Alanon to promote continued sobriety for community participants. SJBHC also participates in "Celebrate Life Methamphetamine Free", to prevent first time use of methamphetamine, eliminate on-going use, and improve methamphetamine treatment through education, social marketing and advocacy. SJBHC also sponsors trainings for community therapists on various topics to promote a continuum of care and to help prevent re-hospitalization of patients.

IDENTIFIED NEED & POPULATION SERVED

In today's managed care environment patients must be discharged from inpatient settings as soon as they no longer require acute care. Many patients leave the hospital with unresolved issues that, while not requiring hospitalization, still need attention. Many of these people have inadequate resources to continue outpatient treatment and/or are most comfortable continuing to work with SJBHC staff; therefore, the free or low cost weekly aftercare programs meet the needs of these individuals.

KEY OBJECTIVES

1. To promote wellness, prolong and maximize remission for Mental Health and Substance Use graduates.
2. To promote clean and sober activities and increase support systems.
3. Provide a continuum of care for all patients.

EVALUATION

The SJRHS Community Health Education Evaluation Forms and patient satisfaction surveys are used at the conclusion of the Aftercare Program, which is usually one year. Additionally, the readmission rate to the hospital within 30 days is tracked to determine if the Support Groups and Aftercare Program may have a supportive influence in maintaining wellness.

FUTURE PLANS

The Substance Use Aftercare Program will continue to be provided to all program graduates for the next fiscal year. The hospital will evaluate the need to implement psychiatric aftercare program. Continue to provide trainings as needed to community therapists. Evaluate the need for physician led community presentations on Mental Health & Substance Use topics.

PROGRAM DIGESTS

Behavioral Evaluation Services	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Behavioral Health & Preventative Health X Drug and Alcohol Use & Preventative Health X Suicide Risk
Program Emphasis	<ul style="list-style-type: none"> X Disproportionate Unmet Health-Related Needs X <u>Primary Prevention</u> X Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Broader Community, Underserved & Poor as this is a free service for the entire community to screen for suicide and other behavioral health or substance abuse issues only patients that are seen but not admitted are counted as community benefit.
Program Description	Free 24 hour Behavioral Evaluations for patients at risk for suicide Sponsored Support Groups, Aftercare and Trainings to address drug and alcohol prevention and behavioral health.
FY 2011	
Goal FY 2011	Ensure all patients in the community who present to the facility for evaluation or need an evaluation as requested by local emergency rooms for suicidal behavior or other behavioral health/substance abuse issues are seen.
2011 Objective Measure/Indicator of Success	Review of call logs and completed behavioral evaluations to ensure all patients' needs were met.
Baseline	Patient access to 24 hour crisis intervention is limited in San Joaquin and surrounding communities
Intervention Strategy for Achieving Goal	Hire and train staff
Result FY 2011	Provided Free Evaluations to approximately 1,500 persons this year
Hospital's Contribution / Program Expense	Staff time worth \$208,345
FY 2012	
Goal 2012	Provide requested evaluations 100% of the time
2012 Objective Measure/Indicator of Success	Review of call logs and completed evaluations
Baseline	Patient access to 24 hour crisis intervention is limited in San Joaquin and surrounding communities continues
Intervention Strategy for Achieving Goal	Continue to staff Behavioral Evaluation Department on a 24 hour, 365 day basis and pilot an evaluator in SJMC ER program

Support Groups and Aftercare	
Hospital CB Priority Areas	X Behavioral Health & Preventative Health X Drug and Alcohol Use & Preventative Health Suicide Risk
Program Emphasis	X Disproportionate Unmet Health-Related Needs X <u>Primary Prevention</u> X Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Broader Community, Underserved & Poor as these are free groups to all community members and free aftercare for program graduates for prevention of substance abuse.
Program Description	Free or low cost support groups and aftercare for program graduates
FY 2011	
Goal FY 2011	To promote wellness and maximize remission rates for previous patients
2011 Objective Measure/Indicator of Success	Decreased readmissions to the hospital
Baseline	Limited number of support groups for our population of patients
Intervention Strategy for Achieving Goal	Promote the support groups and aftercare program during the patients' stay to increase the number of participants
Result FY 2011	Provided support groups or aftercare to approximately 1,200 patients this year
Hospital's Contribution / Program Expense	Staff time and resources worth \$52,109
FY 2012	
Goal 2012	Increase the number of patients in our aftercare program and decrease number of readmissions Increase services for adults, children and adolescents
2012 Objective Measure/Indicator of Success	More than 1,200 patients in aftercare, decreased number of readmissions
Baseline	Number of support groups for our population of patients continues limited
Intervention Strategy for Achieving Goal	Continue to provide free support groups and aftercare programs

COMMUNITY BENEFIT AND ECONOMIC VALUE

St. Joseph's Behavioral Health Center
 Complete Classified Summary
 For period from 7/1/2010 through 6/30/2011

SJBH uses the cost accounting methodology

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization	
					Expenses	Revenues
Benefits for Living in Poverty						
Traditional Charity Care	59	94,301	0	94,301	0.8	0.8
Totals for Living in Poverty	59	94,301	0	94,301	0.8	0.8
Benefits for Broader Community						
Community Services						
Community Benefit Operations	2	3,445	0	3,445	0.0	0.0
Community Building Activities	13	2,841	0	2,841	0.0	0.0
Community Health Improvement Services	4,644	260,454	0	260,454	2.3	2.3
Health Professionals Education	55	168,590	0	168,590	1.5	1.5
Totals for Community Services	4,714	435,330	0	435,330	3.9	3.9
Totals for Broader Community	4,714	435,330	0	435,330	3.9	3.9
Total Community Benefit	4,773	529,631	0	529,631	4.7	4.7
Unpaid costs of Medicare	613	5,080,000	4,051,000	1,029,000	9.1	9.2
Totals with Medicare	5,386	5,609,631	4,051,000	1,558,631	13.8	13.9
Totals Including Medicare	5,386	5,609,631	4,051,000	1,558,631	13.8	13.9

Community Benefit/Social Accountability (CBISA On-Line) reporting has been implemented at SJBHC. The software provides standardized tools for conducting an inventory of quantifiable community benefits. Data is updated monthly and included in Monthly Operating Report (MOR), quarterly reports for CHW and annually for this report.

The community benefit economic value provided by the programs and services are reported in several categories, which include:

Medical Care Services: Includes Charity Care, the un-reimbursed costs for Medicare and other applicable government programs

Other Community Benefits: Identified community benefit programs and initiatives and associated in-kind or un-reimbursed costs. The economic value was determined by calculating expenses minus any offsetting revenues such as fundraising, grants, and contributions. This results in the net community benefit of the programs.

Summary

The economic value of the quantifiable community benefits provided by SJBHC fiscal year 2011 is \$529,631 net community benefit.

Non-Quantifiable Benefits: Community Involvement and Capacity Building

SJMC/SJBHC prioritized and dedicated much of Community Health and other senior management staff efforts and time to working with other healthcare providers, community based organizations and individuals to jointly develop consensus on community values, needs, priorities and program plans. Sharing resources and our assets/strengths contributes to success in building the community's ability and strength.

Strengths/resources that SJBHC provides to our respective communities are:

- Advocacy at local, state and national levels for the under-served and poor
- Psychiatric clinical experience for community colleges and universities
- Organizational leadership and management expertise
- Facilitation skills for group process
- Sponsoring community member leadership training and development
- Budgeting and strategic planning skills
- Health care expertise, skills, human resources, and supplies
- Community Health education
- Encouraging and supporting volunteer efforts of our employees and others associated with our organizations
- Facility space for community-based meetings
- “Convener” for special needs and community groups/individuals
- Quality improvement skills and principles

The above partially lists our facility’s contributions to the community that are sometimes difficult to quantify. It is through the commitment of our organization and its resources that we can significantly contribute to the health of our community. By partnering with other providers, community-based agencies and individuals in both the public and private sectors we can build consensus, plan and act together to address unmet health needs. Each community partner brings its strengths, commitment and energy to become part of the larger relationship necessary to meet the significant needs and improve the health status of our community.

TELLING THE STORY

SJMC/SJBHC Community Health staff present the Community Health Goals & Priorities for Community Benefit Plan to community collaboratives, CBO's, neighborhood groups, Community Board and the Community Health & Advocacy Committee.

In addition, SJMC/SJBHC and the 25 organizations involved in the SJCCHAC established a web site for access by any community member or organization to the 200 pages of data, the Executive Summary and information on the collaborative project and membership. The SJMC logo is posted on the web site and by clicking on the logo can access its web site. In the 2010-2011 Community Health Assessment, the SJCCHAC also published a new report "Telling our Story: How We're Making a Difference". This publication is also posted on the web site: www.HealthierSanJoaquin.org. The Strategic Plan 2011 – 2013 will be available which includes goals for community health improvement. The Community Needs Index (CNI) published by CHW was shared with the Community Health & Advocacy Committee of the Community Board and the Healthier Community Coalition for input and discussion.

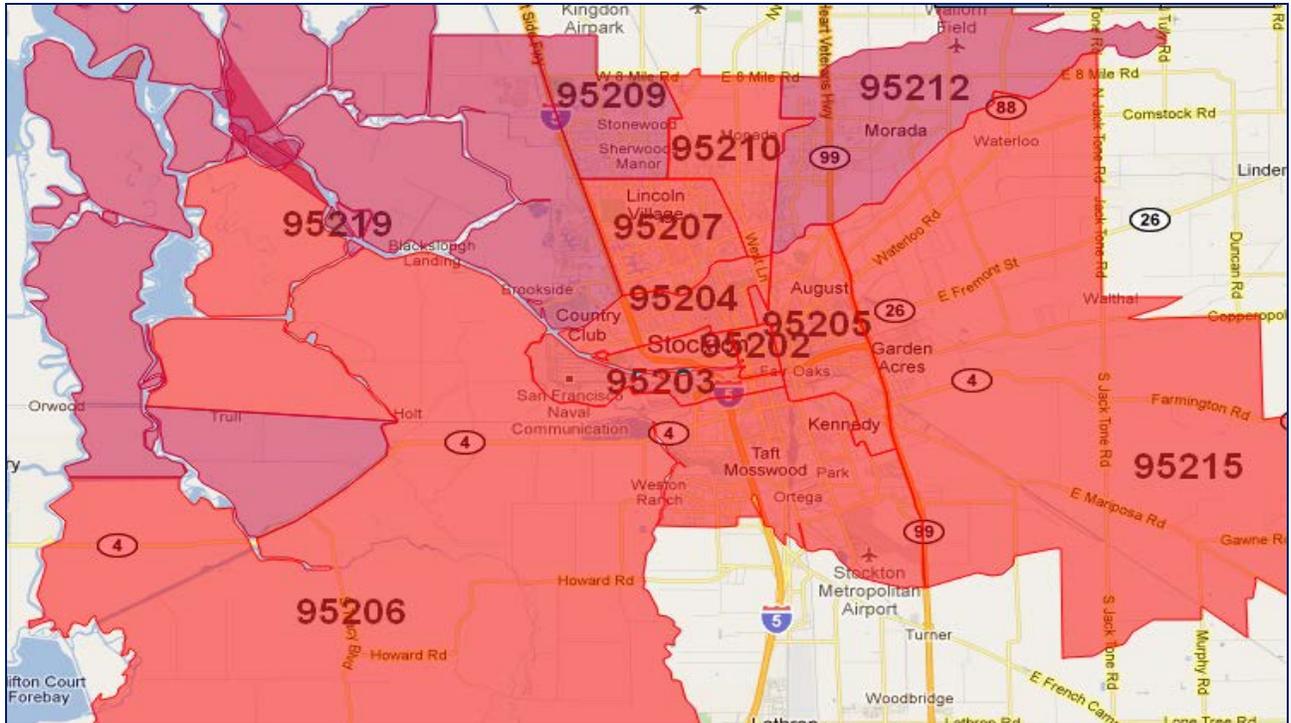
Appendix

- Community Needs Index, Map of the Community
- Community Advisory Board Membership Roster
- Community Benefit Committee Roster
- Summary of Patient Financial Assistance Policy

Community Needs Index (CNI)

- CHW's CNI Index is a tool used to measure community needs in specific geographic area by analyzing the degree to which a community has the following health care access barriers:
 - Income Barriers
 - Cultural / Language Barriers
 - Insurance Barrier
 - Housing Barriers
 - Education Barriers
- Using statistical modeling, the combination of above barriers results in a score between 1 (less needy) and 5 (most needy)
- Analysis has indicated significant correlation (96%) between the CNI and preventable hospital admissions
- Communities with scores of "5" are more than twice as likely to need inpatient care for preventable conditions than communities with a score of "1"

CHW COMMUNITY HEALTH INDEX ST. JOSEPH'S BEHAVIORAL HEALTH CENTER SERVICE AREA



Lowest Need

■ 1 - 1.7 Lowest

■ 1.8 - 2.5 2nd Lowest

■ 2.6 - 3.3 Mid

■ 3.4 - 4.1 2nd Highest

Highest Need

■ 4.2 - 5 Highest

	Zip Code	CNI Score	Population	City	County
■	95202	5	7189	Stockton	San Joaquin
■	95203	5	17318	Stockton	San Joaquin
■	95204	4.4	28269	Stockton	San Joaquin
■	95205	5	36900	Stockton	San Joaquin
■	95206	4.8	68371	Stockton	San Joaquin
■	95207	4.6	52837	Stockton	San Joaquin
■	95209	3.8	41120	Stockton	San Joaquin
■	95210	4.8	47106	Stockton	San Joaquin
■	95212	3.4	12664	Stockton	San Joaquin
■	95215	4.6	23035	Stockton	San Joaquin
■	95219	3.6	28646	Stockton	San Joaquin

St. Joseph's Community Board of Directors July 1, 2010 – June 30, 2011

Name	Occupation
Occeletta Briggs	Retired Nurse Executive
The Honorable Michael Coughlan	Superior Court Judge
Michael P. Duffy	Credit Union Executive
Sister Patricia Farrell, O.P.	Dominican Sister of San Rafael
Joelle Gomez	Women's Center Executive
Sister Raya Hanlon, O.P.	Dominican Sister of San Rafael
Kathleen Lagorio Janssen	Agri-Businesswoman
David Jensen, M.D.	Pathologist
Florence Kamigaki (Chair)	Retired Social Worker/Community Volunteer
David Lim, M.D.	Cardiologist
Steve Moore	San Joaquin County Sheriff
Carol J. Ornelas	Low-Income Housing Development Executive
David Robinson, D.O.	Psychiatrist
Sister Elaine Stahl, R.S.M.	Sister of Mercy
John Vera	Retired San Joaquin County Human Services Administrator
Donald J. Wiley	Hospital President & CEO
Robin Wong, M.D. (Vice Chair)	Family Practitioner

COMMUNITY HEALTH & ADVOCACY COMMITTEE

Briggs, Occeletta
Chair, Community Health & Advocacy Committee
July 2010 – December 2010

Duffy, Michael
Chair, Community Health & Advocacy Committee
January 2011 – June 2011

Adubofour, Kwabena, O.M., MD, FACP
East Main Clinic & Diabetes Intervention Center

Amato, Tom
Director
People & Congregations Together (PACT)

Briggs, Occeletta, RN, MS, MFT
Community Board Member

Collier, Pat
Director Community Services
St. Joseph's Medical Center

Davis, Terry, Sister SND de Namur
Diocese of Stockton

Michael Duffy
Community Board Member

Figueroa, Edward
Co-Director
St. Mary's Interfaith Community Services

Founts, Mick
Deputy Superintendent
SJC Office of Education

Furst, Karen MD, MPH
Health Officer
San Joaquin County Public Health

Good, Rich
YMCA

Kavanaugh, Robert
Community Member

Kendle, John
Director, SJMC
Support Services

Morrow, Robin
Senior Health Educator
Health Plan of San Joaquin

Newton, Abby, O.P.
Vice President Mission Integration &
St. Joseph's Foundation
St. Joseph's Medical Center

Nomura, Gloria
Community Member

Pettis, Natalie
Director Marketing & Communication
St. Joseph's Medical Center

Ramirez, Elvira
Director
Catholic Charities

Sanchez, Annette
El Concilio

Sims, Don
C.D. Program Manager
St. Joseph's Behavioral Health

Singson, Joan
Director of Health Education
Community Medical Centers

Williams, Dwight
Reverend
New Bethel Church

Williams, Harvey
University of the Pacific

CATHOLIC HEALTHCARE WEST SUMMARY OF PATIENT FINANCIAL ASSISTANCE POLICY (June 2008)

Policy Overview:

Catholic Healthcare West (CHW) is committed to providing financial assistance to persons who have health care needs and are uninsured or under-insured, ineligible for a government program, and otherwise unable to pay for medically necessary care based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable health care services, and to advocate for those who are poor and disenfranchised, CHW strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Financial assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with CHW's procedures for obtaining financial assistance, and to contribute to the cost of their care based on individual ability to pay. Individuals with financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.

Eligibility for Patient Financial Assistance:

- Eligibility for financial assistance will be considered for those individuals who are uninsured, ineligible for any government health care benefit program, and unable to pay for their care, based upon a determination of financial need in accordance with the policy.
- The granting of financial assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, or immigration status, sexual orientation or religious affiliation.

Determination of Financial Need:

- Financial need will be determined through an individual assessment that may include:
 - a. An application process in which the patient or the patient's guarantor is required to cooperate and supply all documentation necessary to make the determination of financial need;
 - b. The use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay;
 - c. a reasonable effort by the CHW facility to explore and assist patients in applying for appropriate alternative sources of payment and coverage from public and private payment programs; and will take into account the patient's assets and other financial resources.
- It is preferred but not required that a request for financial assistance and a determination of financial need occur prior to rendering of services. The need for financial assistance may be re-evaluated at each subsequent rendering of services, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known.
- CHW's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of financial assistance. Requests for financial assistance shall be processed promptly, and the CHW facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

Patient Financial Assistance Guidelines:

Services eligible under the policy will be made available to the patient on a sliding fee scale, in accordance with

financial need as determined by the Federal Poverty Level (FPL) in effect at the time of the determination as follows:

- Patients whose income is at or below 200% of the FPL are eligible to receive free care;
- Patients whose income is above 200% but not more than 350% of the FPL are eligible to receive services at the average rates of payment the CHW facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater in amount for the same services;
- Patients whose income is above 350% but not more than 500% of the FPL are eligible to receive services at 135% of the average rates the CHW facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater for the same services;
- Patients whose income exceeds 500% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of the CHW facility.

CHW's administrative policy for Eligibility and Application for Payment Assistance shall define what qualifies as income for these purposes.

Communication of the Financial Assistance Program to Patients and the Public:

- Information about patient financial assistance available from CHW, including a contact number, shall be disseminated by the CHW facility by various means, including the publication of notices in patient bills and by posting notices in the Emergency and Admitting Departments, and at other public places as the CHW facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the CHW facility.
- Any member of the CHW facility staff or medical staff may make referral of patients for financial assistance. The patient or a family member, a close friend or associate of the patient may also make a request for financial assistance.

Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient financial assistance will be included within the Social Accountability Budget of the CHW facility. CHW facilities will report patient financial assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.
- Patient financial assistance statistics shall be disclosed in annual financial statements but shall not include amounts that are properly considered to be bad debt or contractual discounts.

Relationship to Collection Policies:

- CHW system management shall develop policies and procedures for internal and external collection practices by CHW facilities that take into account the extent to which the patient qualifies for financial assistance, a patient's good faith effort to apply for a governmental program or for financial assistance from CHW, and a patient's good faith effort to comply with his or her payment agreements with the CHW facility.
- For patients who qualify for financial assistance and who are cooperating in good faith to resolve their hospital bills, CHW facilities may offer interest-free extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences and will not send unpaid bills to outside collection agencies.

Regulatory Requirements:

In implementing this policy, CHW management and CHW facilities shall comply with all federal, state and local laws, rules and regulations that may apply to activities conducted pursuant to this policy.