



St. Joseph's Medical Center

A member of CHW



St. Joseph's Medical Center

**Community Benefit Report 2011
Community Benefit Plan 2012**

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EXECUTIVE SUMMARY –

St. Joseph's Medical Center (SJMC) is a religious-sponsored, not-for-profit, community hospital located in central Stockton. Celebrating a history of 111 years of service to the community since it was founded in 1899 by Father William O'Connor and administered by the Dominican Sisters of San Rafael; St. Joseph's has a well-established tradition of partnering with the community. Since 1996 SJMC has been a part of Catholic Healthcare West (CHW) a not-for-profit network of hospitals and health services providing an extensive continuum of care in California, Arizona and Nevada.

The primary service area of St. Joseph's Medical Center is Stockton, pop. 292,133 (2010) with a secondary service area of San Joaquin County, population of 694,293 (2010). SJMC also serves as a referral for tertiary care for surrounding counties, which include Alpine, Amador, Calaveras, Mariposa, Stanislaus and Tuolumne Counties.

SJMC currently has 365 beds, which include a new patient care pavilion that opened in March 2010. The organization has approximately 2,430 employees, making it the largest employer in San Joaquin County with 350 volunteers and an affiliated medical staff of over 418 physicians. Admissions for FY10 were 19,000; over 10,000 of those admissions originated in the Emergency Department, the busiest in San Joaquin County, which had 47,984 visits. The off-site Immediate Care Clinic had 28,284 visits during FY10.

St. Joseph's has three "Centers of Excellence": a Comprehensive Heart Center, Comprehensive Cancer Center and Women and Infants Center, including a Level II Neonatal Intensive Care Unit.

Responding to the identified needs in the 2011 Community Health Needs Assessment and guided by our 2011-2013 Strategic Plan, SJMC continued to focus on providing access to care and services to the underserved and uninsured members of San Joaquin County.

Having two mobile units allows SJMC to reach people in identified high need areas and provide increased access to care.

- **CareVan:** is a mobile medical clinic offering free health services including health screening, education and referral services consistently through the year. Multiple new clinic sites have been added for FY11. Partnerships have been developed with free clinics, Federally Qualified Health Clinics (FQHCs), San Joaquin Public Health Department and collaborating non-profit organizations to develop a resource network for those persons served.
- **Mobile Mammography Unit:** Breast cancer screening services are provided to women living in a 24 county radius from as far North as Humboldt/Lassen Counties going South to Tulare County. In San Joaquin County we provide breast and cervical cancer screening. Services are provided to un- and underinsured women either at no or low cost. Partnerships are formed with local low-cost clinics, community groups and CDP providers to reach identified women.
- **Multicultural Outreach Program:** bilingual outreach personnel speak Spanish, Hmong, and Lao and work with and within those community groups to bring mobile services to areas of need for mammograms, screening clinics, education and navigation services.

To augment the services above that are providing access the following programs have been further developed:

Cancer Navigation Program: in collaboration with SJMC Cancer "Center of Excellence" and recently re-opened Women's Imaging Center we have developed a comprehensive, multicultural navigation service that spans the continuum from screening to diagnosis to treatment and follow-up through all SJMC facilities and the local community.

Diabetes Education: An eight part class has been moved into the community at churches, community centers, homeless clinics, and food banks with excellent response.

St. Joseph's commitment to providing access to health care services to the non- and underserved is evidenced by the value of our community benefit. The FY11 total benefit equals \$44,108,994.

MISSION STATEMENT

1. OUR MISSION

St. Joseph's Medical Center, Catholic Healthcare West and our 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.

2. OUR VISION

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

3. OUR VALUES

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

St. Joseph's Community Benefit activities are guided by our Mission and thus are integrated through all levels of the organization.

Infrastructure supporting Community Benefit activities include:

Executive Leadership: our hospital President Mr. Don Wiley along with the Administrative team ensures that the hospital allocates adequate resources to assess, develop and implement community benefit initiatives that respond to the unmet health priorities selected in collaboration with community partners. The Community Board 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.

Community Health and Advocacy Committee (CH&A) provides oversight for Community Benefit Activities and maintains awareness of activities in the community. The Director, Community Health facilitates this meeting, coordinating content with the Chair. The membership of the CH&A Committee includes representation of community-based organizations, and represents the ethnic diversity and resources available in the community.

Leadership and Community Benefit Planning Process

The President of St. Joseph's Medical Center 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.

The Community Board advises and participates in the planning and evaluation process with Senior Management. The Community Board appointed a Community Health and Advocacy Committee to oversee the Community Health and Advocacy Plan and Program strategies. The Committee Chair is a Community Board Member and reports back to the Community Board monthly on its findings and recommendations. Minutes from the committee's meeting are included in the Community Board packet monthly. The membership of the Committee includes the Mission Services and Foundation V.P., Community Health Director, Medical Staff, San Joaquin County Public Health representative, community-based organizations and stakeholders representing the diversity of the service area.

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 methodology for determining priorities. This is done by Healthier Communities Coalition, after reviewing the outcomes compared to Horizons 2010. Health outcomes are compared to expected goals and community activities and effort around those outcomes that fall short are looked at to see where the highest impact can be made with the available resources
4. Support of environmental concerns.
5. Advocacy for 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. 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 is a member and reports to the Community Health and Advocacy Committee of the Community Board.

Developing priorities is based on the findings of the San Joaquin County Community Health Assessment which has been updated in C.Y. 2010-2011, the Community Needs Index (CNI) and Ambulatory Sensitive Conditions (ASC) findings, among data sources.

Input and advice from the Community Health & Advocacy Committee of the Community Board and the leadership of community collaborative, primarily The Healthier Community Coalition (HCC), and Chronic Disease and Obesity Task Force of the San Joaquin Public Health Department is sought and utilized to develop goals and priorities, compared with Horizon 2010. Also, considered are the strengths and resources of SJMC and the assets of the community.

The Director of Community Health and V.P. of Foundation and Mission Services for SJMC, with the facilitation of SJMC Business Planning, updates and incorporates the priorities and goals in the Strategic Plan for SJMC FY 2011-13.

Updates on progress toward goals for the Strategic Plan are provided quarterly to SJMC Business Planning for inclusion in the Administrative Team update.

The CHW Community Grants program is a collaboration with community partners and the CH&A Committee. Suggestions are taken regarding those agencies in the community that are doing the work that address the identified priorities and they are among the agencies invited to submit letters of intent to receive grant funds.

SJMC is well integrated into the community and many of the members of the administrative and management teams serve on the Boards of Community Coalitions and Collaboratives to offer consult and represent St. Joseph's in the Community. Some examples:

- Hospital President was part of the group of Community leaders called together to consult on planning for reorganization or operations and services at San Joaquin General Hospital.
- President and CNE were called on to collaborate in community planning for a university nursing program expansion into the Stockton area.
- Community Health Director consults monthly with Stockton-based St. Mary's free clinic in managing resources.
- Foundation Director serves on the Board of the local Council for the Spanish Speaking, El Concilio, to consult on community supported activities.
- Community Health Director participates in Leadership Council for Community Transformation and Strategic Planning for San Joaquin Public Health Department. Membership consists of local legislators and business leaders to integrate health improvement issues into community business decisions.
- SJMC plays an integral part in collaborating with San Joaquin General Hospital Residency program in providing medical post-graduate education.
- SJMC provides hospital based clinical nursing instructors by agreement with San Joaquin Delta College.
- SJMC sends out alerts received from SJ Public Health Department to St. Joseph's Faith Community Nurses, to reach out at a community grass-roots level to quickly deliver information through that network. Approximately 10,000 congregation members can be reached.

St. Joseph's has adopted the Corporate Environmental Policy 6.5 and trained all employees. There is currently an Environmental Action Committee that meets monthly. SJMC won the Practice Green Health "Environmental Leadership Circle Award 2010". We currently are working with local farms to recycle food waste from the prep areas in the kitchen. We have recycled 139.92 tons at the end of FY10.

Some additional efforts:

- SJMC provides a weekly farmers market for employees.
- We have previously won the “Making Medicine Mercury Free Award”
- We have switched totally to digital x-rays, eliminating x-ray films
- We just finished assisting Kaweah Delta, Visalia, CA to start a recycling program in their surgery department.
- SJMC is part of the San Joaquin County Green Team. We are also a member of the Northern California Pollution Prevention Group, sponsored by the California EPA

We have applied for the Practice Green Health Award for 2011.

COMMUNITY

San Joaquin County (SJC) is located in the Central Valley of California and shares many similarities with the counties to the South. SJC is a federally designated Medically Underserved Area (MUA).

The primary service area of St. Joseph's Medical Center (SJMC) is Stockton (pop. 292,133 -2010) and the secondary service area is San Joaquin County (pop. 694,293 – 2010). SJMC also serves as a referral for tertiary care for surrounding counties. SJMC is the largest private employer in San Joaquin County. 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 Heart Center our Cancer Center and our Women's and Children's Services.

An overview of San Joaquin County demographics follows; primary source The California Department of Finance, Demographic Research Unit, Population Projections for California and Its Counties 2000-2050 as utilized in the San Joaquin County 2011 Community Health Status Report, San Joaquin Public Health Services and the Healthier San Joaquin County Community Assessment 2011. Population in SJC grew 10% from 2004 to 2010. Over the same time California's population grew by 7%. Over the last ten years, the bulk of the growth in SJC has been in the minority populations. There has been a large increase in Hispanic and Asian/Pacific Islander populations. The White population has decreased over the last 10 years and is now roughly the same size as the Hispanic population in the county, the two groups make up approximately three-quarters of the county population. African-American residents are about 7% without much change.

The languages spoken by students ages 5-17 at home outlines the county-wide diversity. According to the American Community Survey in 2009, thirty-nine percent (39%) of children spoke a language other than English in their homes. The primary language other than English is Spanish, followed by Hmong and Khmer.

While there has been continuous growth in the last ten years, between 2000-2009 the greatest percent increase in the population was in the 50-64 year age range. SJC is still predominately comprised of children and adults aged 0-49.

The median household income in SJC increased from \$41,282 in 2000 to \$54,711 in 2009. Despite this increase, SJC remains poorer than California as a whole, with a greater percentage of the SJC population living below federal poverty levels. Household income varies by race/ethnicity. While more than 45% of African Americans and one-third of Hispanics have incomes less the \$35,000.

SJC has similar rates of poverty compared to California for Whites and Hispanics but much higher rates of poverty for both African Americans and Asians. In 2009, 15% of Asians, 20% of Hispanics and 30% of African Americans were living in poverty while only 8% of Whites were.

Approximately 20% of adults in San Joaquin County had no health insurance. One in four of SJC residents were enrolled in MediCal compared to nearly one in five across the state. There has been a slight increase in MediCal enrollments from 21% in 2003 to 24% in 2009. There were 212 primary care providers in SJC serving MediCal patients in 2009, however 33% of those providers were not accepting new MediCal patients an increase from 18% in 2007. There are approximately 900 fewer specialists accepting MediCal patients and it is unknown how many of the remainder are not accepting new MediCal patients.

The incidence of homeless children enrolled in SJC schools has more than doubled since 2006-2007 from 1,194 to 2648 in 2009-2010 with most of them in grades Kindergarten through 5. The high school graduation rate has been steadily declining from 92% in 2003-2004 to 74% in 2008-2009 and has fallen below the state overall at 79% in 2008-2009.

There are other health care facilities that are also able to respond to health needs of the community: The county owned hospital San Joaquin General Hospital, a smaller private hospital Dameron Hospital, there are multiple FQHCs within the 13 locations of Community Medical Center plus two free clinics serving the homeless and the mobile clinic services provided by St. Joseph's CareVan.

COMMUNITY BENEFIT PLANNING PROCESS

The San Joaquin County Community Health Assessment Collaborative (SJC₂HAC) was first formed in 2004 in order to complete the Community Health Needs Assessment mandated by the State of California (SB697). The collaborative evolved from the 2001 Needs Assessment Group that was co-funded and composed of St. Joseph's Medical Center, Dameron Hospital, Sutter Tracy Community Hospital, Kaiser Permanente and Health Plan of San Joaquin (Medicaid 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:

- Utilize a process that will engage local stakeholders;
- Generate knowledge and findings that could lead to collaborative project development;
- Identify information and data that would be useful for policy and advocacy work;
- Establish "A Call for Action" that leads to ongoing collaboration;
- Assess both community needs and assets;
- Develop end products that are user-friendly and audience appropriate;
- Develop a comprehensive community dissemination plan; and
- Provide a mechanism for ongoing tracking and monitoring.

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 (Diabetes, Asthma and Obesity)
 - Early Entry into Pre-natal Care
 - Development/facilitation of community input process.
- II. Finalize and publish a Community Plan for distribution and/or presentation of the 2011 report.
- 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 digital "Dashboard of Indicators" for:
 - Ongoing tracking and monitoring.
 - Evaluating project process, product and ongoing plans at completion.
- V. How We're Making a Difference Report
Included in the 2011 report are local stories of agencies in San Joaquin County who are making a difference to improve access to health care for local residents. These stories are inserted throughout each section in the report.

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

The SJCCHAC again chose Applied Survey Research (ASR) to complete the 2011 Assessment.

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 summer, 2010, reviewed the original fifty-five quality-of-life indicators 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 and September of 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 are attempted with a random sample of residents 18 years or older in San Joaquin County. For the 2011 report, cell phone numbers were also utilized.
- Face –to-Face Community Survey: In addition to the telephone surveying, trained community volunteers and staff go into the community and distribute surveys to residents and selected groups and organizations throughout the County. Self-administered and face-to-face surveys are 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.

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 for 2001, 2003, and 2005
- California Healthy Kids Survey

San Joaquin County Community Health Assessment Collaborative (SJC₂HAC) 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.

Priority setting:

Preliminary goal setting is ongoing with the recent results of the 2010-2011 San Joaquin County Community Health Assessment (SJCCHAC). Initial discussion centers on the consistent problems facing a community with high needs and high levels of poverty. There is no zip code in the Stockton CNI Map that is higher than 3.6 and most are higher than 4.1 community health forum is being planned for October with the San Joaquin Public Health Department. The goals, set as a result of collaboration with the 2007-2008 SJCCHAC and the Healthier Communities Coalition that drove our current programs were:

- Access
 - High CNI scores correlate with higher levels of poverty, which restricts access to health care.
 - Adolescent and Youth Services, focus on Tobacco, Alcohol and Drug Usage, preventative and Behavioral Health
- Chronic Disease
 - Childhood Obesity
 - Asthma
 - Diabetes
- Prenatal Care
 - Early entry

Collaborative efforts are growing around Chronic Disease, specifically diabetes within community partners working with the SJ Public Health Department to develop and implement a 5-year Strategic Plan for San Joaquin County. Health priorities identified were obesity, asthma, heart disease/stroke and diabetes.

The prior "Healthier San Joaquin County Community Assessment 2011" 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.

Key issues identified in the assessment were:

- Health Insurance Coverage
Adult residents in SJC report 80% having health insurance coverage in 2007, 85% for California. For children and youth (0 - 17 years), the percentage of coverage was 96% in 2007. Additionally, 96% of respondents to the telephone survey and 85% of face-to-face survey respondents indicated that their children had health insurance at the time of the 2010 survey.
- Emergency Department Use
In 2010, 18% of San Joaquin County telephone survey respondents (up from 12% in 2007) and 27% of face-to-face (up from 24% in 2007) respondents reported using the emergency department as their main source of care.
- Prenatal Care
From 1997 to 2009, the percentage of San Joaquin County women receiving first trimester prenatal care was consistently substantially lower than in the state of California. In 2009, 73% of San Joaquin County mothers received first trimester prenatal care compared to 81% of California mothers. The state rate has decreased from 86% in 2005 while SJC has improved from 70% in 2005.
- Teen Births
A baby born to a teen mother is more likely to live in poverty. Between 1998 and 2006, 11 - 15% of births in the County were to teenagers. In 2009, 11% of County births were to teens; this was a higher percentage than that of the state of California (9%). The better news is that, during the same year, 61% of teen mothers (15 – 19 years) received adequate prenatal care in the County.
- Youth Tobacco, Alcohol and Drug Usage
From 2008 to 2009, over one-fourth 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%). Smoking was less prevalent but still a concern. Between 7% and 29% of high school students reported using tobacco in the past 30 days.
- Asthma.
In 2010, the same percentage of youth ages 1 - 17 in San Joaquin County and California had been diagnosed with asthma (15%). San Joaquin County adults were diagnosed with asthma (15%), an improvement over 2007 but higher than the state (13%).

- Diabetes

The percentage of adult telephone respondents with diabetes rose from 11% in 2004 to 16% in 2010. Those receiving treatment increased from 79% to 84%.

- Obesity and Nutrition

In 2007, over 29% of adults were obese. In 2010 self reported BMIs from the telephone survey indicated the 40.5 were overweight and 28% were obese.

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

- Community Needs Index (CNI)
- San Joaquin County, Community Health Status Report, 2011

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 Barriers, Housing Barriers, Education Barriers.
- 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."

All zip codes within Stockton rank between 3.6 and 5.0 (see Appendix)

The San Joaquin County Community Assessment Collaborative works with San Joaquin Public Health Department and the community partners to review the CHNA data as well as the SJPHD report to determine county need. Factors considered were areas of identified highest needs, severity of identified problem, an increase in the statistics from one assessment to the current, current SJMC demographics and community partners with strong area commitments.

With a large, uninsured Latino population, many efforts are made at making any resources offered culturally sensitive. We work closely with the Council of Spanish Speaking (El Concilio) to complement each other's programs. The CareVan stops there to hold free clinics monthly.

Also, during the past year we have focused on the Hmong population of women for breast health services, to diversify our Mobile Mammography Program, through a grant funded by The Avon Foundation. The services of the Mobile Mammography program are funded primarily through grants (Komen, Safeway) and community donations. With private funding for the past 5 years we have been able to provide breast screening and treatment services for women aged 18-39. This age group is not eligible for those services through other programs.

SJMC participates on the Chronic Disease and Obesity Task Force of the SJ Public Health Department and its leadership committee. We are currently involved in a county-wide effort of capacity building via application for a Community Transformation Grant offered by the Centers for Disease Control. The effort is around building healthy communities and involving community leaders to make healthier decisions for the communities they serve. The health care goals center on nutrition, obesity reduction/prevention, hypertension, and diabetes education prevention/treatment.

SJMC works closely with and fosters community partners who are addressing identified needs that we are not directly addressing. The CHW Grants program has funded programs on Early Entry into Prenatal care, Childhood Obesity, and Nutrition programs. We collaborate closely with our healthcare partners; free clinics, FQHCs, to improve access to care via our CareVan and Mobile Mammography programs. St Joseph's Behavioral Health has youth and adolescent programs for access to counseling and treatment.

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 and SJMC 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, Emergency Department and Immediate Care Clinic.

(See Appendix)

PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES –

The following key Community Benefit Programs and initiatives that St. Joseph's has focused on during the last year include:

Improving Access to Healthcare:

- St. Joseph's CareVan services with referral collaboration to local FQHCs
- St. Joseph's Mobile Mammography Program – serving 24 counties in Northern and Central California
- St. Joseph's Cancer Navigator program – collaborating with Cancer Center and newly re-opened Women's Imaging Center.
- St. Joseph's Nurse Call Center

Preventing and/or Managing Chronic Health Conditions:

- Asthma Management Strategies Class
- COLD Club of San Joaquin County, Pulmonary Rehab
- Development and opening of the outpatient "Diabetes Management Center"
- STROKE Club
- Special Needs Caregiver Program

Education and Community Support:

- Basics to a Healthy Life – Community Diabetes Education
- Heart Fair
- Heart Walk
- Heart Health Diet Instruction
- Faith Community Nurse Program
- St. Joseph's Interfaith Caregivers – Senior program
- Skin Cancer screening
- Prostate Cancer screening
- Women's Health Breast Cancer Awareness Fair
- "We Can" Weekend – Cancer Center
- Patient Transportation

Education of Healthcare Professionals:

- Hamilton Middle School Health Careers
- Hospital Based Clinical Nurse Instructors
- Lincoln High School "Windows on Your Future"
- Clinical Experience –
 - LVN Nursing Students
 - AA degree RN program
 - BSN degree students
 - BSN Expansion Program
 - RN to BSN students
 - Paramedic and EMT Training
 - Pharmacy Intern Program
 - PT and OT Interns
 - Respiratory Therapy Clinical Preceptors
 - Radiology Tech Interns
 - San Joaquin General Residency Program
 - Sonographer Internships
 - Clinical Laboratory Scientist Training Program
 - Graduate Social Work Internship Program

How we serve our community is a dynamic process and programs are evaluated for effectiveness.

Following are Program Digests that address key programs focused on identified priorities.

CAREVAN DIABETES EDUCATIONAL PROGRAM	
Hospital CB Priority Areas	<input checked="" type="checkbox"/> <i>Access to healthcare</i>
Program Emphasis	<input checked="" type="checkbox"/> <i>Disproportionate Unmet Health-Related Needs</i>
Link to Community Needs Assessment	Access to health education.
Program Description	The CareVan Diabetes Education Program is an eight part educational series taught by an RN, Certified Diabetic Educator emphasizing self-management, healthy lifestyle, and the reduction of complications.
FY 2011	
Goal FY 2011	The goals for FY 2011 are listed below. <ol style="list-style-type: none"> 1. Create an 8-part Diabetes educational series endorsed by the American Diabetes Association. 2. Build partnerships with community agencies to provide space to offer classes. 3. Offer 2-3 series of Diabetes classes at various community centers in English and Spanish on a weekly basis. 4. Offer a glucometer to each student diagnosed with Diabetes after attending six classes as an incentive. 5. Two Diabetes and/or B/P screening clinics will be offered on the CareVan mobile unit monthly to offer screening to community members.
2011 Objective Measure/Indicator of Success	At least 50% of the participants will report improvement in self-management and adoption of healthy lifestyle changes utilizing at least four diabetes classes running per week.
Baseline	Over 9% of San Joaquin County (SJC) residents were diagnosed with Diabetes, compared to 8% in California in 2007. SJC has consistently had higher rates of Diabetes in California from 2003-2009.
Intervention Strategy for Achieving Goal	The Diabetes classes are offered 3-4 times weekly providing the community access to education. The CareVan mobile unit is scheduled twice a month to provide screening clinics.
Result FY 2011	924 patients were screened for Diabetes and/or B/P at the <i>CareVan Screening Clinics</i> . 20% of the patients screened for Diabetes had an abnormal high blood sugar. Each patient screened for Diabetes received education on the signs and symptoms of Diabetes. Patients with an abnormally high blood sugar were encouraged to attend the educational series. Resource information for follow-up care was provided as needed. The Diabetes series was offered 3-4 times weekly at various community agencies, in English and Spanish, and offered in the morning, afternoon and/or evenings. 3,030 class participants attended the Diabetes classes. From a sample of class participants, 90% self-reported improvement in self management and adoption of healthy lifestyle changes.
Hospital's Contribution / Program Expense	St. Joseph's Medical Center's contribution to the program was \$51,861.

FY 2012	
Goal 2012	Fifty per-cent (50%) of the Diabetes Educational Series class participants will self-report an improvement in two indicators, 1) improvement in activity level; 2) and improvement in one area of diet/nutrition.
2012 Objective Measure/Indicator of Success	The number of community members attending the Diabetes classes will continue to increase as outreach efforts improve and the number of Diabetes Screening clinics increase.
Baseline	An estimated 90,000 persons have incomes below the federal poverty levels in San Joaquin County. With its large population of migrant farm workers, high unemployment rates and high poverty, approximately 100,000 residents live without health insurance or the ability to pay for medical services. In California the prevalence of Diabetes in adults is 6.6 %. San Joaquin County is ranked the 7th county above the state rate at 7.8%.
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Appropriate signage, distribution of flyers, e-mail blasts to community partners will be used to inform community members of Diabetes classes. 2. New partnerships will be developed to further expand the Diabetes Educational Series. 3. 3- 4 screening clinics will be held monthly. 4. One of the four series will be held consistently at one site. 5. The use of HgA1C testing will be explored to measure lifestyle changes in class participants.
Community Benefit Category	A2 Community Based Clinic Services

CAREVAN PROGRAM	
Hospital CB Priority Areas	<input checked="" type="checkbox"/> <i>Access to Health Care</i>
Program Emphasis	<input checked="" type="checkbox"/> <i>Disproportionate Unmet Health-Related Needs</i>
Link to Community Needs Assessment	Access to health services.
Program Description	The CareVan is a mobile medical clinic offering free health services including health screening, education and referral services; medical diagnoses and treatment. The CareVan provides health care to uninsured persons in San Joaquin County.
FY 2011	
Goal FY 2011	The goals for FY 2011 are listed below. <ol style="list-style-type: none"> 1. Increase the number of CareVan sites with the goal of scheduling 10-15 clinics at different sites on a monthly basis. 2. Schedule approximately 4 Walk-In Clinics on a weekly basis. 3. Schedule 1-2 health screening clinics in the community on a monthly basis. 4. Evaluate the success of the new CareVan model by patient satisfaction, survey information, number of patients seen and the number of clinics scheduled.
2011 Objective Measure/Indicator of Success	The number of Walk-In Clinics, Screening Clinics and patients seen.
Baseline	There is a high rate of uninsured individuals in the community that lack access to care. The CareVan is a mobile health unit providing health services to areas in San Joaquin county of high need.
Intervention Strategy for Achieving Goal	The CareVan offered 4 walk-in clinics weekly and 2 screening clinics monthly providing access to care.
Result FY 2011	<ol style="list-style-type: none"> 1. 3,285 patients were served on the <i>CareVan Walk-In Clinics</i>. 64% of those served reported that they would have not sought treatment elsewhere. 13% reported they would have gone to the ER. 3,285 patients were educated on the different types of care available in the community-ER, Immediate Care and Primary Care services and screened for Medi-Cal eligibility. Resource information was provided as needed to those that required follow-up care. 2. 924 patients were screened for Diabetes and/or B/P at the <i>CareVan Screening Clinics</i>. 60% of those screened for blood pressure had an abnormal blood pressure. Of the 60%, 36% were advised to be rechecked in a few months and 24% were advised to follow-up with an MD. 20% of the patients screened for Diabetes had an abnormal high blood sugar. Each patient screened for Diabetes received education on the signs and symptoms of Diabetes.
Hospital's Contribution / Program Expense	St. Joseph's Medical Center in-kind contribution to the program was \$881,912.

FY 2012	
Goal 2012	The CareVan program will increase the number of patients seen by 10% and provide access to care and screening services to approximately 4,600 patients.
2012 Objective Measure/Indicator of Success	The number of community members seen at the CareVan clinics will continue to increase as outreach efforts improve.
Baseline	An estimated 90,000 persons have incomes below the federal poverty levels in San Joaquin County. With its large population of migrant farm workers, high unemployment rates and high poverty, approximately 100,000 residents live without health insurance or the ability to pay for medical services. In California the prevalence of Diabetes in adults is 6.6 %. San Joaquin County is ranked the 7th county above the state rate at 7.8%.
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. The CareVan sites will be evaluated on a quarterly basis for efficacy. 2. Appropriate signage will be used to inform community members of CareVan services. 3. Staff will be available outside in front of the CareVan at the start of clinics to educate community members of the CareVan clinic services. 4. New partnerships will be developed to further expand the CareVan sites.
Community Benefit Category	

MOBILE MAMMOGRAPHY PROGRAM

Hospital CB Priority Areas	<input checked="" type="checkbox"/> Access to Health Care
Program Emphasis	Community Clinic
Link to Community Needs Assessment	Access to Care
Program Description	Breast and cervical cancer screening services are provided to women living in a 22-county radius via a mobile mammography unit. Services are provided to women facing barriers to accessing screening services including financial, geographic, language and cultural barriers. Services are low cost or billable to 3 rd party insurance. The service area extends north to Shasta and Lassen County, south to Tulare County, and west to San Mateo County and east to the Nevada border.
FY 2011	
Goal FY 2011	<ol style="list-style-type: none"> 1. Expand clinic services in northern California through partnerships with health care clinics. 2. Increase women served by 10%. 3. Increase the number of clinics by 10%. 4. Integrate more with St. Joseph's Women's Imaging Services. 5. Continue to secure outside grant funding to offset costs of program operations.
2011 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> 1. 152 clinics were held, a 0% increase. 2. 2444 mammograms completed, a 9% increase. 3. 781 clinical breast exams, a 68% decrease. 4. 494 pap smears performed, a 69% decrease. 5. 4 breast cancers and 3 cervical cancer, a 48% decrease 6. 333 first time mammograms, a 76% increase
Baseline	Although other mobile mammography units exist in a few areas within the state, their services are not done using digital technology and their service area is limited. Our unit is the only mobile digital mammography unit providing services to an area of California that is similar in size to North Carolina. Over 1,000,000 women potentially qualify for this service in the 22 counties in California.
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. Expand mammography only clinics as our main business. 2. Target partnership building with Federally Qualified Health Centers, Indian Health Services, and Low cost clinics. 3. Limit Cancer Detection Program clinics to Stockton area only. 4. Increase offsite clinic locations to Safeway Grocery Stores. 5. Expand services to counties in central California. 6. Create northern and southern loops.

Result FY 2011	<ol style="list-style-type: none"> Expanded mammography only clinics as our main business. Targeted partnership building with Federally Qualified Health Centers, Indian Health Services, and Low cost clinics. Limited Cancer Detection Program clinics to Stockton area only, approximately 3 times per month. Increased offsite clinic locations to Safeway Grocery Stores. Expanded services to counties in central California. Added clinics in Winters, Valley Springs, and Yuba City. Created northern and southern loops; Northern loop – Burney, Fall River Mills, & Bieber. Southern loop – Hoopa Native American Community.
Hospital's Contribution / Program Expense	<p>The State of California's Cancer Detection Program was billed for covered services at minimal reimbursement through Medi-Cal billing. In addition, commercial insurance was billed for Medi-Cal, Medi-Care and other 3rd party payors. For those without any form of insurance, an \$80 low cost option was available.</p> <p>Safeway Foundation has become a major contributor to the Mobile Mammography Program to the sum of \$500,000 per year. Grants were received from the <i>Avon Breast Cares Fund</i> for \$65,000 and the <i>Susan G. Komen Cancer for the Cure</i> for \$75,000.</p> <p>Hospitals contribution to program \$1,329,108.</p>
FY 2012	
Goal 2012	<ol style="list-style-type: none"> Expand clinic services through partnerships with health care clinics and providers. Increase women served by 10%. Increase the number of clinics by 10%. Decrease number of cancelled clinics. Continue to secure outside grant funding to offset costs of program operations. Resolve billing issues – with Family Pact Insurance and Rad Advantage.
2012 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> Number of clinics provided. Number of mammograms performed. Number of cancers detected. Number of first time mammograms. Number of clinics cancelled.
Baseline	<p>This program will provide low cost mammograms to women in a 22 county radius that have financial, geographic, language and cultural barriers preventing access to early detection services. With grant funding and funding from the Cancer Detection Program, Safeway Foundation, Susan G. Komen Foundation, & the Dobbins Family Foundation, services will be offered on an ongoing basis. Partnerships will be developed with FQHC's, Indian Health Services, and other low cost health care providers in Northern California.</p>
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> Expand mammography clinics as our main Target partnership building with Federally Qualified health Centers, Indian Health Services, and Low cost clinics. Continue to limit Cancer Detection Program clinics to Stockton area only, maximum of 3 per month. Increase offsite clinic locations to Safeway Grocery Stores. Expand services to counties California that lack mammography services.
Community Benefit Category	A2 Community-Based Clinic Services.

NAVIGATOR PROGRAM	
Hospital CB Priority Areas	<input checked="" type="checkbox"/> Chronic Disease – Focus on Diabetes, Asthma, Obesity, Breast cancer
Program Emphasis	<input checked="" type="checkbox"/> Primary Prevention
Link to Community Needs Assessment	Access to Care
Program Description	Our goal for the navigator program is to reach out to newly diagnosed cancer patients and to offer resources for newly diagnosed cancer patients.
FY 2011	
Goal FY 2011	Our goal for 2011 was to follow-up on all the biopsies done at St. Josephs Women's Imaging. The follow-up call will be done the week after the biopsy. The patient will have the opportunity to ask questions regarding the biopsy procedure. The patient that has a positive diagnosis can ask questions and have the ability to have a Navigator help them through their journey. The Navigator program will be available for all new cancer diagnoses with referrals coming from Physician offices, hospital staff, and community outreach.
2011 Objective Measure/Indicator of Success	Documented all new patient interventions. The navigator program had 220 consults from Jan 2011-August 2011.
Baseline	Patient population is seeking education and resources to help them through the cancer diagnosis.
Intervention Strategy for Achieving Goal	Started calling all the biopsy patients. Educated hospital staff and physicians in the community of our services.
Result FY 2011	Many positive patient comments. Educated and touched 220 patients in the community.
Hospital's Contribution / Program Expense	Staff time for three clinical specialist. Advertisement material for Physician offices. Several ads in local magazines.
FY 2012	
Goal 2012	Increase patient education and awareness of local treatment opportunities. Educate patients on services, financial, emotional, that can help them through the diagnosis of cancer.
2012 Objective Measure/Indicator of Success	Document patient encounters. Follow up on patients through their cancer diagnosis.
Baseline	Patients are unaware of the services we have to offer.
Intervention Strategy for Achieving Goal	Call all biopsy patients for an initial introduction to the Navigator program. Educate the physicians and hospital staff to send referrals to the Navigator program.

NURSE CALL CENTER	
Hospital CB Priority Areas	✓ Improve access to primary health care, targeting uninsured/underinsured, low income and culturally diverse populations
Program Emphasis	✓ Disproportionate Unmet Health-Related Needs
Link to Community Needs Assessment	The Nurse Call Center provides community members with 24/7 accurate, consistent and easily accessible health information that will assist callers in maintaining and improving their health status.
Program Description	The program provides access to Registered Nurses via the telephone. Community members can have confidential access to current health and wellness information and resources. The RN's assist the caller in accessing the most appropriate level of care for their immediate health care needs. There is free access to an audio health library in English and Spanish. Additionally interpreter services are available for all other languages at no cost to the caller. Physician Referral is provided for the entire community.
FY 2011	
Goal FY 2011	<ol style="list-style-type: none"> 1. Involve the Nurse Call Center with the H2H (Hospital to Home) Initiative to assist patients with the transformation back to the home environment and to decrease readmission. 2. Continue collaboration with St. Joseph's Home Health in regards to CHF patients discharged from Home Health Services. 3. When performing discharge calls, encourage patients to use the Nurse Call Center as a resource for medical issues/questions which may arise during the recovery at home. 4. Continue to provide free nurse advice services to the community served by St. Joseph's Medical Center in a human and compassionate manner. 5. Market NCC services to assist with offsetting the operating costs of the community line.
2011 Objective Measure/Indicator of Success	Monthly reporting of statistical data for all services and programs. Ongoing monitoring of call flow, volumes, sources, dispositions, abandonment rates and time in queue including review of staffing ratios in comparison to call volume.
Baseline	The Community Nurse Advice line is available to any and all residents of San Joaquin County. The NCC is focused on providing the community access to health and wellness information with RN support and recommendations per medically approved guidelines. For FY 2011 the NCC received 172,063 total calls of those total calls 67,095 were community benefit calls.
Intervention Strategy for Achieving Goal	<ol style="list-style-type: none"> 1. NCC initially participated on the Hospital to Home committee and now has a RN representative on the LEAN (Transformation Care) Team which targets, on admission, specific risk factors to decrease the readmission rate. 2. Forty-one patients were referred to the NCC by St. Joseph's Home Health for CHF follow up calls. 258 Calls were logged by the NCC to those patients. 3. The Nurse Call Center has included the Nurse Advice number in the script when performing discharge calls. 4. Positive feedback from callers on the community line—referred not only by SJMC entities but various physician's offices and hospitals within San Joaquin County. 5. NCC Management actively pursuing contracts to offset costs of Community Line.

Result FY 2011	The nurse advice line continues to be available, free of charge, to all members of the community regardless of hospital association. One new contract added in FY 2011 to assist with offsetting costs. NCC assisted with decreasing hospital readmission on CHF patients discharged from Home Health services.
Hospital's Contribution / Program Expense	St. Joseph's Medical Center in-kind contribution to the program \$2,165,079
FY 2012	
Goal 2012	<ol style="list-style-type: none"> 1. Collaboration of NCC services with Program Manager of Mercy Telehealth Network in regards to Stroke risk management services. 2. Actively pursue additional contracts to offset costs of Community Line. 3. Continue collaboration with St. Joseph's Home Health concerning CHF patients and explore other disease entities to assist with prevention of readmission.
2012 Objective Measure/Indicator of Success	<ol style="list-style-type: none"> 1. Ongoing meetings and review of software scheduled with Program Manager of Mercy Telehealth Network. 2. RFI (Request for Information) sent to CalOptima in regards to establishing Nurse Call Center services for service area in Orange County. 3. Ongoing conversations with Director of Community Health services in regards to opportunities for NCC to perform outbound calls for chronic disease with specific risk factors.
Baseline	The current and continued volume along with statistical data reflect the need for Nurse Call Center services to continue for our community and the individuals we serve not only through inbound calls but also the outbound calls performed by the NCC.
Intervention Strategy for Achieving Goal	Continue to provide monthly statistical data for all services and programs. Meet with representatives of community, medical groups and health plans to improve and expand services. Update and customize software to meet the needs of the community. Ongoing monitoring efficiency of nursing staff as it relates to the computerized program.

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses Revenues	
<u>Benefits for Living in Poverty</u>						
Traditional Charity Care	3,153	4,110,815	0	4,110,815	1.0	0.9
Unpaid Cost of Medicaid	54,106	108,869,000	94,667,000	14,202,000	3.5	3.1
Community Services						
Cash and In-Kind Contributions	240	874,770	0	874,770	0.2	0.2
Community Benefit Operations	0	328,782	0	328,782	0.1	0.1
Community Health Improvement	38,134	3,222,238	4,404	3,217,834	0.8	0.7
Subsidized Health Services	2	1,036,091	0	1,036,091	0.3	0.2
Totals for Community Services	38,376	5,461,881	4,404	5,457,477	1.4	1.2
Totals for Living in Poverty	95,635	118,441,696	94,671,404	23,770,292	5.9	5.2
<u>Benefits for Broader</u>						
Community Services						
Cash and In-Kind Contributions	2,828	285,175	0	285,175	0.1	0.1
Community Building Activities	114	1,568,400	0	1,568,400	0.4	0.3
Community Health Improvement	311,580	4,378,842	1,779,398	2,599,444	0.6	0.6
Health Professions Education	4,434	3,857,147	80,243	3,776,904	0.9	0.8
Research	37	267,779	0	267,779	0.1	0.1
Totals for Community Services	318,993	10,357,343	1,859,641	8,497,702	2.1	1.9
Totals for Broader Community	318,993	10,357,343	1,859,641	8,497,702	2.1	1.9
Totals - Community Benefit	414,628	128,799,039	96,531,045	32,267,994	8.0	7.1
Unpaid Cost of Medicare	42,424	135,131,000	123,290,000	11,841,000	2.9	2.6
Totals with Medicare	457,052	263,930,039	219,821,045	44,108,994	11.0	9.7
Totals Including Medicare	457,052	263,930,039	219,821,045	44,108,994	11.0	9.7

SJMC uses the cost accounting methodology.

Community Benefit and Economic Value –

St. Joseph's Medical Center is the largest Non-For-Profit employer in San Joaquin. As such, the influence and benefit felt by the community extends not only to areas of highest need in the community, but to the community in general by those people associated with St. Joseph's. One of our goals this year has been to inform the staff and providers of the programs available in the community so that they might be a resource to their families, friends and neighborhoods.

As indicated in our listed community benefit activities, SJMC contributes many of its strengths and resources to the community. These efforts help sustain and expand existing community resources, therefore building community capacity. At all organizational levels our staffs are encouraged to be involved in community activities thus providing support, representation and leadership to community resources and capacity building.

SJMC has dedicated leadership and Community Health Department time and resources to work closely with other healthcare providers, community based organizations and individuals to develop and share resources. The resultant information sharing is an on-going process that keeps all informed of community benefit activity.

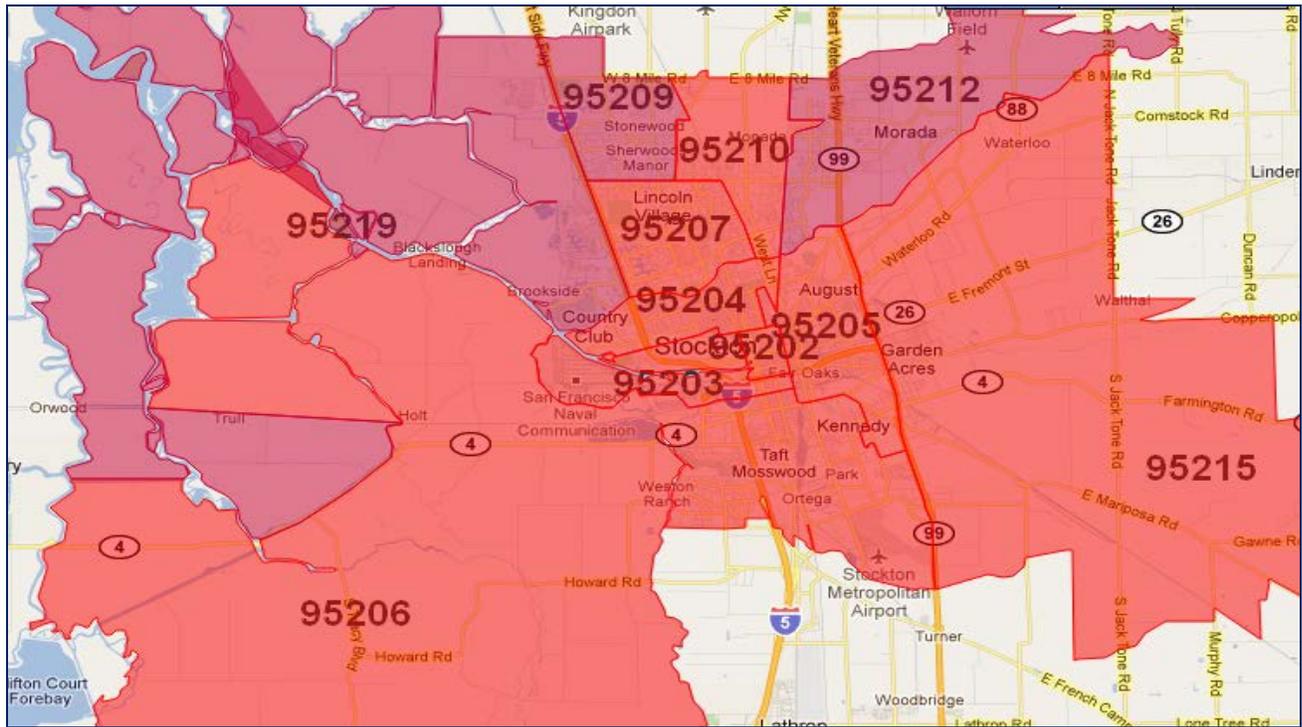
When the Community Benefit report is completed and reviewed, the report is presented to the Community Health and Advocacy Committee for approval. Once achieved the Report is sent to the Community Board for approval. When appropriate the collaborative and partners will be notified. Discussion of progress is an ongoing process at monthly meetings.

The Community Benefit report is then posted on the St. Joseph's Medical Center website at www.stjosephscare.org. The recently 2011 Community Health Needs Assessment is available at www.healthiersanjoaquin.org

Appendix

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

CHW COMMUNITY HEALTH INDEX ST. JOSEPH'S MEDICAL 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	7,189	Stockton	San Joaquin
■	95203	5	17,318	Stockton	San Joaquin
■	95204	4.4	28,269	Stockton	San Joaquin
■	95205	5	36,900	Stockton	San Joaquin
■	95206	4.8	68,371	Stockton	San Joaquin
■	95207	4.6	52,837	Stockton	San Joaquin
■	95209	3.8	41,120	Stockton	San Joaquin
■	95210	4.8	47,106	Stockton	San Joaquin
■	95212	3.4	12,664	Stockton	San Joaquin
■	95215	4.6	23,035	Stockton	San Joaquin
■	95219	3.6	28,646	Stockton	San Joaquin
■	95220	3.2	6,984	Stockton	San Joaquin
■	95242	3.8	25,477	Stockton	San Joaquin
■	95336	3.8	44,898	Stockton	San Joaquin
■	95337	4.2	30,322	Stockton	San Joaquin
	Total	4.3	458,472		

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"

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

Name	Occupation
Occeletha 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 R.N., M.H.S
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.