



## St. Joseph's Medical Center

Community Benefit Report 2012  
Community Benefit Implementation Plan 2013



St. Joseph's  
Medical Center  
A Dignity Health Member

Community Health Department  
1800 North California St.  
Stockton, CA 95204  
StJosephsCares.org

A message from Chief Executive Officer, St. Joseph's Medical Center and Board Chair

At St. Joseph's Medical Center we share a commitment to optimize the health of the community we are privileged to serve. Vital to this effort is the collaboration we enjoy with our community partners. How we contribute to the quality of life and the environment in our communities has always been a key measure of our success and it will continue to be so as we move forward.

In January 2012 Dignity Health, formerly Catholic Healthcare West, announced changes in our governance structure and name that will better position the system to welcome new partners in the changing healthcare landscape. The new name, Dignity Health, was chosen because dignity has been one of our core values since our founding. It is deeply embedded in our culture and clearly describes who we are and what we stand for. Our new governance structure more accurately reflects our current composition of both religiously sponsored and community sponsored hospitals.

During fiscal year 2012 we, like the nation, were impacted by the continuing economic downturn and experienced both successes and challenges. Despite declining revenue from government sponsored patients, we provided \$68,989,355 in charity care, community benefits and unreimbursed patient care.

At St. Joseph's Medical Center we strive to manage our resources and advance our healing ministry in a manner that benefits the common good now and in the future. Despite today's challenges we see this as time of great hope and opportunity for the future of healthcare. We want to acknowledge and thank the women and men who have worked together in a spirit of collaboration to address the health priorities of our community through health and wellness programs and services.

In accordance with policy the St. Joseph's Medical Center Board of Directors has reviewed and approved the annual Community Benefit Report and Implementation Plan at their October 26, 2012 meeting.

Donald J. Wiley  
President & CEO  
St. Joseph's Medical Center

Robin Wong, MD  
Chair  
St. Joseph's Community Board

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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 112 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 Dignity Health, formerly Catholic Healthcare West (CHW)<sup>1</sup> a not-for-profit network of hospitals and health services providing an extensive continuum of care throughout the western United States.

The primary service area of St. Joseph's Medical Center is Stockton, pop. 296,357 (2011) with a secondary service area of San Joaquin County, population of 696,214 (2011). 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 359 beds, which include a patient care pavilion that opened in March 2010. The organization has approximately 2,445 employees, making it the largest private employer in San Joaquin County with 380 volunteers and an affiliated medical staff of over 489 physicians. Admissions for FY12 were 18,818; 10,000 of those admissions originated in the Emergency Department, the busiest in San Joaquin County, which had 47,654 visits. The off-site Immediate Care Clinic had 26,173 visits during FY12, and the Home Health Agency made 21,295 visits.

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 FY12. 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.

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

**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 program has been further developed:

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<sup>1</sup>For more information on the name change, please visit [www.dignityhealth.org](http://www.dignityhealth.org)

**Cancer Navigation Program:** in collaboration with SJMC Cancer “Center of Excellence”, Women’s Imaging Center and the Mobile Mammography Program 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.

To address two of the chronic care needs of the community, SJMC has chosen the Congestive Heart Failure Program and the Diabetes Education Program as our Long Term Improvement Goals (LTIP). The goal of both of these programs is to provide education to participants and their families to empower them to make the necessary behavioral changes to manage their conditions outside the hospital.

St. Joseph’s commitment to providing access to health care services and improved quality of life in the community is evidenced by the total value of our community benefit. The FY12 total benefit is \$68,989,355, which includes the unpaid costs of Medicare and MediCal, financial assistance and community services.

# MISSION STATEMENT

## DIGNITY HEALTH MISSION STATEMENT

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

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

# 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 based on the Community Health Needs Assessment.
- 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 an 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 resulting priority-setting process.
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 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 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 the Community Board.

Community partners the Healthier Community Coalition (HCC) which St. Joseph's participates in, and Chronic Disease and Obesity Task Force of the San Joaquin Public Health Department have developed goals for San Joaquin county based on Public Health's five-year strategic plan, the San Joaquin County Community Health Needs Assessment, updated in 2011; and the Community Needs Index (CNI). The goals are to improve: Access to care, Asthma, Heart Disease, Obesity and Mental Health services. At St. Joseph's, the Director of Community Health and V.P. of Foundation and Mission Services for SJMC take these goals and priorities to the Community Health and Advocacy Committee and then to the Community Board. With the facilitation of SJMC Business Planning, the priorities and goals are adopted, and incorporated in the Strategic Plan for SJMC 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 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 is part of University of Pacific's collaborative effort, "Beyond Our Gates"
- President and CNE were called on to collaborate in community planning for a university nursing program expansion into the Stockton area that is now operational.
- Community Health Director consults monthly with Stockton-based St. Mary's free clinic in managing resources. SJMC actively participates with Community Medical Centers and Health Plan of San Joaquin in the Medical Home project, with Emergency Food Bank in the Mobile Farmer's Markets and the area-wide Hunger Task Force
- 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 play 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.
- St. Joseph's Parish Nurse Program facilitates information and alerts from SJ Public Health Department to quickly deliver information to approximately 10,000 congregation members in a very short time-frame.

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" in 2010 and 2011. We have currently recycled 1.5 million tons of waste, paper and wood for CY 2011.

Some additional efforts:

- SJMC provides a weekly farmers market for employees.
- We have previously won the "Making Medicine Mercury Free Award"
- We just finished assisting Kaweah Delta, Visalia, CA to start a recycling program in their surgery department. Prior to that we helped a facility in Canada get a Green team started.
- 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

- SJMC built, planted, maintained and harvested out first Community Garden in 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. 296,357 -2011) and the secondary service area is San Joaquin County (pop. 696,214 – 2011). SJMC also serves as a referral for tertiary care for surrounding counties, such that the service area is 362,671. 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, another 1.6% from 2010 to 2011. Over the same time California's population grew by 7%, and 1.2% from 2010-2011. 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.

The languages spoken by student's 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 2000-2012 the greatest percent increase in the population was in the 36-54 year age range. SJC is still predominately comprised of children and adults aged 0-54. The median household income in SJC increased from \$41,282 in 2000 to \$54,341 in 2010. Despite this increase, 27% earn \$25-50K for head of household. SJC remains poorer than California as a whole, with a greater percentage of the SJC population living below federal poverty levels at 16%. Household income varies by race/ethnicity.

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. Housing units were 51% occupied by owners and 40% by renters.

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 77% in 2010. The CNI score is 4.6.

- Population: Ages 0-5=10.8%; 6-11=11.3%; 12-17=10.4%; 18 & older=67.5%
- Diversity: Caucasian 39.6%; Hispanic 35.7%; Asian 14.5%; African American 6.9%; American Indian/Alaska Native 0.7%; Other 2.6%

- Average Income: \$54,341
- Uninsured: 28%
- Unemployment: 9.9%
- No HS Diploma: 23%
- Renters: 40%
- CNI Score:4.6
- Medicaid Patients: 24%
- Other Area Hospitals: Stockton 2, Lodi 1, Tracy 1, Lathrop 1, Manteca, 1

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, uninsured and working poor. There are also the mobile clinic services provided by St. Joseph's CareVan.

# COMMUNITY BENEFIT PLANNING

The San Joaquin County Community Health Assessment Collaborative (The Collaborative) was first formed in the late nineties in order to complete the Community Health Needs Assessment mandated by the State of California (SB697). The collaborative was and is co-funded and composed of St. Joseph's Medical Center, Dameron Hospital, Sutter Tracy Community Hospital, Kaiser Permanente, Health Plan of San Joaquin (Medicaid option HMO), First Five of San Joaquin, Community Medical Centers (FQHC group) and the San Joaquin County Public Health Department..

The 2011 report shares the purpose of the earlier assessments 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:

- The San Joaquin County Community Health Assessment will highlight community or geographic specific information, including:
  - Quantitative secondary data for selected indicators reflecting the needs of the county's population.
  - Qualitative and quantitative primary and secondary data and information for areas of focus.
- Produce an Executive Summary summarizing analyses, key findings, comparisons to state and national health trends and defining priorities for collaborative work.

The San Joaquin County Community Health Assessment Collaborative will jointly fund the project. Funding will be ongoing to support the goals developed.

For the 2011 Community Health Needs Assessment, the Collaborative again chose Applied Survey Research (ASR)

## Methodology:

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**San Joaquin County Community Health Assessment Collaborative 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.

**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:**

County-wide priorities were agreed upon by the contributors based on recent results of the 2010-2011 San Joaquin County Community Health Assessment. Initial discussion centered 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 lower than 3.6 and most are higher than 4.1. A Community Health Forum, for the community, was held in October, 2011 in partnership with the San Joaquin Public Health Department. The priorities have been essentially unchanged from one triennial assessment to another and they are:

- Access to health care
  - High CNI scores correlate with higher levels of poverty, which restricts access to health care.
- Chronic Disease – high or increasing incidence of disease, with a focus on:
  - Obesity
  - Asthma
  - Diabetes
- Prenatal Care
  - Early entry into care

This information was then presented to the hospital and with the knowledge of the community’s unmet health needs and identified priorities; the hospital established the focus areas for community benefit programming within its resources, expertise and the programs that are already meeting the needs.

The collaboratives, coalitions and partnerships that SJMC is already involved in provides the support for other community based programs so that resources are not duplicated in the community.

The “Healthier San Joaquin County Community Assessment 2011” Executive Summary and full report is on a collaborative-created and owned web site: [www.healthiersanjoaquin.org](http://www.healthiersanjoaquin.org). The web site provides access to all the data indicators and survey findings from the assessment in addition to the reports. The Assessment is also found on SJMC’s website [www.stjosephscares.org](http://www.stjosephscares.org).

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

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

Community Needs Index (CNI)

- Dignity Health’s CNI Index is a tool used to measure community needs in specific geographic area (zip code) 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 as communities with a score of “1.”

All zip codes within the city of 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.

SJMC participates on many leadership committees in the community to stay informed of where the resources are in the community. With a large, uninsured Latino population, many efforts are made at making any resources offered culturally sensitive. SJMC works closely with the Council of Spanish Speaking (El Concilio) to complement each other’s programs. To that end also 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. We utilize an internal outreach worker that speaks Hmong and Mien so that we have been able to make inroads into these communities.

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 and the “Medical Home Program” in the community. St Joseph’s Behavioral Health has youth and adolescent programs for access to counseling and treatment.

St. Joseph’s, with the mobile units providing access to care, is fortunate to be able to respond quickly to emerging needs. The CareVan specifically can provide free health clinics at migrant worker camps during harvesting season, with a change in hours to meet the population needs. We have been able to obtain census tract information from public health to locate those specific areas of concentrated need within the high-need CNI zip codes to provide services, and have partnered with schools in those areas to capture the parents of the students. We identified those census tracts where the average family income was less than \$15,000 per year. We have held very successful Mammography clinics at the apartment buildings primarily populated by Hmong women with the help of our outreach worker in both Stockton and Sacramento.

One of our community grants sponsors a “Patient Navigator” from the FQHC to work with us one day per week to capture the uninsured for enrollment into government programs or entrance into the FQHC system by making an appointment for a follow-up appointment for them before they leave the CareVan that day. Almost half of the contacts made are connected with programs or resources.

SJMC strives to keep community benefit programming consistent with the identified priorities either by directly providing the program, supporting our community partners with programs that meet the need or support through the Dignity Health Community Grants program. SJMC will maintain a dynamic community benefits program that responds to changing priorities, community need and other organizations that work in the community.

Consistent with the Mission, Dignity Health maintains a special commitment to caring for the economically disadvantaged. Dignity Health and its facilities demonstrate this commitment both through the direct provision of Charity Care, but also through the Community Benefit Programs. Dignity Health 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 provided during the last year include:

##### **Improving Access to Healthcare:**

- St. Joseph's CareVan services with referral collaboration to local FQHCs and partnering with school in high needs census tracts.
- 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 Women's Imaging Center.
- St. Joseph's Nurse Call Center
- St. Joseph's Interfaith CareGivers Program – provides transportation to physician appointments
- Charity Care for uninsured/underinsured and low income residents
- Clinical experience for medical professionals program.
- Emergency Department Physician Services for Indigent Patients
- Support of St. Mary's Dining Room 'Virgil Gianelli' Free clinic.
- Support of Gospel Rescue Mission Respite program for homeless patients discharged from inpatient stays
- Dignity Health Community Grant Program – Catholic Charities' Early Entry into Prenatal Care"
- Dignity Health Community Grant Program – Asian Pacific Self-Development Assn. – Health Outreach to Cambodian low-income families
- Dignity Health Community Grant Program – Dignity's Alcove – Outreach to homeless veterans

##### **Preventing and/or Managing Chronic Health Conditions:**

- Asthma Management Strategies Class
- COLD Club of San Joaquin County, Pulmonary Rehab
- Chronic Disease Management with the "Diabetes Management Center" and the Coumadin Clinic
- STROKE Club
- Special Needs Caregiver Program
- Basics to a Healthy Life" – Community Diabetes Education in response to screening clinics on the CareVan
- Congestive Health Failure Readmission initiative
- Congestive Health Failure Community Class
- Community Diabetes Education Readmission initiative.
- Home Care Services
- Faith Community Nurse Program education and support
- Strategic Planning and leadership for the development of San Joaquin COPD and Asthma Coalition
- San Joaquin County Diabetes Workgroup collaboration with community partners and local Medical Society to develop "Health Hub", a website where all of the resources for diabetes education are available to providers and the general public.

##### **Improving Physical Activity and Dietary Habits:**

- Dignity Health Community Grants Program – SJC Office of Ed.- Physical Education program/equipment for alternative high school system.
- Dignity Health Community Grants Program – University of California Extension – Salad in a Wheelbarrow Project.

These and other programs are continuously monitored for performance and quality and provided with support to ensure success.

The following Program Digests explain a few of our larger programs.

# PROGRAM DIGEST

<b>CareVan Program</b>	
<b>Hospital CB Priority Areas</b>	Please add the Hospital Priority Areas identified in the Community Needs Assessment for your hospital here <input type="checkbox"/> Improve access to health for the under-uninsured and culturally diverse population is the community
<b>Program Emphasis</b>	Please select the emphasis of this program from the options below: <input type="checkbox"/> Disproportionate Unmet Health-Related Needs
<b>Link to Community Health Needs Assessment</b>	Access to health services
<b>Program Description</b>	The CareVan program is a mobile medical clinic offering free health services including health screenings, education and referral services; medical diagnoses and treatment. The CareVan provides health care to under-uninsured persons in San Joaquin County.
<b>FY 2012</b>	
<b>Goal FY 2012</b>	The CareVan program will increase the number of patients seen
<b>2012 Objective Measure/Indicator of Success</b>	The number of community members seen as the CareVan clinics will increase as outreach efforts improve
<b>Baseline</b>	An estimated 90,000 persons have incomes below the federal poverty levels in San Joaquin County. With its 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
<b>Intervention Strategy for Achieving Goal</b>	The CareVan sites will be evaluated on a quarterly basis for efficacy. Appropriate signage will be used to inform community members of CareVan services. Staff will be available outside in front of the CareVan at the start of clinics to educate community members of the CareVan clinic sites.
<b>Result FY 2012</b>	The CareVan provided services to 3,966 patients at 213 clinics. 10% of Walk in Clinic patients would have gone to the Emergency Department or Urgent Care Clinics, and 66% would not have sought care at all; 39% of patients' screened at Diabetes & Blood Pressure Screening Events had abnormal results. Clinics sites are evaluated at least quarterly; signage is used to inform community members of CareVan sites/services; flyers are distributed to area businesses, and are available on line and via phone. Staff member from Community Medical Centers has been present at clinics to assist patients with information and screening for eligibility to medical homes. Fifty-nine contacts have been made and 23 patients have been approved or have pending applications for government healthcare; 27 patients have been referred to other community resources
<b>Hospital's Contribution / Program Expense</b>	St. Joseph's Medical Center provided \$707,916 in support for the program
<b>FY 2013</b>	
<b>Goal 2013</b>	The CareVan program will provide services to 3,600 patients at Walk-In –Clinics (calculated by 3 clinics/week, 25 patients/clinic, 48 weeks) The Care Van program will provide screening services to 1,200 patients, an increase of 10% over last year and continue to assist patients find medical homes.
<b>2013 Objective Measure/Indicator of Success</b>	Number of patients who access the CareVan at Walk-In-Clinics and Screening Clinics will increase by 10%. Measure referrals to medical homes
<b>Baseline</b>	FY 2011-12 – 3,966 patients were seen at CareVan Walk-In-Clinics, and at Patient Screening Clinics
<b>Intervention Strategy for Achieving Goal</b>	Provide information regarding CareVan Clinic schedule via multiple means, electronic, flyers, telephone, website and radio public announcement. Four signs will be hung in appropriate areas prior to each clinic. Evaluate sites quarterly for efficacy; results of the Care Van sites will be evaluated quarterly. Develop new partnerships and strengthen existing partnerships. Provide information and screening for eligibility to medical homes
<b>Community Benefit Category</b>	A2a

# PROGRAM DIGEST

<b>CareVan Diabetes Educational Program</b>	
<b>Hospital CB Priority Areas</b>	Please add the Hospital Priority Areas identified in the Community Needs Assessment for your hospital here <input type="checkbox"/> Improve access to health for the under-uninsured and culturally diverse population is the community
<b>Program Emphasis</b>	Please select the emphasis of this program from the options below: <input type="checkbox"/> Disproportionate Unmet Health-Related Needs
<b>Link to Community Health Needs Assessment</b>	Access to health services
<b>Program Description</b>	The CareVan Diabetes Educational Program is an eight part educational series taught by an RN, Certified Diabetic Educator emphasizing self-management, healthy lifestyles, and reduction of complications.
<b>FY 2012</b>	
<b>Goal FY 2012</b>	The Diabetes Educational Series class participants will increase by 5% offering Diabetes Education to approximately 3,200 community members. 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. Improvement in one area of diet/nutrition
<b>2012 Objective Measure/Indicator of Success</b>	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
<b>Baseline</b>	In California the prevalence of Diabetes in adults is 6.6%. San Joaquin County is ranked the 7 <sup>th</sup> county above the state rate of 7.8%.
<b>Intervention Strategy for Achieving Goal</b>	Appropriate signage will be used to inform community members of Diabetes Classes. New partnerships will be developed to further expand the Diabetes Educational Series 3-4 Screening Clinics will be held monthly One of the four series will be held consistently at one site The use of HgA1C testing will be explored to measure lifestyle changes in class participants
<b>Result FY 2012</b>	131 Community Diabetes Classes were conducted with 2,662 participants
<b>Hospital's Contribution / Program Expense</b>	St. Joseph's Medical Center provided \$159,228 in support to the program
<b>FY 2013</b>	
<b>Goal 2013</b>	Conduct 144 Community Diabetes Classes, with an average of 20 patients per class, totaling 2,880 participants. Continue to support Diabetes Education Series with 50% of participants self reporting.
<b>2013 Objective Measure/Indicator of Success</b>	Track number of Diabetes classes and number of class participants with 50% or more participants improving
<b>Baseline</b>	131 Community Diabetes Classes were conducted with 2,662 participants
<b>Intervention Strategy for Achieving Goal</b>	Provide information regarding diabetes class schedule via multiple means; electronic, flyers, telephone and website Develop new partnerships and strengthen existing partnerships 3-4 Screening Clinics will be held monthly Consistently hold one class series at a single site Ask where and how they heard about the classes
<b>Community Benefit Category</b>	A2a

# PROGRAM DIGEST

<b>Cancer Navigator Program</b>	
<b>Hospital CB Priority Areas</b>	<input checked="" type="checkbox"/> Chronic Disease – Focus on Diabetes, Asthma, Obesity, Breast cancer <input checked="" type="checkbox"/> Improve access to primary care for the under-uninsured and culturally diverse populations in the community
<b>Program Emphasis</b>	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention
<b>Link to Community Health Needs Assessment</b>	Access to health services
<b>Program Description</b>	Our goal for the navigator program is to reach out to newly diagnosed cancer patients and to offer resources to assist them with the continuum of their care
<b>FY 2012</b>	
<b>Goal FY 2012</b>	Increase patient education and awareness of local treatment opportunities and community resources. Educate patients on services, financial resources, emotional support that can help them through their diagnosis of cancer
<b>2012 Objective Measure/Indicator of Success</b>	Documented patient encounters. Follow up on patients through their cancer diagnosis
<b>Baseline</b>	Patients are unaware of the resources and services available to them. Physicians are unaware of the resources that are available to their patients.
<b>Intervention Strategy for Achieving Goal</b>	Follow up with all patients requiring biopsy for an initial introduction to the Navigator program. Hold "Navigator" informational meetings at physician offices/office staff. Navigator materials printed in publications (Foundation Focus and Cancer Quarterly, distribution 20,000) Educate Nurse Call Center regarding the Navigator program for appropriate referrals. Educate hospital staff to send referrals to the Navigator program when a patient is newly diagnosed with cancer.
<b>Result FY 2012</b>	FY 2012, 353 contacts were made from Cancer Services, 220 from Women's Imaging and 158 from Community Outreach for a total of 731 contacts.
<b>Hospital's Contribution / Program Expense</b>	St. Joseph's Medical Center provided \$96,404 in support to the program
<b>FY 2013</b>	
<b>Goal 2013</b>	To increase the utilization of the Navigator service through continued information strategies directed at patients and physicians to get the service to the patients.
<b>2013 Objective Measure/Indicator of Success</b>	Increase patient encounters by 20%, track conversion of encounters to utilization of SJMC Cancer Services
<b>Baseline</b>	Increase contacts to 877 from a baseline of 731 for previous FY. The navigator program remains underutilized
<b>Intervention Strategy for Achieving Goal</b>	Institute computerized referral process within the medical center; utilize the Physician Liaison position continue Navigator awareness in the physician community; study the feasibility of creating a position specific to a Navigator Nurse.
<b>Community Benefit Category</b>	A3e & A2f

# PROGRAM DIGEST

<b>Nurse Call Center</b>	
<b>Hospital CB Priority Areas</b>	<input checked="" type="checkbox"/> Improve access to primary care for the under-uninsured and culturally diverse populations in the community
<b>Program Emphasis</b>	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs
<b>Link to Community Health Needs Assessment</b>	Improve access for the under-uninsured and culturally diverse populations in the Community.
<b>Program Description</b>	The Nurse Call Center provides confidential access to Registered Nurses telephonically for evaluation and recommendations for appropriate level of care from 911 to homecare.
<b>FY 2012</b>	
<b>Goal FY 2012</b>	<ol style="list-style-type: none"> <li>1. Collaboration of NCC services with Program Manager of Mercy Telehealth Network in regards to Stroke risk management services.</li> <li>2. Actively pursue additional contracts to offset costs of Community Line.</li> <li>3. Continue collaboration with St. Joseph's Home Health concerning CHF patients and explore other disease entities to assist with prevention of readmission</li> </ol>
<b>2012 Objective Measure/Indicator of Success</b>	<ol style="list-style-type: none"> <li>1. Collaborated with Mercy Telehealth Network in regards to availability of Nurse Call Center to assume after hours role as contact because of budget restraints was unable to assist further with the development of the program but did obtain valuable information to share with staff in regards to stroke risk management for community.</li> <li>2. Added additional revenue by securing one new contract and extending hours for an additional contract.</li> <li>3. Continued collaboration with Home Health; with decreased admission rate on patients enrolled in program.</li> </ol>
<b>Baseline</b>	The Nurse Call Center is the only free program available within the community and the only telephonic resource available to the community to assist callers with evaluation of symptoms and referral to the appropriate level of care.
<b>Intervention Strategy for Achieving Goal</b>	<ol style="list-style-type: none"> <li>1. Ongoing meetings/calls with the Mercy Telehealth Network coordinator. Reviewed various software programs and assisted in selecting the "best fit" for the patients to be served.</li> <li>2. Presentations in regards to Nurse Call Center program.</li> <li>3. Updated database with patient information in regards to selected patients; contacted patients in a timely manner and 24/7 access number provided to patients to call.</li> </ol>
<b>Result FY 2012</b>	Allowed Nurse Call Center to continue 24/7 access to a registered nurse regardless of insurance or lack of insurance or even hospital affiliation.
<b>Hospital's Contribution / Program Expense</b>	St. Joseph's Medical Center provided \$1,851,396 in support to the program
<b>FY 2013</b>	
<b>Goal 2013</b>	The Nurse Call Center goal is to continue and extend community access to nurse advice in a timely and accurate manner.
<b>2013 Objective Measure/Indicator of Success</b>	Increase volume of Community Calls (within San Joaquin County) by 3% from FY 2012 baseline of 60,169.
<b>Baseline</b>	Increase contacts to 877 from a baseline of 731 for previous FY. The navigator program remains underutilized
<b>Intervention Strategy for Achieving Goal</b>	Input from community as well as statistical review supports the need for the Nurse Call Center due to economic issues uninsured/underinsured as well unemployment within San Joaquin County. This service assists callers in making healthcare decisions on a daily basis.
<b>Community Benefit Category</b>	A3e

# PROGRAM DIGEST

<b>Mobile Mammography Program</b>	
<b>Hospital CB Priority Areas</b>	<input checked="" type="checkbox"/> Improve access to primary care for the under-uninsured and culturally diverse populations in the community <input checked="" type="checkbox"/> Chronic Disease – Focus on Diabetes, Asthma, Obesity
<b>Program Emphasis</b>	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention
<b>Link to Community Needs Assessment</b>	Improve access for the under-uninsured and culturally diverse populations in the Community.
<b>Program Description</b>	Breast cancer screening services are provided to women living in a 24-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 <sup>rd</sup> 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.
<b>FY 2012</b>	
<b>Goal FY 2012</b>	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.
<b>2012 Objective Measure/Indicator of Success</b>	Number of clinics provided Number of mammograms performed. Number of cancers detected. Number of first time mammograms. Number of clinics cancelled.
<b>Baseline</b>	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.
<b>Intervention Strategy for Achieving Goal</b>	Expand mammography only clinics as our main business. 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 in California that lack mammography services.
<b>Result FY 2012</b>	A total of 169 clinics were held. A total of 3,491 clinic visits were held, consisting of 2,899 screening mammograms, 705 clinical breast exams and 568 pelvic exams. There was an 18% increase in number of screening mammograms and number of clinics held. 577 women received their first mammogram on the MMU. 20 clinics were cancelled, compared to 29 the previous FY. 12 breast and 2 cervical cancers were detected. No additional grant funding has been secured. Billing issues with RadAdvantage continue.
<b>Hospital's Contribution / Program Expense</b>	St. Joseph's Medical Center provided \$1,851,396 in support to the program
<b>FY 2013</b>	
<b>Goal 2013</b>	To continue to support the community by providing this service to under-uninsured women
<b>2013 Objective Measure/Indicator of Success</b>	1. Number of clinics provided 2. Number of mammograms performed. 3. Number of cancers detected. Number of first time mammograms.
<b>Baseline</b>	A total of 169 clinics were held, with a total of 3,491 clinic visits
<b>Intervention Strategy for Achieving Goal</b>	1. Screening mammography is the main service provided. 2. Target partnership building with Federally Qualified Health Centers, Indian Health Services, and Low cost clinics. 3. Continue to limit Cancer Detection Program clinics to Stockton area only. 4. When feasible, hold MMU clinics at Safeway Grocery Stores. Expand services to counties in California that lack mammography services.
<b>Community Benefit Category</b>	A3e

This implementation strategy specifies community health needs that the Hospital has determined to meet in whole or in part and that are consistent with its mission. The Hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During the three years ending December 31, 2015, other organizations in the community may decide to address certain needs, indicating that the Hospital then should refocus its limited resources to best serve the community.

# Community Benefit & Economic Value

192 St. Joseph's Medical Center  
 Complete Summary  
 For Period from 7.1.11 through 6.30.12

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses	Revenues
<b><u>Benefits for Living in Poverty</u></b>						
Financial Assistance	3,305	5,433,900	0	5,433,900	1.4	1.3
Medicaid	42,815	114,756,049	87,712,966	27,043,083	6.9	6.2
<b>Community Services</b>						
Community Benefit Operations	0	351,740	0	351,740	0.1	0.1
Community Health Improvement Services	9,985	3,428,389	3,500	2,424,889	0.9	0.8
Financial & In-Kind Contributions	272	799,125	0	799,125	0.2	0.2
<b>Totals for Community Services</b>	<b>10,257</b>	<b>4,579,254</b>	<b>3,500</b>	<b>3,575,754</b>	<b>1.2</b>	<b>1.1</b>
<b>Totals for Living in Poverty</b>	<b>56,377</b>	<b>124,769,203</b>	<b>87,716,466</b>	<b>37,052,737</b>	<b>9.5</b>	<b>8.5</b>
<b><u>Benefits for the Broader Community</u></b>						
Community Services						
Community Building Activities	329	878,275	0	878,275	0.2	0.2
Community Health Improvement Services	185,456	3,948,143	1,551,009	2,397,134	0.6	0.6
Financial & In-Kind Contributions	1,588	460,652	0	460,652	0.1	0.1
Health Professions Education	4,423	3,428,323	80,690	3,347,633	0.9	0.8
Research	126	250,526	0	250,526	0.1	0.1
Subsized Health Services	33	10,398	0	10,398	0.0	0.0
<b>Totals for Community Services</b>	<b>191,955</b>	<b>8,976,317</b>	<b>1,631,699</b>	<b>7,344,618</b>	<b>1.9</b>	<b>1.7</b>
<b>Totals for Broader Community</b>	<b>191,955</b>	<b>8,976,317</b>	<b>1,631,699</b>	<b>7,344,618</b>	<b>1.9</b>	<b>1.7</b>
<b>Totals - Community Benefit</b>	<b>248,332</b>	<b>133,745,520</b>	<b>89,348,165</b>	<b>44,397,355</b>	<b>11.4</b>	<b>10.2</b>
<b>Unpaid Cost of Medicare</b>	<b>55,753</b>	<b>136,845,000</b>	<b>112,253,000</b>	<b>24,592,000</b>	<b>6.3</b>	<b>5.7</b>
<b>Totals with Medicare</b>	<b>304,085</b>	<b>270,590,520</b>	<b>201,601,165</b>	<b>68,989,355</b>	<b>17.7</b>	<b>15.9</b>
<b>Totals Including Medicare</b>	<b>304,085</b>	<b>270,590,520</b>	<b>201,601,165</b>	<b>68,989,355</b>	<b>17.7</b>	<b>15.9</b>

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.

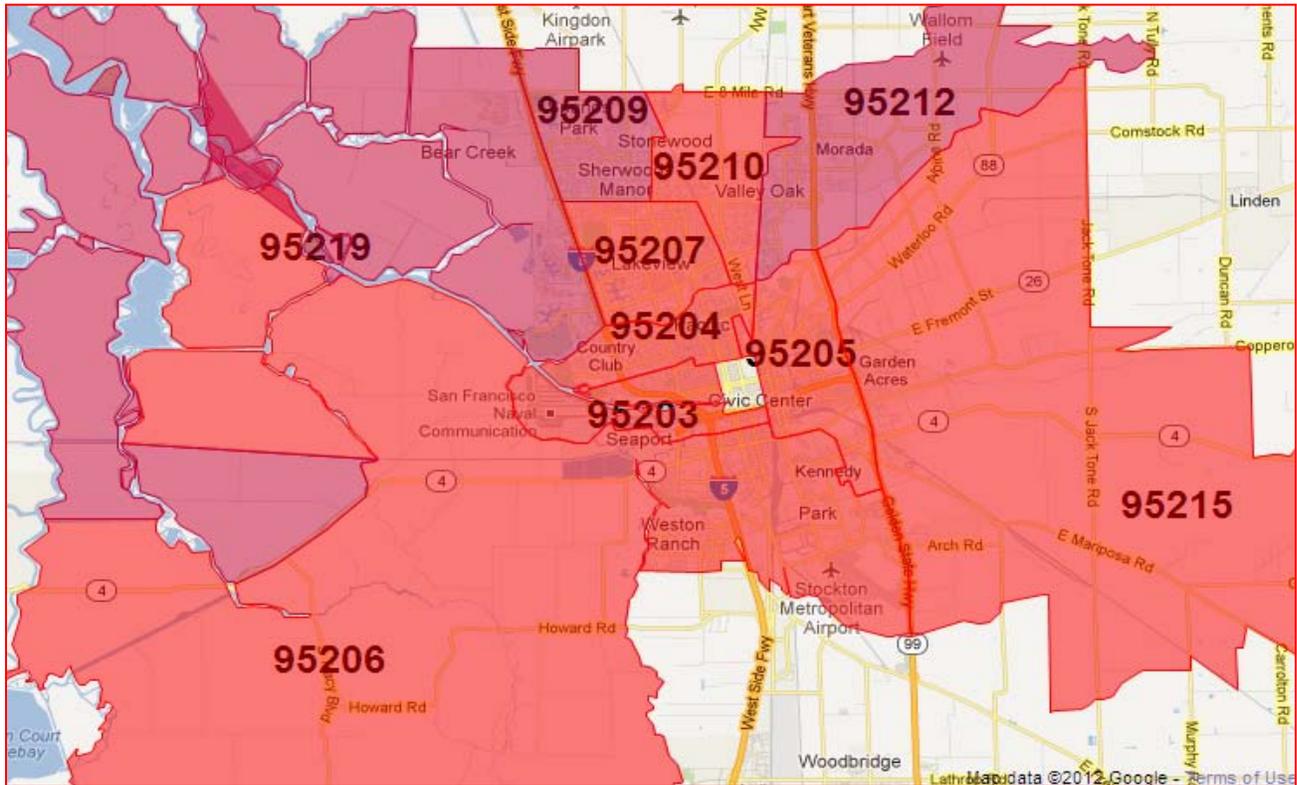
SJMC has dedicated leadership and Community Health Department time and resources to work closely with other healthcare providers, community based organizations and individuals to develop and share resources. The resultant information sharing is an on-going process that keeps all informed of community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

When the Community Benefit Report and Implementation Plan 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 and Implementation Plan is then posted on the St. Joseph's Medical Center website at [www.stjosephscares.org](http://www.stjosephscares.org) as well as on the Dignity Health website at [Dignityhealth.org](http://Dignityhealth.org). The recently 2011 Community Health Needs Assessment is available at [www.healthiersanjoaquin.org](http://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



Lowest Need

Highest Need

■ 1 - 1.7 Lowest  
 ■ 1.8 - 2.5 2nd Lowest  
 ■ 2.6 - 3.3 Mid  
 ■ 3.4 - 4.1 2nd Highest  
 ■ 4.2 - 5 Highest

<u>Zip Code</u>	<u>CNI Score</u>	<u>Population</u>	<u>City</u>	<u>County</u>	<u>State</u>
<span style="color: red;">■</span> 95203	5	16823	Stockton	San Joaquin	California
<span style="color: red;">■</span> 95204	4.6	27683	Stockton	San Joaquin	California
<span style="color: red;">■</span> 95205	5	36486	Stockton	San Joaquin	California
<span style="color: red;">■</span> 95206	4.8	66869	Stockton	San Joaquin	California
<span style="color: red;">■</span> 95207	4.6	50917	Stockton	San Joaquin	California
<span style="color: maroon;">■</span> 95209	4	41199	Stockton	San Joaquin	California
<span style="color: red;">■</span> 95210	4.8	47156	Stockton	San Joaquin	California
<span style="color: maroon;">■</span> 95212	3.4	14638	Morada	San Joaquin	California
<span style="color: red;">■</span> 95215	4.6	22558	Stockton	San Joaquin	California
<span style="color: maroon;">■</span> 95219	3.6	28631	Stockton	San Joaquin	California

**CNI Score Median: 4.6**

# ST. JOSEPH'S COMMUNITY BOARD OF DIRECTORS JULY 1, 2011 – JUNE 30, 2012

The Honorable Michael Coughlan	Superior Court Judge
Prasad R. Dighe, M.D.	Oncologist
Michael P. Duffy	Credit Union Executive
Sister Patricia Farrell, OP	Dominican Sister of San Rafael
Joelle Gomez (VCH)	Women's Shelter Executive
Sister Raya Hanlon, O.P.	Dominican Sister of San Rafael
Kathleen Lagorio Janssen	Agri-Businesswoman
David Lim, M.D	Cardiologist
Steve Moore	San Joaquin County Sheriff
Steven Morales	Business Owner
Jonise C. Oliva	Business Owner
Carol J. Ornelas	Low-Income Housing Development Executive
David Robinson, D.O.	Psychiatrist
Constance Smith	RN; Nurse Anesthetist, Educator
Sister Elaine Stahl, R.S.M.	Sister of Mercy
Donald J. Wiley	Hospital President & CEO
Robin Wong, M.D. (Vice Chair)	Family Practitioner

# Community Health & Advocacy Committee

Duffy, Michael  
Chair, Community Health & Advocacy Committee

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

Amato, Tom  
Director  
& Congregations Together (PACT)

Briggs, Occeletta, RN, MS, MFT  
Community Member

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

Davis, Terry, Sister SND de Namur  
Diocese of Stockton

Figueroa, Edward  
Co-Director  
St. Mary's Dining Room

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 & People  
St. Joseph's Foundation  
St. Joseph's Medical Center

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

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, Harvey  
University of the Pacific

**DIGNITY HEALTH**  
SUMMARY OF PATIENT PAYMENT ASSISTANCE POLICY  
(June 2012)

**Policy Overview:**

**Dignity Health is committed to providing payment 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, Dignity Health strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Payment assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with Dignity Health's procedures for obtaining payment 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 Payment Assistance:

- Eligibility for payment 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 payment 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 Dignity Health 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 payment assistance and a determination of financial need occur prior to rendering of services. The need for payment 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 payment assistance becomes known.
- Dignity Health's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of payment assistance. Requests for payment assistance shall be processed promptly, and the Dignity Health facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

#### Patient Payment 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 termination 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 Dignity Health 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 Dignity Health 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 Dignity Health facility.

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

#### Communication of the Payment Assistance Program to Patients and the Public:

- Information about patient payment assistance available from Dignity Health, including a contact number, shall be disseminated by the Dignity Health 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 Dignity Health facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the Dignity Health facility.
- Any member of the Dignity Health facility staff or medical staff may make referral of patients for payment assistance. The patient or a family member, a close friend or associate of the patient may also make a request for payment assistance.

#### Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient payment assistance will be included within the Social Accountability Budget of the Dignity Health facility. Dignity Health facilities will report patient payment assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.
- Patient payment 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:

- Dignity Health system management shall develop policies and procedures for internal and external collection practices by Dignity Health facilities that take into account the extent to which the patient qualifies for payment assistance, a patient's good faith effort to apply for a governmental program or for payment assistance from Dignity Health, and a patient's good faith effort to comply with his or her payment agreements with the Dignity Health facility.
- For patients who qualify for payment assistance and who are cooperating in good faith to resolve their hospital bills, Dignity Health 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, DIGNITY HEALTH MANAGEMENT AND DIGNITY HEALTH FACILITIES SHALL COMPLY WITH ALL FEDERAL, STATE AND LOCAL LAWS, RULES AND REGULATIONS THAT MAY APPLY TO ACTIVITIES CONDUCTED PURSUANT TO THIS POLICY