



St. Joseph's Medical Center

Community Benefit Report 2013 Community Benefit Plan 2014



A message from Donald J. Wiley, President and Joelle Gomez, Board Chair, St. Joseph's Medical Center

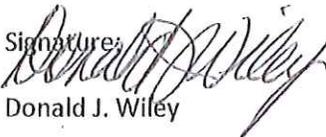
When we talk about health care today, the words *budget*, *cut*, and *restraint* get used a lot. It is impersonal and it is a way to look at health care by the numbers rather than by the patient. One word that has somehow lost its meaning is also the word we believe in most of all – the word *care*. At St. Joseph's Medical Center, we strive to reintroduce humankindness to an industry focused on finance.

The Affordable Care Act created the National Prevention Council and called for the development of a National Prevention Strategy to realize the benefits of prevention for the health of all Americans. The overarching goals of the plan are to empower people, ensure healthy and safe community environments, promote clinical and community preventive services, and eliminate health disparities.

The Dignity Health system goals reflect those of health reform, namely expanding access, redesigning the delivery system, and utilizing limited resources in better, more coordinated ways so that quality can be continuously improved and patients and communities are healthier. These goals will be achieved through thoughtful *care*, whether it is demonstrated in the hospital or through the programs and services we offer in the community.

At St. Joseph's Medical Center we share a commitment to optimize the health of our community. In fiscal year 2013 St. Joseph's Behavioral Health Center provided \$1,681,066 in financial assistance, community benefit and unreimbursed patient care. Because we care, how we contribute to the quality of life and the environment in our communities has always been and will continue to be a key measure of our success.

In accordance with policy, the St. Joseph's Medical Center Community Board has reviewed and approved the annual Community Benefit Report and Implementation Plan at their September 27, 2013 meeting.

Signature: 
Donald J. Wiley

President

Signature: 
Joelle Gomez

Community Board Chair

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Executive Summary

St. Joseph's Medical Center (SJMC) and St. Joseph's Behavioral Health Center are religious-sponsored, regional hospitals located in central Stockton.

St. Joseph's Medical Center celebrates a history of 114 years of service to the community. 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, 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. 362,671 (2012) with a secondary service area of Lodi, Linden, Manteca, Tracy and Valley Springs, pop. 187,997 (2012). SJMC also serves as a referral for tertiary care for surrounding counties.

St. Joseph's Medical Center currently has 366 beds, a physician staff of over 400, and more than 2,400 employees. Specializing in cardiovascular care, comprehensive cancer services, and women and children's services including neonatal intensive care, St. Joseph's is the largest hospital and private employer in Stockton. Nationally recognized as a quality leader, St. Joseph's is consistently chosen as the "most preferred hospital" by local consumers.

Hospital admissions for FY 2013 were 18,103, including 2508 babies born. Emergency department visits were 51,824 approximately 20% evolving into hospital admits. There were 110,000 outpatient registrations which included Immediate Care Clinic, Home Health Care, Women's Imaging and Out-patient Radiology.

St. Joseph's Behavioral Health (SJBH) established services in 1974 as a patient care unit at St. Joseph's Medical Center in Stockton. In 1988, the program expanded operations to the current location, 2510 North California Street. SJBH, is a 35 bed licensed not-for-profit psychiatric hospital serving Central California, with 128 employees and 18 medical staff. There were 1,560 admission and 9,334 outpatient visits. Specialized Geropsychiatric services meet the mental health needs of the elderly population. Inpatient and partial hospitalization services are provided to adults, 18 years and older. Outpatient services are provided for adults, adolescents and children older than 5 years.

The primary service area of St. Joseph's Behavioral Health Center serves San Joaquin County, as well as parts of Stanislaus, Merced, Sacramento and Calaveras Counties which is a population total of 1,321,876 (2011). Secondary service areas are the further outlying areas of Tuolumne, Stanislaus, Sacramento and Calaveras Counties for an additional population total of 754,953.

Guided by our Mission and responding to the Community Health Needs Assessment priorities incorporated into the 2013-2015 Strategic Plan and the 2014 Implementation Plan we continue to focus on providing access to care and services to the underserved and uninsured members of San Joaquin County. Also, responding to the changing healthcare environment, some programs previously providing community benefit were modified or discontinued with arrangements for service being made for those previously served.

St. Joseph's community programs build capacity in our community and collaborative partnerships with other health care providers. The following programs are the cornerstone of SJMC and SJBHC Community Benefit:

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, four days per week, to under-/uninsured persons in San Joaquin County with a focus on seasonal agricultural workers.

The Community Diabetes Educational Program is an eight part educational series taught by an RN, Certified Diabetes Educator emphasizing self-management, healthy lifestyles, and reduction of complications. This program is currently taught in English and Spanish and will soon also be offered in Hmong.

St. Joseph's Interfaith Caregiver (SJIC) Program provides no-cost services to seniors living independently to enable safe aging-in-place. Through trained volunteers services provided include friendly visiting, respite care, yard clean up, home safety assessments, transportation and referrals.

The Faith Community Nurse Program supports the development of health ministries within a variety of faith communities. This program is a partnership between St. Joseph's Medical Center, faith communities, and registered nurses who become ministers of health in their congregations.

Special Needs Caregiver Program provides the focused expertise of an R.N. which enables St. Joseph's Medical Center to serve patients with Developmental Disabilities in the most effective and caring way. To enhance daily approaches to care, the program strives to offer updated information to staff in an effort to continuously increase their knowledge and understanding of Intellectual Disabilities

The Dobbins Program is a special program set up as a source of assistance for women 19-39 years of age whose primary care provider has determined that further breast diagnostic testing is needed and who have no resources to cover expenses.

Behavioral Evaluation Services : St. Joseph's Behavioral Health Center provides free Behavioral Evaluations to assess patient needs and risks and to provide referrals 24-hours daily, 365 days per year to anyone who presents at the facility or at community hospital Emergency Departments. These services are provided regardless of the individual's ability to pay or eligibility for care at our facility.

Support Groups & Aftercare Services: St. Joseph's Medical Center and St. Joseph's Behavioral Health Center sponsor support groups and free aftercare groups that support those in the community living with a new or continuing life-affecting diagnosis.

St. Joseph's Medical Center 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 FY 2013 total benefit was \$70,585,166 which includes the unpaid costs of Medicare and MediCal, financial assistance and community services. St. Joseph's Behavioral Health Center 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 FY 2013 total benefit was \$1,681,066, which includes the unpaid costs of Medicare, financial assistance and community services.

MISSION STATEMENT

I. Hospital's Mission

A. 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. Donald J. 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 (CHNA).
- The St. Joseph's 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. (See **Appendix A** for a roster of Community Board members)
- The Community Health & Advocacy Committee (CH & A) provides oversight for community benefit activities. The membership of the Committee includes representation of community-based organizations, and also represents the ethnic diversity of the community. The Director of St. Joseph's Medical Center, Community Health facilitates the meeting, coordinating content with the Chair, who is a member of the St. Joseph's Community Board. (See Appendix B for a roster of Community Health & Advocacy Committee members)

Leadership and Community Benefit Planning Process

St. Joseph's Medical Center leadership system is driven by the core values of Dignity Health: Dignity, Justice, Collaboration, Stewardship and Excellence. The President of SJMC has the overall responsibility for the Mission and Community Benefit Strategic Planning process. The St. Joseph's Community Board approves the annual Community Benefit budget. Adequate resources are allocated to carry out the Community Benefit Plan through the operations and capital budgeting process each fiscal year. New Community Benefit programs must be accepted as part of the Strategic Plan of the Hospital before they can be included in the Community Benefit process and must respond to an identified need established through the most recent Community Health Needs Assessment (CHNA).

The St. Joseph's Community Board advises and participates in the planning and evaluation process with Senior Management and the CH & A to oversee the Community Benefit strategies. The CH & A Chair is a St. Joseph's Community Board Member and reports findings and recommendations to the Community Board monthly. The membership of the CH & A includes the Vice President of Mission Integration, Director of Community Health, Medical Staff, San Joaquin County Public Health representative, community-based organizations and community members representing the diversity of the service area.

The Director of Community Health has the responsibility of representing SJMC while developing community partnerships. Other responsibilities are to plan, organize, develop, evaluate and manage the Community Health Services and strategies approved by Senior Management, St. Joseph's Community Board and Vice President of Strategic Planning.

During 2012-13, a Community Health Needs Assessment (CHNA) was conducted by St. Joseph's Medical Center as part of the San Joaquin County Community Health Assessment Collaborative for the 700,000 residents of San Joaquin County. The health needs identified, through an analysis of both quantitative and qualitative data, are listed below. These are prioritized according to the degree of support in the findings. All needs are noted as a "health driver", or a condition or situation that contributes to a poor health outcome.

1. Access to primary and preventive care service
2. Lack of or limited access to health education
3. Lack of limited access to dental care
4. Limited cultural competence in health care and related systems
5. Limited or no nutrition literacy/access to healthy and nutritious foods, food security
6. Limited transportation options
7. Lack of safe and affordable places to be active

SJMC identified the three primary health needs among the seven that aligned with its mission and organizational capacity: Access to primary and Specialty Care; Health Education; and, Culturally Competent Care. The CHNA and Implementation Plan was approved by the Community Health & Advocacy Committee and submitted to the St. Joseph's Board and approved at their May 31, 2013 meeting.

St. Joseph's Medical Center and St. Joseph's Behavioral Health Center participate in the annual Dignity Health Community Grants Program. The objective of Dignity's Health Community Grants Program is to award grants to nonprofit organizations whose proposals respond to the priorities identified in the CHNA. Based on the 2011 CHNA, grants totaling \$127,800 were awarded to organizations whose proposals responded to the priorities identified which were;

1. Access to healthcare, including mental health services for youth and adolescents
2. Chronic Disease: Diabetes, Obesity and Asthma

Dignity Health Community Investment Program has been investing in STAND since 2000 (Stockton Taking Action to Neutralize Drugs) which purchases decaying single-family houses, rehabilitates the units and sells them to first time low-income homebuyers.

Non-Quantifiable Benefits

SJMC is well integrated into the community and many of the members of the Administrative Team, Management Teams and employees at various levels in the organization serve on the Boards of Community Coalitions and collaboratives to offer consult and represent SJMC in the Community. Some examples:

- The Business Council of San Joaquin County whose focus is business attraction, retention and expansion within the limits of the county and the seven incorporated cities within the county.
- Beyond Our Gates, a partnership of community leaders and University of Pacific with a focus on developing new initiatives in the area of education and successful achievement of reading by third grade.
- California Health Care Facility Advisory Committee, a newly built 1774 bed Department of Corrections medical facility.
- The Board and Programming Committee of St. Mary's Dining Room, a charitable organization serving working poor and homeless with the Virgil Gianelli Medical Clinic, St. Raphael's Dental clinic, meals, social services, clothing and a hygiene center.
- San Joaquin Public Health Department Chronic Disease Strategic Planning, initiated formation of the Obesity and Chronic Disease Task Force, Diabetes Task Force and the Asthma Coalition.
- SJMA provides hospital based clinical nursing instructors by agreement with San Joaquin Delta College.
- Through SJMC's employee philanthropic organization, the Spirit Club, fundraising and volunteerism has assisted local organizations with donations of holiday meals, school supplies, Christmas gifts, books and clothing.

St. Joseph's has adopted the Corporate Environmental Policy and offers training to all new employees. The Environmental Action Committee meets monthly with the current goal to build solar panels over the employee parking lot. SJMC won the Practice Green Health "Environmental Leadership Circle Award" for the 8th consecutive year in 2012 and is currently recycling 50% of its waste stream, approximately 350,000 lbs per month. Additional achievements for FY 2013 are:

- The only medical facility to be designated "Certified Green Business" by the San Joaquin County Recon Team.
- Has donated all of the produce from the St. Joseph's/Jerry Roek Memorial Community Garden to St. Mary's Dining Room.
- Installed a "Recycling Station" in the cafeteria.
- Participating in the Wellness Initiative.
- Healthier Hospitals Initiative highlighted St. Joseph's water conservation and green initiative through its laundry program, which has drastically reduced the hospital's footprint and local landfill usage.

Community

San Joaquin County is located in the Central Valley of Northern California and is home to approximately 700 thousand residents. The County seat is Stockton, the largest incorporated city in the county. Stockton is home to almost half of the county's residents. San Joaquin County is a federally designated Medically Underserved area (MUA). St. Joseph's Medical Center's primary service area is Stockton, with a secondary service area of the remainder of San Joaquin County and includes Valley Springs.

Central California (San Joaquin County) was hit hard in the recent recession, and San Joaquin County fared worse than the state average on many measures of economic distress. Unemployment for the county was 14.4% compared to the state rate of 10.1%. The County earned a nation-wide reputation for its high number of home foreclosures, and as of March 2013 22% of all homes were in some stage of foreclosure compared to the state rate of 14% and national rate of 12%. Stockton the largest city in San Joaquin County filed for bankruptcy protection in June 2012. Like other counties in California's fertile central valley, San Joaquin is heavily agricultural.

The Population in San Joaquin County is 702,612 (2012 approximate) ([2010 U.S. Census Bureau](#)). The population grew 2.5% from April 2010 to July 2012 (2012 approximate) and is expected to grow to 810,845 by 2020. The bulk in growth has been in the Hispanic/Latino population and is predicted to increase 3.7% by 2020 ([California Department of Finance, 2000–2050 Race/Ethnic Population with Age and Sex Detail, 2007](#)).

The languages spoken by students' ages 5-17 at home outlines the county-wide diversity. According to the 2010 U.S. Census Data 39% spoke a language other than English in their homes. The primary language other than English is Spanish, followed by Hmong and Khmer.

The high school graduation rate has slightly decreased from 77% in 2007 to 76.6% in 2011, persons with Bachelor's Degree or higher was 30.2% in 2011 (2012 approximate) ([2010 U.S. Census Bureau](#)).

Of all patients treated and discharged at St. Joseph's Medical Center (2012) 27% had Medicare Insurance, 42% had Medi-Cal, 22% had either an HMO or PPO and 9% are self pay (uninsured).

Demographics (San Joaquin County) ([2010 U.S. Census Bureau](#))

- Population
 - Ages 0-5 = 7.7%
 - Ages 6-17 = 28.6%
 - Ages 18-64 = 52.7%
 - Ages 65 & older = 11%
- Average Income, \$53,764
- Uninsured, 19%
- Unemployment, 14.4%
- No High School Diploma, 23.4%
- Renters, 39.3%
- Rural, unincorporated 20%
- CNI Score, 4.8 (Stockton)
- Medicaid Patients, 22%
- Other area hospitals:
 - Dameron Hospital, Stockton
 - Lodi Community Hospital, Lodi
 - Sutter Tracy Hospital, Tracy
 - San Joaquin County General Hospital, Lathrop
 - Doctors Hospital of Manteca, Manteca
- Diversity
 - White 36%
 - Hispanic/Latino 35.9%
 - African American 8.2%
 - Asian 15.7%
 - Native American 2.0%
 - Pacific Islander .07%
 - Two or more races 2.13%

Other care facilities able to respond to the health needs of the community are multiple FQHC's, two free clinics (Tracy Free Clinic, St. Mary's Free Clinic) and St. Joseph's Medical Center's Care Van.

(See Appendix C for most current Stockton CNI Map)

COMMUNITY BENEFIT PLANNING PROCESS

Community Health Needs Assessment Process

During 2012-13, a Community Health Needs Assessment (CHNA) was conducted in San Joaquin County. The assessment process was initiated and co-chaired by St. Joseph's Medical Center, St. Joseph's Behavioral Health Center, Dameron Hospital, Sutter Tracy Hospital and Kaiser Permanente who provided equal financial and in-kind support for the assessment process. First 5 of San Joaquin, Community Medical Centers, Health Plan of San Joaquin, Lodi Health Hospital and San Joaquin County Public Health provided financial and in-kind support. Other non-profit organizations providing health or related services within the county were invited to participate.

The Community Health Needs Assessment Collaborative (the Collaborative) was first formed in the late nineties. The core group of the Collaborative retained Valley Vision, Inc., to lead the assessment process. Valley Vision, Inc. is a non-profit (501(c) (3) consulting firm serving a broad range of communities across Northern California. The organization's mission is to improve quality of life through delivery of high-quality research on important topics such as healthcare, economic development, and sustainable environmental practices. As the lead consultant, Valley Vision assembled a team of experts from multiple sectors to conduct the assessment that included: 1) a public health expert, 2) a geographer, 3) additional public health practitioners and consultants to collect and analyze data.

Focus Groups: Members of the community representing demographic groups with unique attributes (race and ethnicity, age, sex, culture, lifestyle, or residents of a particular area of San Joaquin County) were recruited to participate in focus groups. A standard protocol was used for all focus groups to understand the lived experience of these community members as it relates to health disparities and chronic disease. In all, a total of eight focus groups were conducted (for a complete list of focus groups see Appendix E in CHNA report). Content analysis was performed on focus group interview notes and/or transcripts to identify key themes and salient health issues affecting the community residents.

A community-based participatory research orientation was used to conduct the assessment, which included both primary and secondary data. Primary data collection included input from more than 180 members of San Joaquin County, expert interviews with 45 key informants, and focus group interviews with 137 community members. Further input was gathered at meetings of the Healthier Community Coalition and the annual Community Health Forum, held in November 2012. In addition, a community health assets assessment collected information about more than 300 assets in the greater San Joaquin County area. Secondary data included health outcome data, socio-demographic data, and behavioral and environmental data at the ZIP code or census tract level. Health outcome data included Emergency Department (ED) visits, hospitalization, and mortality rates related to heart disease, diabetes, stroke, hypertension, chronic obstructive pulmonary disease, asthma, and safety and mental health conditions. Socio-demographic data included race and ethnicity, poverty (female-headed households, families with children, people over 65 years of age), educational attainment, health insurance status, and housing arrangement (own or rent). Behavioral and environmental data such as crime rates, access to parks, availability of healthy food, and leading causes of death helped describe the general living conditions.

Analysis of both primary and secondary data revealed 10 specific Communities of Concern (defined by ZIP code boundaries) living with a high burden of disease in San Joaquin County. These 10 communities had consistently high rates of negative health outcomes that frequently exceeded county, state, and Healthy People 2020 benchmarks. They were confirmed by experts as areas prone to experiencing poorer health outcomes relative to other communities in the county.

Health Needs Identified

The health needs identified through an analysis of both quantitative and qualitative data are listed below. These are prioritized according to the degree of support in the findings. All needs are noted as a "health driver", or a condition or situation that contributed to a poor health outcome.

1. Access to primary and preventative care service
2. Lack of or limited access to health education
3. Lack of limited access to dental care
4. Limited cultural competence in health care and related systems
5. Limited or no nutrition literacy/access to healthy and nutritious foods, food security

6. Limited transportation options
7. Lack of safe and affordable places to be active

Following the prioritization and ranking noted above, SJMC identified the three primary health needs among the seven that aligned with its mission and organizational capacity. To identify these primary health needs, a facilitator administered a questionnaire to The Vice-President of Mission Integration, Vice-President of Strategic Planning, The Director of Community Health and the Community Benefit Specialist using the criteria noted below.

1. Of the identified health needs for San Joaquin County, which are most closely connected to the mission of SJMC?
2. From SJMC's point of view and priorities, rank the list of health needs in order of importance from most important (1) to least important (7).
3. Based on your responses to the questions above, what are the top three health needs SJMC is interested in addressing in its specific service area? Why?

This prioritization process identified three priority issues for SJMC:

1. Access to Primary and Specialty Care
2. Health Education
3. Culturally Competent Care

The "2013 Community Health Needs Assessment" Executive Summary and full report is on the Collaborative created and owned web site; www.healthiersanjoaquin.org. The website provides access to previous Community Health Needs Assessments. The Assessment is also found on SJMC's website www.stjosephscares.org; Dignity Health's website www.DignityHealth.org and a printed copy is available upon request in the Community Health Department of SJMC.

Assets Assessment: Data was collected on health programs and support services within the county and the specific Communities of Concern. The first step involved compiling a list of existing resource directories. Next, additional assets identified through internet and related searches were added to the master list. Detailed information for each asset was then gathered through review of the organization websites and, when possible, direct contact with staff via phone. The assets are organized by ZIP code with brief discussion in the body of the report and detailed in Appendix H.

Developing the Hospital's Implementation Plan

Building on the steps described above, a Valley Vision facilitator led SJMC Vice President for Mission Integration, Vice President for Strategic Planning, Director of Community Health and Community Benefit Specialist through a strategic planning process to develop the implementation plan. SJMC evaluated all current Community Benefit programs and their relation to the selected primary health needs. In many instances the structure was in place for existing programs to address the selected primary health needs. Where there was a deficiency, new programs or practices were developed. This process resulted in the development of the implementation plan described below.

1. Access to Primary and Specialty Care
 - a. Utilize resources to meet needs of undocumented populations and the uninsured; and after ACA implementation, address the access needs of those left behind by ACA
 - b. Utilize resources to address the unmet dental needs of the Stockton community's most vulnerable populations
 - c. Expand SJMC's Interfaith Caregivers Senior Program
2. Health Education
 - a. Reach out to connect with residents in their communities and in culturally appropriate ways to deliver health education that positively affects health behaviors leading to improved health
 - b. Support community partners in developing programs to assist SJMC in addressing health needs priorities
3. Culturally Competent Care
 - a. Explore best practices that can be integrated into the community to deliver culturally competent care
4. Policy Work to Improve Community Health
 - a. Includes all identified priorities as stated above

Planning for the Uninsured/Underinsured Patient Population

Dignity Health is committed to providing payment assistance to persons who have health care needs and are uninsured or underinsured, ineligible for a government program, and otherwise unable to pay for medically necessary care based on their individual financial situations. Bi-lingual signage that addresses the hospitals Patient Payment Assistance Program is posted in key areas of the hospital facility. (Copy of Dignity Health Patient Payment Assistance Policy Appendix D

V. Plan Report and Update Including Measurable Objectives and Timeframes

The following programs were developed in response to identified community needs and are guided by the following five core principles:

- Disproportionate Unmet Health-Related Needs
- Primary Prevention
- Seamless Continuum of Care
- Build Community Capacity
- Collaborative Governance

Below are the major initiatives and key community based programs operated or substantially supported by St. Joseph's Medical Center in FY 2012-13. Programs that will continue operation in FY 2013-14 are noted by an asterisk (*).

Access to Health Care: high CNI scores correlate with higher levels of poverty, which restricts access to health care

- Charity Care for uninsured/underinsured and low income residents*
- Patient Assistance Program*
- Enrollment assistance for government sponsored insurance plans*
- Dignity Health Community Grants Program*
 - Mercy Housing California, Healthy at home resident services program
 - Catholic Charities, Outreach Program to improve access to early prenatal care
- Nurse Call Center
- Dobbins Program for Breast Health Services "Serving Women under 40 years old"*
- Mobile Mammography Program
- St. Mary's Dining Room "Virgil Gianelli" Free Clinic, monthly communication regarding resources*
- St. Joseph's Interfaith Caregiver Program, providing transportation, friendly visiting,*
- St. Joseph's CareVan, mobile medical clinic providing free episodic services, responding to community need with hours and locations*
- Special Needs Caregiver Program, hospital based program to identify patients with Developmental Disabilities or other Special needs and coordinate care and resources*
- Faith Community Nurse Program, education regarding community resources*

Preventing and/or Managing Chronic Health Conditions: high or increasing incidence of disease, focusing on Obesity, Asthma, Diabetes

- Community Diabetes Educational Program, (English & Spanish) classes in the community*
- Asthma Management Strategies Class*
- COLD Club of San Joaquin County, Pulmonary Rehabilitation*
- Dignity Health Community Grants Program*
 - Dorothy L. Jones Community Health Center/Community Partnership for Families of San Joaquin, after school fitness program addressing childhood obesity and other related issues amount "at risk" teens
 - YMCA of San Joaquin, Healthy Youth & Families Living Initiative
- STROKE Club*

Culturally Competent Care: develop education in multiple languages that will empower class attendees to become self advocates when utilizing the medical system.

These and other programs are monitored for performance, quality and relevance with ongoing improvements to ensure their success. The Community Health & Advocacy Committee and the San Joaquin Community Board receive semiannual updates on program performance and news.

The following pages include Program Digests for a few of the programs that address one or more of the Initiatives.

PROGRAM DIGEST

Cancer Navigator Program – Medically Underserved	
Hospital CB Priority Areas	<ol style="list-style-type: none"> 1. Access to primary and preventive care services 2. Lack of or limited access to health education 3. Limited cultural competence in health care & related systems
Program Emphasis	<ul style="list-style-type: none"> <input type="checkbox"/> Disproportionate Unmet Health-Related Needs <input type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Access to primary and preventive care service Limited cultural competence in health care and related systems
Program Description	The Navigator Program is designed to reach out to cancer patients by offering resources, education and support through their cancer journey
FY 2013	
Goal FY 2013	Increase patient education and awareness of local treatment opportunities and community resources to the medically underserved. Educate patients on services, financial resources, emotional support that can help them through their diagnosis of cancer.
2013 Objective Measure/Indicator of Success	Document patient encounters. Follow up on patients through their cancer diagnosis.
Baseline	100 underserved patients
Intervention Strategy for Achieving Goal	When calling patients offer assistance to them through their surgery, treatment plan and provide education
Result FY 2013	A total of 100 medically underserved patients were navigated
Hospital's Contribution / Program Expense	\$40,075
FY 2014	
Goal 2014	Increase patient education and awareness of local treatment opportunities and community resources to 100 medically underserved patients. Educate patients on services, financial resources, emotional support that can help them through their diagnosis of cancer.
2014 Objective Measure/Indicator of Success	To follow up with 100% of patients referred for navigation
Baseline	100 underserved patients
Intervention Strategy for Achieving Goal	Navigate medically underserved cancer patients by offering resources, education and support
Community Benefit Category	A32

PROGRAM DIGEST

CareVan Program	
Hospital CB Priority Areas	<ol style="list-style-type: none"> 1. Access to primary and preventive care services 2. Lack of or limited access to health education 3. Limited cultural competence in health care & related systems
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ☐ Seamless Continuum of Care ✓ Build Community Capacity ☐ Collaborative Governance
Link to Community Needs Assessment	Access to primary and preventive care service
Program Description	The CareVan is a mobile medical clinic offering free health services to the underserved/uninsured including health screening, education and referral services; medical diagnoses and treatment. The CareVan offers clinics 3-4 times per week in various high need areas.
FY 2013	
Goal FY 2013	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.
2013 Objective Measure/Indicator of Success	Number of patients who access the CareVan at Walk-In-Clinics and Screening Clinics will increase by 10%.
Baseline	FY 2011-12 – 3,966 patients were seen at CareVan Walk-In-Clinics, and at Patient Screening Clinics
Intervention Strategy for Achieving Goal	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. Develop new partnerships and strengthen existing partnerships. Provide information and screening for eligibility to medical homes.
Result FY 2013	166 walk-in clinics and 58 screening clinics were conducted. A combined total of 3,691 patients were seen on the CareVan. 1,176 received screening services and 2,515 received physical exams. 63% served on the CareVan would have not sought health services at all. 12% would have gone to the Emergency Department for services.
Hospital's Contribution / Program Expense	\$748,596
FY 2014	
Goal 2014	Offer access to care, early prevention screening services, and provide eligibility resources for the underserved population.
2014 Objective Measure/Indicator of Success	See 4,200 patients at 168 clinics (3.5 clinics x 48 weeks = 168)
Baseline	166 walk-in clinics
Intervention Strategy for Achieving Goal	All clinics will have Blood Sugar and Blood Pressure screening available. Expand hours to include afternoon clinics. Expand locations to include migrant worker camp areas. Explore opportunities to offer specialty care. Include patient navigator on the CareVan to connect patients to community services and eligibility resources. Evaluate sites quarterly for efficacy; results of the Care Van sites will be evaluated quarterly. Connect people with community resources through the Affordable Care Act.
Community Benefit Category	A2a

PROGRAM DIGEST

Diabetes Educational Program	
Hospital CB Priority Areas	<ol style="list-style-type: none"> 1. Access to primary and preventive care services 2. Lack of or limited access to health education 3. Limited cultural competence in health care & related systems
Program Emphasis	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	<p>Access to primary & preventive care services Lack of or limited access to dental care Limited cultural competence in health care & related systems</p>
Program Description	<p>The Diabetes Education Program, "Basics to a Healthy Life," is an eight part educational series taught by a RN, Certified Diabetic Educator emphasizing self-management, healthy lifestyle, and the reduction of complications. The classes are offered at various locations at least 4 times per week in English and Spanish.</p>
FY 2013	
Goal FY 2013	<p>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 improvement.</p>
2013 Objective Measure/Indicator of Success	<p>Offer 1 or 2 class series in a different language. 75% of students will have increased knowledge and 50% will self-report an increase in healthy behaviors.</p>
Baseline	<p>The healthier San Joaquin report in 2011 the percentage of adults with diabetes in San Joaquin County has consistently been higher than that of California. In 2007, the percentage of adults with diabetes was 9% in San Joaquin County and 8% in California. The program offers an 8-part educational series to teach students how to take better control of their Diabetes through education and healthy lifestyle changes. Pre-diabetics are also encouraged to participate to offer early intervention and prevent Diabetes.</p>
Intervention Strategy for Achieving Goal	<p>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 Provide pre and post test to class participants to determine what percentage is improving</p>
Result FY 2013	<p>There were 171 classes conducted and a total of 2,208 class participants attended. A small sample of class participants attending at least 6 classes revealed 85% had increased knowledge in Diabetes. 60% had self-reported an increase in physical activity. 45% had self-reported an increase in their fruit and vegetable intake.</p>
Hospital's Contribution / Program Expense	<p>\$119,700</p>
FY 2014	
Goal 2014	<p>The goal of this program is to outreach and connect with community members and offer culturally competent education to improve health knowledge and increase healthy behaviors.</p>
2014 Objective Measure/Indicator of Success	<p>Offer 1 or 2 class series in a different language. 75% of students will have increased knowledge and 50% will self-report an increase in healthy behaviors.</p>
Baseline	<p>171 classes FY 2013 increase by 10% = 188 classes.</p>
Intervention Strategy for Achieving Goal	<p>Build new partnerships in high need areas to offer classes. Offer classes in additional languages. Contact patients seen at the CareVan with abnormally high blood sugars and invite them to classes. Maintain appropriate data to measure class effectiveness. Link with existing programs at the medical center.</p>
Community Benefit Category	<p>A1a</p>

PROGRAM DIGEST

Dobbins Program	
Hospital CB Priority Areas	<ol style="list-style-type: none"> 1. Access to primary and preventive care services 2. Lack of or limited access to health education 3. Limited cultural competence in health care & related systems
Program Emphasis	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Improve access to primary care
Program Description	The program is set up for women 18-39 years of age who have breast problems and primary care provider has determined that baseline screening or further breast diagnostic testing is needed. These patients have no other resources such as private insurance, Medi-Cal or Family Pact to cover expenses.
FY 2013	
Goal FY 2013	To increase breast cancer screening and diagnostic services to young women with clinical findings.
2013 Objective Measure/Indicator of Success	Young women between the age of 19 and 39 will have access to critical diagnostic services for the detection of breast cancer when they present with breast symptoms. Women accessing services will be measured as well as the number of breast cancers detected.
Baseline	Currently there are no services for women underinsured/uninsured between the under the age of 40. There is a strong need to provide access to diagnostic services for these women.
Intervention Strategy for Achieving Goal	Through physician referrals will continue to provide this service
Result FY 2013	296 patients were seen, services included, 90 Breast Biopsies, 231 Breast Ultra Sounds, 119 Diagnosis Mammograms, 6 Screening Mammograms, and 6 Clinical Exams were done. Four Breast Cancers were diagnosed.
Hospital's Contribution / Program Expense	\$60,066
FY 2014	
Goal 2014	Continue program as defined above
2014 Objective Measure/Indicator of Success	Young women between the age of 19 and 39 will have access to critical diagnostic services for the detection of breast cancer when they present with breast symptoms. Women accessing services will be measured as well as the number of breast cancers detected. 290 women will be seen for services, MMU was retired in FY 2012-13 therefore no Clinical Breast Exams will be provided by this program.
Baseline	296 patients were seen, services included breast biopsies, breast ultra sounds, diagnostic mammograms, screening mammograms
Intervention Strategy for Achieving Goal	To provide services up to diagnosis and provide enrollment assistance into the state program
Community Benefit Category	A2f

PROGRAM DIGEST

Special Needs Caregiver Program	
Hospital CB Priority Areas	<ol style="list-style-type: none"> 1. Access to primary and preventive care services 2. Lack of or limited access to health education 3. Limited cultural competence in health care & related systems
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity
Link to Community Needs Assessment	<p>Access to primary and preventive care services Lack of or limited access to health education</p>
Program Description	<p>Hospital based program to identify patients with Developmental Disabilities or other Special Needs. Coordinate care and resources, provide accommodation, staff education, address issues of legal consenting, communication and appropriate care facilitation, collaborate with community supports, advocate, and promote sensitivity and dignity to persons with disabilities.</p>
FY 2013	
Goal FY 2013	<p>Increase patient referrals to Special Needs RN; provide ongoing education to nursing staff and to community members. Provide accommodations for Special Needs patients.</p>
2013 Objective Measure/Indicator of Success	<p>FY 2012-13 190 patients were seen and 5 in-service classes were taught. Implemented referral system through Meditech EHR.</p>
Baseline	<p>Valley Mountain Regional Center serves 5 counties for developmentally delayed individuals, 50% of these individuals reside in the San Joaquin County</p>
Intervention Strategy for Achieving Goal	<p>Plan classes through Learning Center and develop personal knowledge through membership in DDNA and AACN organizations as well as attended a conference at UCSF on Developmental Disabilities for Health Professionals.</p>
Result FY 2013	<p>Improved patient experience, promotion of safety, efficiency, anti-discrimination and accommodation within ADA law.</p>
Hospital's Contribution / Program Expense	<p>St. Joseph's Medical Center provided \$80,093 in support to the program</p>
FY 2014	
Goal 2014	<p>Continue educational classes increasing to 10 cases. Counsel parents of 80% developmentally delayed NICU babies.</p>
2014 Objective Measure/Indicator of Success	<p>Numbers of classes taught. Acceptance /consideration of Business proposal at hospitals in Dignity organizations.</p>
Baseline	<p>190 patients were seen and 5 classes were taught</p>
Intervention Strategy for Achieving Goal	<p>A proposal to expand the Special Needs Caregiver Program has been submitted to the Sacramento Service area through the Innovator's Challenge. Classes for 2014 in planning phase to address Autism. Planning to continue to reach nursing staff through monthly Skills' Days and 1:1 mentoring. Increase collaboration with Social Services to provide services to NICU babies.</p>
Community Benefit Category	<p>A3e</p>

PROGRAM DIGEST

St. Joseph's Interfaith Caregiver Program	
Hospital CB Priority Areas	<ol style="list-style-type: none"> 1. Access to primary and preventive care services 2. Lack of or limited access to health education 3. Limited cultural competence in health care & related systems
Program Emphasis	<ul style="list-style-type: none"> <input type="checkbox"/> Disproportionate Unmet Health-Related Needs <input type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Access to primary and preventive care service Limited transportation options
Program Description	St Joseph's Interfaith Caregivers (SJIC) Program provides free services to seniors living at home and their families. Services include transportation, friendly visiting, respite care, yard clean up, home safety assessments and referrals which are provided by trained volunteers.
FY 2013	
Goal FY 2013	The program will continue to address the needs of seniors living at home and will recruit and sustain volunteers while advocating for volunteer services throughout the county. The program will strengthen its efforts through collaboration with other agencies in the county.
2013 Objective Measure/Indicator of Success	Conduct annual training to ensure volunteer compliance, market needs for volunteers at health fairs and church bulletins; evaluate care receivers for appropriateness for service; refer care-receivers to community resources to address additional needs; make available access to appointments, shopping and errands.
Baseline	Meeting the needs of an increasing vulnerable population of elderly seniors whose quality of life diminishes with cuts in public funding and grants; as seniors age physical and health related issues increase and challenge independence. Requests for services to this program average 120/month; responses to these requests are provided by volunteers or by referrals to more appropriate agencies.
Intervention Strategy for Achieving Goal	Pursue strategic goal to increase volunteers; continue to seek support from interfaith communities; establish a contact person with each member congregation; match volunteers with spouses of respite care receivers; match volunteers to aid chemo/radiation pts; make care receiver referrals to health classes and support groups; provide yard clean up to > 5 elder's homes; outreach to senior organizations for contributions to WWOW; participate in Hunger Task Force, Food Security and Senior Nutrition sub committees, provide volunteer appreciation and volunteer recognition that expresses gratitude for the generous and dedicated commitment that each volunteer provides to provide these services for seniors in Stockton community.
Result FY 2013	Increased number of active volunteers; updated volunteers with mandatory meeting/training; evaluated 47 care receivers with personal visits; provided yard cleanup for 2 elders' homes in collaboration with ARC (training for persons with disabilities); comforted 950 elders with the Warm Woolies for Oldsters in Winter bundles; bundles distributed by partner agencies of St Joseph's Community Health; participated in San Joaquin Hunger Task Force and Senior Nutrition Committee.
Hospital's Contribution / Program Expense	St. Joseph's Medical Center provided \$107,751 in support to the program
FY 2014	
Goal 2014	The program will continue to address the needs of seniors living at home and will recruit and sustain volunteers while advocating for volunteer services throughout the county. The program will strengthen its efforts through collaboration with other agencies in the county Expand SJMC's Interfaith Caregivers Program by: <ol style="list-style-type: none"> 1. Develop additional volunteer training 2. Evaluate Care-receivers prior to and during care for appropriateness 3. Continue outreach to provide services to the elderly population 4. Provide transportation to care-receivers as appropriate to assist aging in place
2014 Objective Measure/Indicator of Success	Conduct annual training to ensure volunteer compliance, market needs for volunteers at health fairs and church bulletins; evaluate care receivers for appropriateness for service; refer care-receivers to community resources to address additional needs; make available access to appointments, shopping and errands.
Baseline	Increasing vulnerable senior population in San Joaquin County, limited public transportation options available to seniors who are no longer able to drive; challenging physical and health related issues of seniors requiring access to primary and specialty care. Requests for services from this program average 120/month; responses to these requests are provided by volunteers or by referrals to more appropriate agencies.
Intervention Strategy for Achieving Goal	Develop additional volunteer trainings; evaluate care-receivers prior to and during care for appropriateness; continue outreach to provide services to the elderly population requiring assistance; provide transportation to care-receivers as appropriate to assist aging in place.
Community Benefit Category	E3d

Community Benefit and Economic Value

	Persons	Total Expense Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses Revenues	
<u>Benefits for Living in Poverty</u>						
Financial Assistance	6,492	5,597,632	0	5,597,632	1.3	1.3
Medicaid	57,174	124,410,837	97,087,541	27,323,296	6.5	6.4
Means-Tested Programs	40	334,834	76,625	258,209	0.1	0.1
Community Services						
Community Benefit Operations	0	319,050	0	319,050	0.1	0.1
Community Health Improvement Services	8,313	3,157,063	0	3,157,063	0.7	0.7
Financial and In-Kind Contributions	109	939,623	0	939,623	0.2	0.2
Subsidized Health Services	229	161,606	0	161,606	0.0	0.0
Totals for Community Services	8,651	4,577,342	0	4,577,342	1.1	1.1
Totals for Living in Poverty	72,357	134,920,645	97,164,166	37,756,479	8.9	8.9
<u>Benefits for Broader Community</u>						
Community Services						
Community Building Activities	467	804,072	0	804,072	0.2	0.2
Community Health Improvement Services	117,965	2,088,435	822,127	1,266,308	0.3	0.3
Financial and In-Kind Contributions	1,617	357,867	0	357,867	0.1	0.1
Health Professions Education	4,228	2,905,553	63,636	2,841,917	0.7	0.7
Research	393	241,535	0	241,535	0.1	0.1
Totals for Community Services	124,670	6,397,462	885,763	5,511,699	1.3	1.3
Totals for Broader Community	124,670	6,397,462	885,763	5,511,699	1.3	1.3
Totals - Community Benefit	197,027	141,318,107	98,049,929	43,268,178	10.2	10.1
Unpaid Cost of Medicare	30,824	126,168,869	98,851,881	27,316,988	6.4	6.4
Totals with Medicare	227,851	267,486,976	196,901,810	70,585,166	16.7	16.6
Grand Totals	227,851	267,486,976	196,901,810	70,585,166	16.7	16.6

The formulas used to calculate Financial Assistance, Medicare and Medi-Cal have been established as policy by Finance and Community Benefit Leadership, utilizing Cost Accounting methodology.

Telling the Story

St Joseph's Medical Center is the largest not-for-profit employer in San Joaquin County. 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 goal has been to inform the staff and providers of the programs available in the community so they can 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.

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 provides opportunity for forming partnerships and preventing duplication of efforts which would waste valuable resources.

Annually the Community Benefit Report and Plan is completed and reviewed, then presented to the Community Health & Advocacy Committee for their review and approval. Once approved by the CH&A it is sent to the San Joaquin Community Board for approval. Key information is presented at the Managers Meeting.

The Annual Community Benefit Report and Implementation Plan is posted on St. Joseph's Medical Center website www.stjosephscares.org and www.dignityhealth.org under Who We Are/Community Health. The 2011 and 2013 Community Health Needs Assessment is also found on those websites and also on www.healthiersanjoaquin.org.

Appendix A

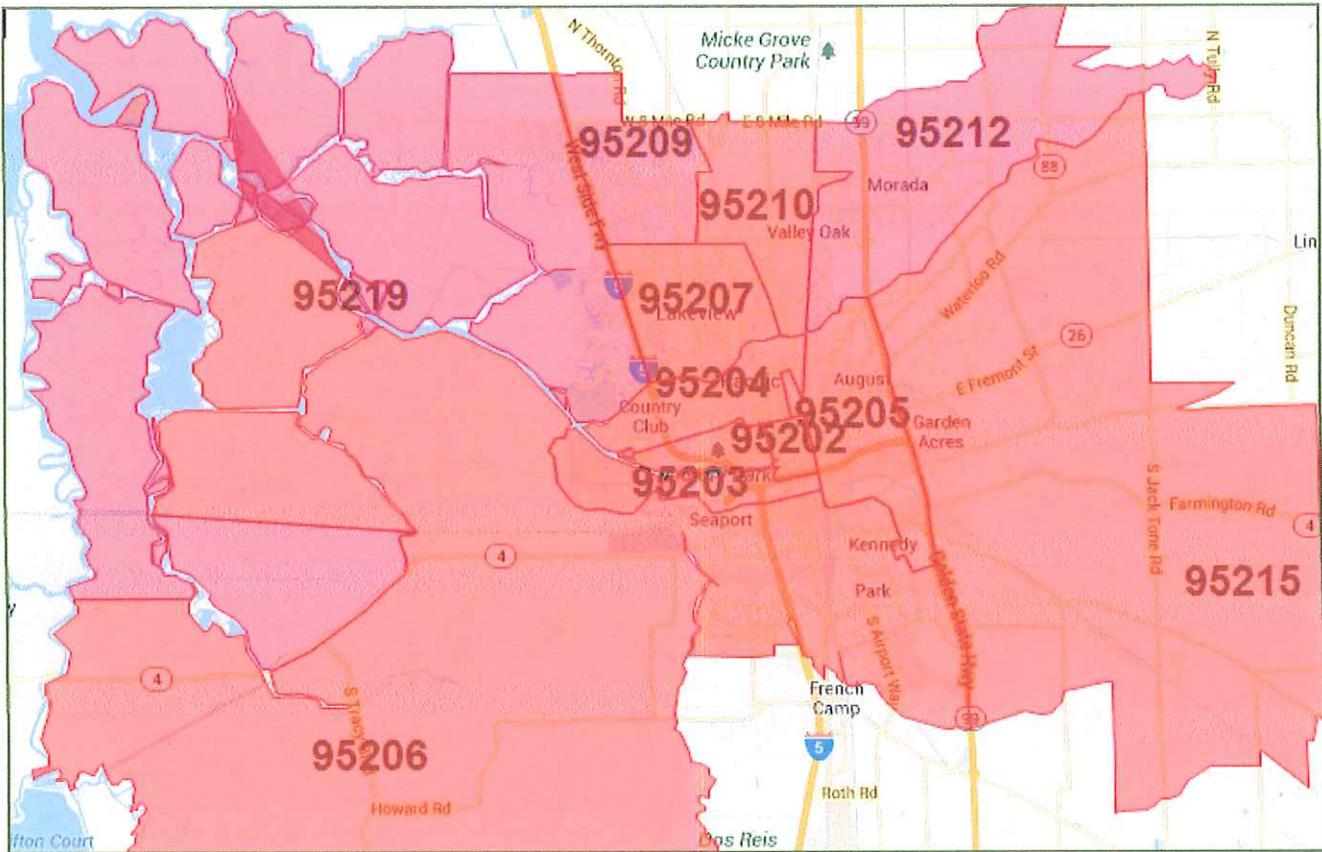
St. Joseph's Community Board of Directors

The Honorable Michael Coughlan	Judge of the Superior Court, San Joaquin County
Prasad Dighe, M.D.	Chief of Staff, Hematologist & Oncologist
Michael Duffy	President, Financial Center Credit Union
Sister Patricia Farrell, OP	Dominican Sisters of San Rafael
Joelle Gomez	Executive Director Women's Youth & Family Services
Sister Raya Hanlon, OP	Dominican Sisters of San Rafael
Kathleen Lagorio Janssen	CEO, Lagorio Family of Companies
David Lim, M.D.	Cardiologist
Sheriff Steve Moore	Sheriff, San Joaquin County
Steven A. Morales	Owner, Mayaco
Jonise C. Oliva	Owner, Deck the Walls
Carol J. Ornelas	CEO, Visionary Home Builders, Inc.
David Robinson, D.O.	Psychiatrist
Constance M. Fitzpatrick Smith	Registered Nurse, Teacher
Sister Elaine Stahl, RSM	Religious Sisters Mercy
Donald J. Wiley	President & CEO, St. Joseph's Medical Center
Robin Wong, M.D.	Family Practice

Appendix B Community Health & Advocacy Committee

Kwabena Adubofour, M.D.	Family Practice
Tom Amato	Director, PACT
Occeletta Briggs	Community Member
Pat Collier	Director Community Health St. Joseph's Medical Center
Sister Terry Davis, SND de Namur	Catholic Diocese of Stockton
Michael Duffy	President, Financial Center Credit Union
Edward Figueroa	Co-Director St. Mary's Interfaith
Mick Founts	Deputy Superintendent San Joaquin County Office of Education
Karen Furst, M.D.	Health Officer, San Joaquin County Public Health
Rich Good	YMCA of San Joaquin
Robert Kavanaugh	Community Member
John Kendle	Director Support Services St. Joseph's Medical Center
Robin Morrow	Senior Health Educator, Health Plan of San Joaquin
Sister Abby Newton, OP	Vice President Mission Services St. Josephs Medical Center
Natalie Pettis	Director Marketing Communication St. Joseph's Medical Center
Elvira Ramirez	Director Catholic Charities
Don Sims	C.D. Program Manager St. Joseph's Behavioral Health Center
Joan Singson	Community Member
Constance Smith	Community Board Member
Harvey Williams	University of the Pacific

APPENDIX C



■ 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

	Zip Code	CNI Score	Population	City	County	State
	95202	5	7,132	Stockton	San Joaquin	California
	95203	5	16,823	Stockton	San Joaquin	California
	95204	4.6	27,683	Stockton	San Joaquin	California
	95205	5	36,486	Stockton	San Joaquin	California
	95206	4.8	66,869	Stockton	San Joaquin	California
	95207	4.6	50,917	Stockton	San Joaquin	California
	95209	4	41,199	Stockton	San Joaquin	California
	95210	4.8	47,156	Stockton	San Joaquin	California
	95212	3.4	14,638	Stockton	San Joaquin	California
	95215	4.6	22,558	Stockton	San Joaquin	California
	95219	3.6	28,631	Stockton	San Joaquin	California

CNI Score Median: 4.8

Appendix D

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.