



Dignity Health™
St. Joseph's Medical Center



St. Joseph's Medical Center

**Community Benefit Report 2014
Community Benefit Implementation Plan 2015**



Community Health
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A message from Donald J. Wiley, President and CEO of St. Joseph's Medical Center, and The Honorable Michael Coughlan, Chair of the Dignity Health St. Joseph's Community Board.

The Hello humankindness campaign launched by Dignity Health is a movement ignited and based on the proven idea that human connection, be it physical, verbal, or otherwise, leads to better health. At Dignity Health the comprehensive approach to community health improvement recognizes the multi-pronged effort needed to meet immediate and pressing needs, to partner with and support others in the community, and to invest in efforts that address the social determinants of health.

At St. Joseph's Medical Center we share a commitment to improve the health of our community and have offered programs and services to achieve that goal. The 2014 Annual Report and 2015 Plan for Community Benefit fulfills section 501 (r) of the Patient Protection and Affordable Care Act, where each hospital must complete a community health needs assessment every three years and develop a community health implementation plan to document how it will address the significant health needs of the community. We are proud to provide this report as a continuation of the work we have done over the past 115 years to better the health of the communities we serve.

In addition, California State Senate Bill 697 requires not-for-profit hospitals to annually report its community benefit efforts and measurable objectives as well as its plans for the coming year. Encouraged and mandated by its governing body, Dignity Health hospitals comply with both mandates at each of its facilities, including those in Nevada and Arizona, and is proud of the outstanding programs and services that have been offered to improve the health of the communities we serve.

In fiscal year 2014, St. Joseph's Medical Center provided \$60,980,735 in financial assistance, community benefit, and unreimbursed patient care. Including the unreimbursed cost of caring for patients covered by Medicare, the total expense was \$76,201,194.

Dignity Health's St. Joseph's Medical Center Board of Directors has reviewed and approved the annual Community Benefit Report and Implementation Plan at their October 24, 2014 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at (209) 467-6384.

(Signatures)


Donald J. Wiley, President & CEO


The Honorable Michael Coughlan, Chairperson,
Board of Directors

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EXECUTIVE SUMMARY

St. Joseph's Medical Center is nationally recognized as a quality leader and consistently chosen as the "most preferred hospital" by local consumers. With 366 beds it is the largest hospital in Stockton, California and serves as a regional hospital specializing in cardiovascular care, comprehensive cancer services, and women and children's services, including neonatal intensive care. With more than 2,200 employees, St. Joseph's is also the largest private employer in Stockton. St. Joseph's Medical Center celebrates a history of 115 years of service to the community and is 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.

St. Joseph's Medical Center (SJMC) has always served a central role in the health of the community in San Joaquin County and responds to changing healthcare needs. With the economic downturn greatly impacting the Central Valley region, this role has become even more critical in ensuring that underserved populations have access to needed healthcare services. In Fiscal Year 2014 the hospital spent over \$50 million in providing care for underserved individuals (unreimbursed costs of providing care to Medicaid and uninsured populations).

Healthcare reform with the implementation of Covered California and the expansion of the Medi-Cal program has greatly affected healthcare delivery in Stockton. Tens of thousands of individuals who previously were uninsured now have healthcare coverage, but unfortunately many are still facing barriers in accessing primary care services. During this time of transition there are delays in the enrollment process and many individuals are unfamiliar with navigating the healthcare system; so people are seeking care in the hospital emergency department, at St. Joseph's Immediate Care Clinic and on the CareVan mobile medical unit. St. Joseph's goal is to provide for their urgent care needs and also link them with a medical home. During this past year St. Joseph's became a qualified Presumptive Eligibility provider for Medi-Cal, offering low-income patients immediate program benefits. In addition St. Joseph's has partnered with Catholic Charities to bring a Health Access Coordinator on-board the CareVan who helps people navigate the healthcare system and become established with their primary care provider for on-going care. Special outreach from the CareVan focuses on low-income populations who are not eligible for public coverage and remain uninsured.

Another area of great need is the growing population of senior adults. While many seniors have strong support systems and are able to remain active and healthy, many others are isolated, lack resources and struggle with multiple health issues. In order to respond to their needs St. Joseph's launched the Homecoming Project in May 2014. The Homecoming Project provides assistance to senior patients after discharge from the hospital. Through a partnership with Catholic Charities a social worker visits the patient in their home and assists them with attending medical appointments, following medication instructions and accessing other social services for which they may be eligible. The Homecoming Project builds upon the existing Interfaith Caregivers Program and helps seniors to stay healthy and live independently in their homes.

One additional way in which St. Joseph's is responding to changing health needs is through health education. With the dramatic increase in diabetes and chronic disease there is a great need to provide people with tools and empowerment for effective self-management. In 2014 St. Joseph's implemented the Chronic Disease Self Management Program developed by Stanford University. In partnership with Community Partnerships for Families of San Joaquin County and Lao Family Community Empowerment, these workshops are now provided at libraries, resource centers, schools and other community sites. This is

a great compliment to St. Joseph's successful clinical program and community health programs for diabetes, leading to better health outcomes.

In addition to services for uninsured and underinsured individuals in the hospital and these new initiatives, St. Joseph's Medical Center also continues to serve the needs of the community through other programs including the Faith Community Nurse Program, Special Needs Caregiver Program, Dobbins Program, and the Community Grant Program. All combined, in Fiscal Year 2014 St. Joseph's Medical Center provided a total community benefit of \$60,980,735 (which excludes the unpaid cost of Medicare, \$15,220,459). This tremendous investment demonstrates St. Joseph's commitment to providing access to health care services and improving the quality of life in the community.

MISSION STATEMENT

Our Mission

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.

Our Vision

A vibrant, national health care system known for service, chosen for clinical excellence, standing in partnership with patients, employees and physicians to improve the health of all communities served.

Our Values

Dignity Health is committed to providing high-quality, affordable health care to the communities we serve. Above all else we value:

Dignity

Respecting the inherent value and worth of each person.

Collaboration

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

Justice

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

Stewardship

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

Excellence

Exceeding expectations through teamwork and innovation.

Hello Humankindness

After more than a century of experience, we've learned that modern medicine is more effective when it's delivered with compassion. Stress levels go down. People heal faster. They have more confidence in their health care professionals. We are successful because we know that the word "care" is what makes health care work. At Dignity Health, we unleash the healing power of humanity through the work we do every day, in the hospital and in the community.

Hello humankindness tells people what we stand for – health care with humanity at its core. Through our common humanity as a healing tool, we can make a true difference, one person at a time.

ORGANIZATIONAL COMMITMENT

Benefitting the community has always been central to the mission and purpose of St. Joseph's Medical Center. Founded in 1899 by Father William O'Connor and administered by the Dominican Sisters of San Rafael, St. Joseph's Medical Center celebrates a history of 115 years of service to the community. This service continues today through the Community Benefit programs of the hospital and includes all levels of hospital leadership and staff. The Community Board along with the Hospital President and Executive Management Team were involved in the Community Health Needs Assessment process, as well as the Community Benefit planning process and prioritization of identified unmet health-related needs, which were used to inform the development of programs for the current year.

The Community Health & Advocacy Committee is a committee of the Community Board and provides continuous input on the community benefit work of the hospital. This committee meets monthly to discuss community needs, revise strategies and programs to respond to changing needs, and monitor progress toward goals. The chair of the committee serves on the Community Board, which maintains oversight of the community benefit work. (Please see the appendices for a list of board and committee members.) Specific roles and responsibilities of the Community Health & Advocacy Committee include the following.

- Participate in Community Benefit planning and oversight, including setting of goals and priorities
- Evaluate and provide input for community benefit programs including program content, program design, program targeting, program continuation or termination, and program monitoring of outcomes.
- Review and approve the Annual Report for submission to the Community Board
- Review and approve the community benefit budget
- Review and approve the Community Needs Assessment and resulting priority setting process
- Support environmental concerns
- Serve as an advocate to address the issues that impact the health of our community

Employees are also actively involved with community benefit activities including volunteering for numerous charitable organizations and events. Through St. Joseph's employee philanthropic organization, the Spirit Club, fundraising and volunteerism has assisted local organizations with donations of holiday meals, school supplies, holiday gifts, books and clothing.

Community Benefit is linked to the hospital's overall planning process and is incorporated into the strategic plan. For example, one of the goals in the hospital's strategic plan is to, "Develop diabetes program by mobilizing existing community health department resources to expand awareness, prevention and screening activities for diabetes". In addition the Manager of Community Health meets regularly with the Executive Management Team regarding evolving needs, new initiatives and program outcomes. Community Benefit work is also incorporated in the hospital's quality improvement process, including an annual report to the Integrated Quality Committee.

The Dignity Health community grants program supports the continuum of care in the community by providing financial support to other not-for-profit organizations. This includes, for example, Community Center for the Blind, the local work of Mercy Housing of California, the local chapter of the National Alliance on Mental Illness, and Stockton Shelter for the Homeless. In addition St. Joseph's Medical Center Foundation is the largest donor for St. Mary's Dining Room, providing significant support each year for their free medical and dental clinics.

The Dignity Health Community Investment Program provides support to expand programs that impact health, including programs that address the social determinants of health. In Stockton the program provides support for two housing programs in low-income neighborhoods. Dignity Health provides a \$250,000 predevelopment loan to Mutual Housing for the rehabilitation of housing for the Cambodian refugee community. The housing facility is operated by the Cambodian community through the Asian Pacific Self-Development and Residential Association (APSARA). This housing has been critical for Stockton in providing a place of safety and cultural identity for the Cambodian community, especially since a 1989 school shooting killed five students, four of whom were offspring of Cambodian refugees. In January this year when the community gathered to commemorate the anniversary of the school shooting, it was at APSARA that they chose to meet.

The Community Investment Program also provides a \$500,000 loan to a community-based organization for the purchase and rehabilitation of foreclosed homes in high need neighborhoods. This work by the group called Stocktonians Taking Action to Neutralize Drugs (STAND) is eliminating the havens for drug activity while simultaneously providing houses to low and moderate income families.

Non Quantifiable Benefits

St. Joseph's Medical Center serves an important role in improving the health of the community through working collaboratively with community partnerships, providing leadership and advocacy, carefully managing resources, assisting with local capacity building and participating in community-wide health planning. The leadership role is especially important in San Joaquin County where individual and community resources are very limited.

Leaders from St. Joseph's serve as board members of numerous community organizations and collaboratives. This includes, for example, the Vice President of Mission Integration serving on the California Health Care Facility Advisory Committee for the Department of Corrections' medical facility in the area. The county-wide Asthma Coalition also benefits from St. Joseph's leadership, as their group is chaired by a respiratory therapist from St. Joseph's. In addition, the Special Needs nurse serves as an expert consultant in the community regarding care for individuals with special needs.

The Manager Community Health chairs the Healthier Community Coalition and is leading the development of community-wide initiatives to address the priority health needs from the Community Health Needs Assessment. This includes initiating the San Joaquin Community Dental Task Force to address the need for dental care services in underserved communities. St. Joseph's also brought together partners to develop next year's diabetes conference for healthcare providers and patients. The hospital is also a member of the Obesity and Chronic Disease Task Force, the Diabetes Workgroup, and the San Joaquin Human Trafficking Task Force. In addition St. Joseph's is a partner in the strategic plan for Community Health Workers which is being jointly created by the local hospitals, county public health department and community partners.

The hospital is also a key partner in community building and ensuring environmental improvement through the ecology initiatives. Staff from St. Joseph's Medical Center voluntarily operate a community garden that provides over 2,000 pounds annually of fresh vegetables which are donated to organizations that prepare free meals for low-income individuals. The hospital won the Practice Green Health "Environmental Leadership Circle Award" for the 8th consecutive year and is currently recycling 50% of its waste stream, approximately 350,000 lbs per month. 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

The primary service area of St. Joseph’s Medical Center is the city of Stockton, with a secondary service area of San Joaquin County. This community has great potential and also has great challenges. There is a large immigrant population in the area with twenty-three percent of people who were born in another country and nearly forty percent who speak a language other than English at home. Primary languages include Spanish, Hmong, Khmer (Cambodian), and Vietnamese.

Approximately fifteen percent of county residents are living on incomes below poverty level. These communities are generally isolated as the majority of low-income families live in county census tracts where more than half of the populations have incomes below 185% of the Federal Poverty Level (FPL). For San Joaquin County, these census tracts are located primarily in the Stockton area. In several of the low-income neighborhoods violence is a major concern, many residents do not have a safe and affordable place to be active, fresh fruits and vegetables are often not available and transportation is limited. Nearly a quarter of students in San Joaquin County do not graduate from high school, and the unemployment rate is over fourteen percent. Statistics from the U.S. Census Bureau (2010) reveal additional information about the community.

Population		685,306		Diversity		Additional Information	
Ages 0-5	7.7%	White	36%	Rural (unincorporated)	20%		
Ages 6-17	28.6%	Hispanic/Latino	35.9%	Unemployment	14.4%		
Ages 18-64	52.7%	African American	8.2%	No High School Diploma	23.4%		
Ages 65 & older	11.0%	Asian	15.7%	Renters	39.3%		
Income		Native American	2.0%				
Average Income	\$53,764	Pacific Islander	0.07%				
		Two or more races	2.13%				

St. Joseph’s Medical Center is located in a federally designated Primary Care Health Professional Shortage Area (HPSA). Many of the communities served by the hospital are designated as Medically Underserved Areas (MUA) and the migrant farmworkers served by the hospital are designated as a Medically Underserved Population (MUP). For community benefit activities, St. Joseph’s partners closely with the other healthcare providers in the region, which include:

- | | |
|-------------------------------------|---------------------------------|
| San Joaquin County Public Health | Sutter Tracy Community Hospital |
| Community Medical Centers (FQHC) | Kaiser Permanente |
| St. Mary’s Free Clinic | Lodi Community Hospital |
| San Joaquin County General Hospital | Dameron Hospital |

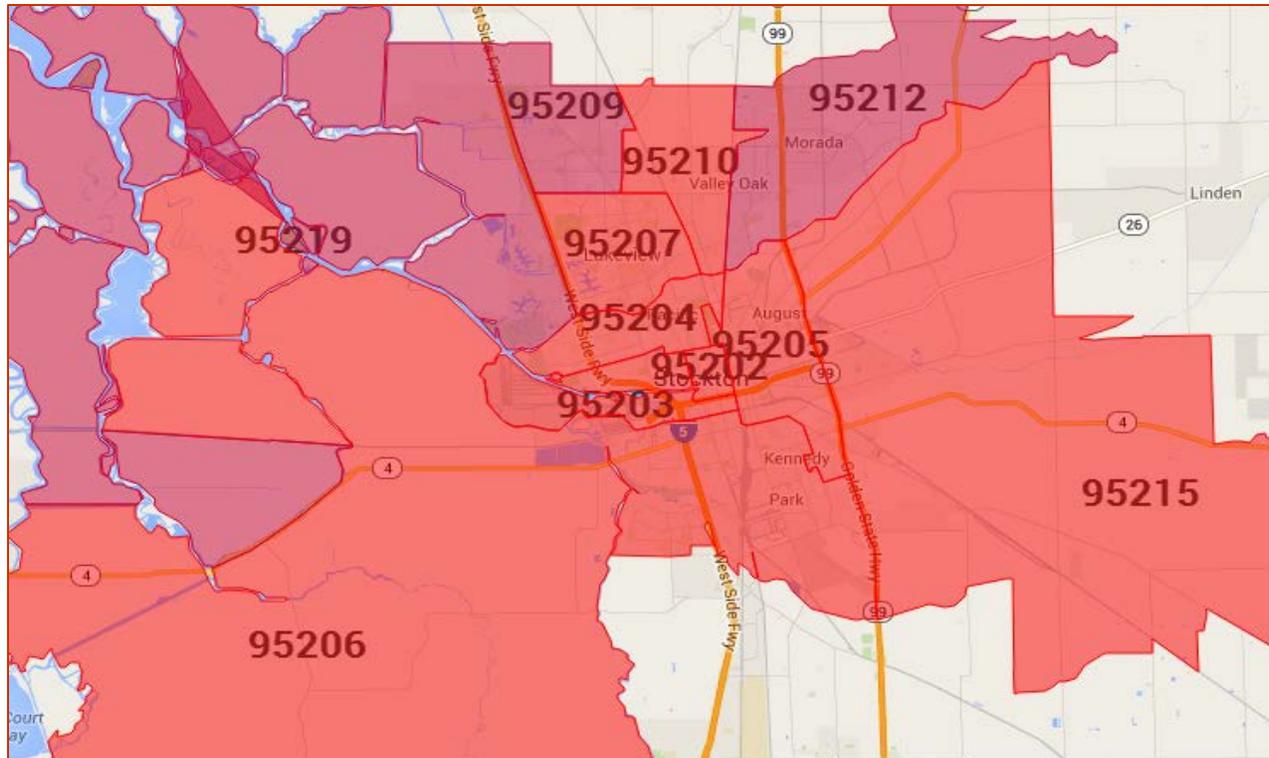
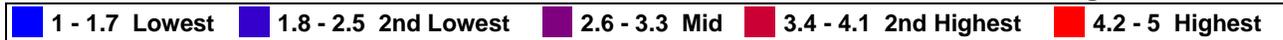
According to the California Health Interview Survey conducted by UCLA Center for Health Policy Research 15.7% of San Joaquin County residents are uninsured and 25.6% have Medi-Cal coverage.

The disproportionate health needs of the Stockton area are perhaps best reflected in the Community Needs Index score. The Community Needs Index (CNI), developed in 2005 by Dignity Health, accounts for the underlying economic and structural barriers that affect overall health. Using a combination of research, literature, and experiential evidence, Dignity Health identified five prominent barriers for health care access: income, culture/language, education, insurance, and housing. A score of 1.0 indicates a zip code with the lowest socio-economic barriers, while a score of 5.0 represents a zip code with the most socio-economic barriers. The median CNI score for the service area of St. Joseph’s Medical Center is 4.8.

ST. JOSEPH'S MEDICAL CENTER

Lowest Need

Highest Need



CNI MEDIAN SCORE: 4.8

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	Morada	San Joaquin	California
95215	4.6	22,558	Stockton	San Joaquin	California
95219	3.6	28,631	Stockton	San Joaquin	California

Over the years many not-for-profit organizations have developed to respond to the vast needs and serve the unique cultures of diverse communities. Partnership with these organizations is a key part of St. Joseph's strategic plan. Community based organizations are able to bridge cultural and linguistic gaps and have established trust and credibility with the communities they serve. Through partnership St. Joseph's is able to provide access to needed healthcare services and health education, along with professional expertise and support for agency capacity-building.

COMMUNITY BENEFIT PLANNING PROCESS

Community Health Needs Assessment Process

The Healthier Community Coalition is a strong coalition that jointly conducts the Community Health Needs Assessment every three years and then works together continuously to address the priority health needs identified in the assessment. The Coalition includes area hospitals, the county health department, and community partners. The community wide assessment process, which covers San Joaquin County, was most recently completed in 2011-13. The assessment process was initiated and co-chaired by St. Joseph's Medical Center, St. Joseph's Behavioral Health Center, Dameron Hospital, Sutter Tracy Community Hospital and Kaiser Permanente, all of whom provided equal financial and in-kind support. First 5 of San Joaquin, Community Medical Centers, Health Plan of San Joaquin, Lodi Memorial Hospital and San Joaquin County Public Health provided additional financial and in-kind support. Many community based organizations within the county also participated in the assessment process.

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, including a public health expert and a geographer as well as additional public health practitioners and consultants to collect and analyze data.

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 residents of San Joaquin County, expert interviews with 45 key informants, and focus group interviews with 137 community members. Members of the community representing different demographic groups were recruited to participate in the 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. Content analysis was performed on focus group interview notes and/or transcripts to identify key themes and salient health issues affecting community residents.

Further input was gathered at meetings of the Healthier Community Coalition and the annual Community Health Forum, held in November 2012. 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 visits, hospitalization, and mortality rates related to heart disease, diabetes, stroke, hypertension, chronic obstructive pulmonary disease, asthma, safety and mental health conditions. Socio-demographic data included race and ethnicity, poverty, vulnerable groups (female-headed households, families with children, people over 65 years of age), educational attainment, health insurance status, and housing arrangement. 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) – neighborhoods where residents are living with a high burden of disease in San Joaquin County. Age-adjusted rates of Emergency Department visits and hospitalizations for several chronic health conditions were analyzed. Visits due to heart disease, diabetes, stroke, and hypertension were consistently higher in the Communities of Concern compared to other zip codes in the health service area. These 10 communities had consistently high rates of negative health outcomes that frequently exceeded county, state,

and Healthy People 2020 benchmarks. Analysis of environmental indicators showed that many of the Communities of Concern had conditions that were barriers to active lifestyles, such as elevated crime rates and a traffic climate unfriendly to bicyclists and pedestrians. Access to healthy food outlets was often limited, while the concentration of fast food and convenience stores was high. The identification of the Communities of Concern was confirmed by experts as areas prone to experiencing poorer health outcomes relative to other communities in the county.

After identifying the areas of the county in greatest need for healthcare interventions, the next step was to identify specific needs to focus on. Priority health needs were determined through in depth analysis of qualitative and quantitative data, and then confirmed by socio-demographic data. A health need was defined as a poor health outcome and its associated driver. A health need was included as a priority if it was represented by rates exceeding established quantitative benchmarks or was consistently mentioned in the qualitative data. After examining key findings from all data sources, a consolidated list of priority health needs for the Communities of Concern in San Joaquin County emerged:

1. Lack of access to primary and preventative care service
2. Lack of or limited access to health education
3. Lack of or limited access to dental care
4. Limited cultural competence in health 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

Assets Assessment Process

In addition to identifying the needs, an assessment of the assets in the community was also completed. The first step involved compiling a list of existing resource directories. Next, additional assets identified through research were added to the master list. Detailed information for each asset was then gathered through a review of materials from the organizations and, when possible, direct contact with staff via phone. The assets are organized by zip code and detailed in the Community Health Needs Assessment.

In all, almost 300 distinct health assets were found to be located in the San Joaquin County Communities of Concern or in adjacent zip codes. These assets include community-based organizations delivering health related services such as counseling; education programs; primary care facilities, including FQHCs and free clinics; food pantries, and homeless shelters. The presence of these organizations presents San Joaquin County with a unique opportunity to enhance community health through increased collaboration and coordination of services.

Developing the Hospital's Implementation Plan

After completing the community-wide needs assessment, priority setting process and asset mapping, each partner of the Healthier Community Coalition developed its own action plan to address various needs that were identified. Together these plans address all of the priority health needs established through the Community Needs Assessment process. Building on the steps described above, a facilitator from Valley Vision led a core group from St. Joseph's through a strategic planning process to develop the hospital's implementation plan. This process considered numerous factors including high utilization of acute healthcare services, the vast numbers of people in the target population, the cultural diversity and health disparity in the service area, and the hospital's areas of expertise. The finding from the asset assessment also informed an understanding of needs that could best be addressed by supporting community partners who have expertise

in those areas. Guided by this analysis it was decided to focus on three of the priority health needs: access to primary and preventive care services, lack of or limited access to health education, and limited cultural competence in health care and related systems. The hospital 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 implementation of the Affordable Care Act (ACA), 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 St. Joseph'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 St. Joseph's in addressing priority health needs
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

Based on the Community Health Needs Assessment, all programs will prioritize services to vulnerable populations with disproportionate unmet health needs. This includes the Communities of Concern, low-income neighborhoods, Latinos, African Americans, and immigrant communities – especially Hmong and Cambodian.

These community benefit programs will not only lead to better health outcomes, but will also help to control healthcare costs by focusing on prevention. Providing preventive services will result in less reliance on acute care services as populations are able to stay healthy and receive timely assistance with healthcare needs.

While the hospital is focused on three of the priority health needs, it is also working to support community partners as they address the other four priority health needs.

- Lack of or limited access to dental care is being addressed by St. Mary's Dining Room, which operates a free dental clinic. St. Joseph's Medical Center Foundation provides funding annually to support the clinic. In addition St. Joseph's Community Health and Advocacy Committee initiated a Community Dental Task Force which has developed a community-wide action plan for additional services.
- Limited or no nutrition literacy/access to healthy foods, food insecurity is an area that St. Joseph's Medical Center is providing funding for through its Dignity Health Community Grants program. St. Joseph's is also a member of the Hunger Task Force.
- Although not an area of focus, St. Joseph's does provide substantial assistance to address the issue of limited transportation options. The Interfaith Caregivers program has numerous volunteers who provide direct transportation assistance to people who are unable to drive to medical and social service appointments, run errands or go shopping.

- Lack of safe and affordable places to be active is also an area where St. Joseph's provides funding for community partners to deliver services. Often programs developed by the community partners address both nutrition and physical activity.

Planning for the Uninsured/ Underinsured Patient Population

In addition to specific Community Health programs, St. Joseph's also provides direct medical care for the uninsured/ underinsured patient population. With the economic downturn greatly impacting the Central Valley region, this role has become even more critical in ensuring that underserved populations have access to needed healthcare services. 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 hospital's Patient Payment Assistance Program is posted in key areas of the hospital facility. (A copy of Dignity Health Patient Payment Assistance Policy can be found in Appendix C.) In FY 2014 the hospital spent over \$50 million in providing care for underserved individuals (unreimbursed costs of providing care to Medicaid and uninsured populations).

The Annual Community Benefit Report and Implementation Plan is posted on St. Joseph's Medical Center website www.stjosephscares.org and at www.dignityhealth.org under Who We Are/Community Health. The 2013 Community Health Needs Assessment executive summary and full report is available on both these websites as well as on a public website that is owned collectively by the Collaborative, www.healthiersanjoaquin.org.

PLAN REPORT AND UPDATE

INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAME

Summary of Key Findings and Initiatives – Fiscal Year 2014

The focus of Community Benefit during Fiscal Year 2014 has been on aligning community benefit with the changing healthcare landscape. Programs were developed in response to the current Community Health Needs Assessment and are guided by the following five core principles:

Disproportionate Unmet Health-Related Needs

Seek to accommodate the needs of communities with disproportionate unmet health-related needs.

Primary Prevention

Address the underlying causes of persistent health problem.

Seamless Continuum of Care

Emphasize evidence-based approaches by establishing operational linkage between clinical services and community health improvement activities.

Build Community Capacity

Target charitable resources to mobilize and build the capacity of existing community assets.

Collaborative Governance

Engage diverse community stakeholders in the selection, design, implementation, and evaluation of program activities.

Below are the major initiatives and key community based programs operated or substantially supported by St. Joseph's Medical Center in 2014. Programs intended to be operating in 2015 are noted by *. New initiatives for 2015 are also included, and identified as such.

Access to Health Care

Rationale: The high Community Needs Index scores in the hospital's service area 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
 - Community Center for the Blind: providing people who are blind skills needed to function independently
 - Mary Graham Children's Foundation: providing funds to cover medical expenses for emancipated San Joaquin County Youth
 - National Alliance on Mental Illness (NAMI) – local chapter: community outreach educational presentations that address mental illness
 - San Joaquin County Office of Education: school based mental health services program
 - Service First: program to reduce pain levels through aquatic wellness services

- Stockton Shelter for the Homeless: health and development screenings for homeless children 0-5
- YMCA: Health Living Initiative, helping families access healthcare and tools for healthy living
- Dobbins Program for Breast Health Services: breast cancer screening services for women under 40 years old*
- St. Mary's Dining Room "Virgil Gianelli" & St. Raphael's Dental Clinic: providing free medical and dental services to the homeless*
- 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*
- Health Access Coordinator: assisting patients in accessing healthcare coverage and linking them with a primary care provider for ongoing care

New Initiative

- Homecoming Project: providing transitional care services to seniors

Community Health Education

Rationale: San Joaquin County ranks very low on health outcomes for chronic disease and the rate of many chronic diseases is increasing.

- Diabetes Education Program: classes in multiple languages in the community*
- Asthma Management Strategies Class*
- COLD Club of San Joaquin County, Pulmonary Rehabilitation*
- Dignity Health Community Grants Program*
 - National Alliance on Mental Illness (NAMI) – local chapter: community outreach educational presentations that address mental illness
 - YMCA: Health Living Initiative, helping families access healthcare and tools for healthy living
- STROKE Club*

New Initiative

- Chronic Disease Self Management Program: currently offering workshops in English and Spanish; will expand to include Hmong and Cambodian

Culturally Competent Care

Rationale: There are disproportionate unmet health needs in immigrant communities. Developing the education in multiple languages will empower class attendees to better manage their chronic health conditions.

- Hmong Diabetes Education Program, diabetes class presented in Hmong*

New Initiatives

- Chronic Disease Self Management Program: currently offering workshops in English and Spanish; will expand to include Hmong and Cambodian
- Training for healthcare providers regarding cultural understanding for special populations in the service area

These programs are continuously monitored for performance and quality with ongoing improvements to facilitate their success. The Community Health & Advocacy Committee, Executive Leadership, the Community Board and Dignity Health receive updates on program performance and news. The following pages include Program Digests for key programs that address one or more of the initiatives listed above.

PROGRAM DIGEST REPORTS

Diabetes Program/ Community Health Education

Hospital Community Benefit Priority Areas	<ul style="list-style-type: none">✓ Health education✓ Cultural competence in health and related systems
Program Emphasis	<ul style="list-style-type: none">✓ Disproportionate Unmet Health-Related Needs✓ Primary prevention
Link to Community Needs Assessment	There is a great disparity of health outcomes for chronic disease in low-income neighborhoods and among certain ethnic groups. The Community Health Education Program focuses on reducing the morbidity and mortality from chronic disease in these populations.
Program Description	Health education workshops, presentations and classes are provided for free throughout the area in languages of the target population. The diabetes education program is a six part educational series taught by a team including an RN, Certified Diabetic Educator and bilingual health educators. The Chronic Disease Self Management Program (CDSMP) is an evidence-based model developed at Stanford University. It is a six part workshop led by trained lay leaders from the community. In addition single presentations are provided to many groups as part of early intervention and prevention strategies.

Fiscal Year 2014

Goal FY 2014	The goal of this program for FY 2014 was to outreach and connect with community members and offer culturally competent education to improve health knowledge and increase healthy behaviors.
2014 Objective Measure/Indicator of Success	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.
Baseline	San Joaquin County is a federally designated Medically Underserved area (MUA) with Stockton being home to almost half of the county's residents. The CHNA revealed 10 specific Communities of Concern living with a high burden of disease. These 10 communities had consistently high rates of negative health outcomes that frequently exceeded county, state, and Healthy People 2020 benchmarks.
Implementation Strategy for Achieving Goal	<p>St. Joseph's Community Health department dedicated additional staff to this program, one fluent in Spanish and one fluent in Hmong, Laotian and Thai. Materials for the Diabetes Education classes were translated into Hmong and the staff member and a community volunteer were trained.</p> <p>To initiate the Chronic Disease Self Management Program (CDSMP), Dignity Health trained five staff members and seven community volunteers in Stockton to become workshop leaders, and several received additional training as Master Trainers.</p>
Result FY 2014	21 class series were held with 744 community members; and a total of 1,223 community members received diabetes education. Diabetic patients who completed the class series were followed-up three months after completion of the class. 97% of these patients had no emergency department visits or

hospitalizations since completing the class. The majority of class participants indicated an increase in physical activity level and/or an improvement in nutritional practices.

**Hospital's Contribution/
Program Expense**

\$461,989 in Community Benefit (\$468,119 total program expense)

Fiscal Year 2015

Goal 2015

Health education programs will be expanded to offer services in more languages in order to reach populations with great health disparities.

**2015 Objective
Measure/Indicator of
Success**

The Diabetes Education class series will be initiated in the Cambodian language. The CDSMP program will be implemented in Hmong and Cambodian. Both the Diabetes Education class series and the CDSMP program will continue to be provided in both English and Spanish on an ongoing basis.

Baseline

The Hmong diabetes class has made a significant impact on program participants. There is a great demand for more of these classes as participants learn to manage their chronic disease and are empowered to take care of their health.

**Intervention Strategy for
Achieving Goal**

Cambodian-speaking instructors will be recruited and the Certified Diabetes Educator will provide them with training. The CDSMP curriculum will be translated into Hmong. The Master Trainers will provide a training course for bilingual community members to become workshop leaders.

**Community Benefit
Category**

A1a

CareVan Mobile Medical Services Program/ Health Access

Hospital Community Benefit Priority Areas	✓ Primary and preventive health care services
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary prevention ✓ Continuum of care ✓ Collaboration
Link to Community Needs Assessment	With a high rate of uninsured individuals and a shortage of healthcare providers, San Joaquin County has historically had a problem with health access.
Program Description	The CareVan is a mobile medical clinic offering free health services to the uninsured and underserved. Services include health screening, education and referral services, medical diagnosis and treatment. The CareVan offers clinics 3-4 times per week in various high need areas.

Fiscal Year 2014

Goal FY 2014	The goal of this program for FY 2014 was to 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	In 2011-12 the California Health Interview Survey conducted by the UCLA Center for Health Policy Research found that 15.7% of area residents were uninsured and 25.6% had Medi-Cal coverage.
Implementation Strategy for Achieving Goal	<p>All clinics will have Blood Sugar and Blood Pressure screening available.</p> <p>Expand hours to include afternoon clinics.</p> <p>Expand locations to include migrant worker camp areas.</p> <p>Explore opportunities to offer specialty care.</p> <p>Include patient navigator on the CareVan to connect patients to community services and eligibility resources.</p> <p>Evaluate sites quarterly for efficacy.</p> <p>Connect people with community resources through the Affordable Care Act.</p>
Result FY 2014	4,508 patients served at 192 clinics.
Hospital's Contribution / Program Expense	\$654,272 in Community Benefit (\$691,627 total program expense)

Fiscal Year 2015

Goal 2015	<p>Partner with a Catholic Charities to provide patients assistance with the healthcare coverage application process. Link patients with a medical home for ongoing care with their assigned Primary Care Provider.</p> <p>Outreach to the remaining uninsured population who are not eligible for free or subsidized coverage options. Engage them in healthcare services.</p>
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	As more people become enrolled with healthcare coverage and are established with a medical home, provide flexible scheduling of clinics to respond to the changing needs of the community.
2015 Objective Measure/Indicator of Success	75% of patients provided with health navigation services. 75% of patients indicate that they are uninsured and do not qualify for subsidized or free coverage. Clinics provide services to an average of 25 patients per clinic day.
Baseline	The Health Access Coordinator began providing services on the CareVan in April 2014. 26% of patients indicated that they were uninsured and ineligible for the subsidized or free plans. Clinic volume decreased from 577 patients per month in January 2014 to 310 patients per month in June 2014. This led to a decrease in the average daily patient volume to 18 patients per clinic day in June 2014.
Intervention Strategy for Achieving Goal	Partner with Catholic Charities to continue funding the Health Access Coordinator. Conduct outreach at health fairs, flea markets, churches, and other locations where the remaining uninsured can be reached. Operate flexible scheduling of the clinic hours to ensure a minimum mean of 25 patients per clinic day.
Community Benefit Category	A2a

Dignity Health Community Grants Program

Hospital Community Benefit Priority Areas	<ul style="list-style-type: none"> ✓ Lack of Access to primary and preventive care services ✓ Lack of or limited access to health education ✓ Lack of or limited access to dental care ✓ Limited cultural competence in health and related systems ✓ Limited nutrition literacy/access to healthy and nutritious foods; food security ✓ Limited transportation options ✓ Lack of safe and affordable places to be active
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary prevention ✓ Continuum of care ✓ Building community capacity ✓ Collaboration
Link to Community Needs Assessment	Responding to the needs of the Communities of Concern and leveraging the expertise of community partners, as identified in the assets assessment of the Community Health Needs Assessment.
Program Description	Providing funding to support community based organizations who will provide services to underserved populations to improve the quality of life. The objective of the Community Grants Program is to award grants to organizations whose proposals respond to the priorities identified in the most recent Community Health Needs Assessment (CHNA) and are located in one of the 10 specific Communities of Concern (identified by zip code).

Fiscal Year 2014

Goal FY 2014	To build community capacity by identifying community organizations and funding programs that are in alignment with the needs identified in the most recent CHNA.
2014 Objective Measure/Indicator of Success	Funding will be awarded to organizations whose programs respond to a need identified in the most recent CHNA and align with at least one of the five core principles (listed in the Program Emphasis above). Grantees will report on these accomplishments twice during the grant period.
Baseline	San Joaquin County is a federally designated Medically Underserved area (MUA) with Stockton being home to almost half of the county's residents. The CHNA revealed 10 specific Communities of Concern living with a high burden of disease. These 10 communities had consistently high rates of negative health outcomes that frequently exceeded county, state, and Healthy People 2020 benchmarks.
Implementation Strategy for Achieving Goal	Once Letters of Intent have been reviewed, select organizations are invited to submit full proposals. Full proposals are reviewed by the Local Review Committee (LRC) and determination is made as to which ones should be recommended for funding.
Result FY 2014	<p>Twelve Community Grants were given, totaling \$310,207. Organizations receiving grants were:</p> <ul style="list-style-type: none"> • Community Center for the Blind, \$10,000 • Delta Healthcare, \$33,207

- Family Resource and Referral Center, \$20,000
- Mary Graham Children's Foundation, \$3,000
- NAMI, \$8,000
- Mercy Housing of California, \$20,000
- Puentes-America, \$48,000
- San Joaquin Office of Education, \$52,000
- Service First, \$15,000
- Stockton Shelter for the Homeless, \$12,000
- University of the Pacific, \$24,000
- Y.M.C.A., \$65,000

Grantees' interim reports reflect that referrals have increased significantly due to outreach and marketing efforts. Other successful activities were reported with cooking demonstrations, nutrition education and food access.

Hospital's Contribution / Program Expense \$310,207

Fiscal Year 2015

Goal 2015	Provide funding for programs that align with strategies developed by the Community Health & Advocacy Committee and the community-wide efforts of the Healthier Community Coalition.
2015 Objective Measure/Indicator of Success	Partnership grants in the following areas: <ul style="list-style-type: none"> • Dental program in schools and after school programs • Community Health Worker program • Mental health
Baseline	<p>In response to the identified priority health need of lack of access to dental care, the Community Dental Task Force was formed. First year priorities include creating a dental program in schools and after school programs.</p> <p>To respond to the priority health needs in the Communities of Concern, the Healthier Community Coalition developed plans for a Community Health Worker program.</p> <p>The Community Health & Advocacy Committee identified mental health as an ongoing need in the service area, especially in relation to its intersection with violence and substance use.</p>
Intervention Strategy for Achieving Goal	Prioritize grant applications that address the three target areas.
Community Benefit Category	E2a

St. Joseph's Interfaith Caregivers/ Community Senior Services

Hospital Community Benefit Priority Areas	<ul style="list-style-type: none">✓ Lack of access to primary and preventive care services✓ Lack of or limited access to health education✓ Limited transportation options
Program Emphasis	<ul style="list-style-type: none">✓ Disproportionate unmet health needs✓ Primary prevention✓ Continuum of care✓ Building community capacity✓ Collaboration
Link to Community Needs Assessment	The Community Health Needs Assessment revealed that there is a great need among seniors living in the hospital service area. Seven of the Communities of Concern had a higher percent of residents over the age of 65 living in poverty compared to the national benchmark. The rates for residents over age 65 living in one of the zip code areas near the hospital was three times the national average.
Program Description	St. Joseph's Interfaith Caregivers program provides free services to seniors living at home. Services include transportation, friendly visiting, respite care, yard clean up, home safety assessments and referrals which are provided by trained volunteers. This program recently expanded to include the Homecoming Project, which provides assistance to patients after hospital discharge. A social worker visits the home to assist with arranging for follow-up medical visits and medication as well as linking seniors with other assistance and social services.

Fiscal Year 2014

Goal FY 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 St. Joseph's Interfaith Caregivers Program through the following: <ol style="list-style-type: none">1. Develop additional volunteer training2. Evaluate care-receivers prior to and during care for appropriateness3. Continue outreach to provide services to the elderly population4. Provide transportation to care-receivers as appropriate to support independent living
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 not 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.
Implementation Strategy	Develop additional volunteer trainings; evaluate care receivers for needs prior to

for Achieving Goal	and during care for appropriateness; continue outreach to provide services to the elderly population requiring assistance; provide transportation to care-receivers as appropriate to support independent living.
Result FY 2014	Provided two annual update education sessions with 90% participation. Oriented and trained 21 new volunteers. Implemented the Homecoming Project and provided services for 32 Homecoming Project patients.
Hospital's Contribution / Program Expense	\$110,089 in Community Benefit (\$121,045 total program expense)

Fiscal Year 2015

Goal 2015	Expand the Homecoming Project to provide services for 80 patients, and provide on-going assistance through the Interfaith Caregivers program.
2015 Objective Measure/Indicator of Success	100 seniors to receive assistance through St. Joseph's Community Senior Services.
Baseline	67 care receivers in the Interfaith Caregivers Program with 1,182 encounters 32 patients in the Homecoming Project
Intervention Strategy for Achieving Goal	Provide funding to the partner agency, Catholic Charities, to conduct home visits and provide Homecoming Project services.
Community Benefit Category	E3d

COMMUNITY BENEFIT AND ECONOMIC VALUE

(which includes Non-Community Benefit – Medicare)

	Total Persons	Offsetting Expense	Revenue	Net Benefit	% of Expenses	Organization Revenues
Financial Assistance	3,389	3,814,314	0	3,814,314	1.0	1.1
Medicaid	61,731	120,579,555	71,034,923	49,544,632	13.1	13.7
Means-Tested Programs	30	132,698	29,974	102,724	0.0	0.0
Community Services						
Community Benefit Operations	0	546,840	0	546,840	0.1	0.2
Community Health Improvement Services	6,412	1,086,379	53,509	1,032,870	0.3	0.3
Financial and In-Kind Contributions	76	760,857	77,402	683,455	0.2	0.2
Subsidized Health Services	147	100,911	41,028	59,883	0.0	0.0
Totals for Community Services	6,635	2,494,987	171,939	2,323,048	0.6	0.6
Totals for Living In Poverty	71,785	127,021,554	71,236,836	55,784,718	14.8	15.4
<u>Benefits for Broader Community</u>						
Community Services						
Community Building Activities	395	1,465,752	20,000	1,445,752	0.4	0.4
Community Health Improvement Services	10,402	780,015	19,219	760,796	0.2	0.2
Financial and In-Kind Contributions	1,262	291,047	10,956	280,091	0.1	0.1
Health Professions Education	3,852	2,635,581	75,545	2,560,036	0.7	0.7
Research	215	164,564	15,222	149,342	0.0	0.0
Totals for Community Services	16,126	5,336,959	140,942	5,196,017	1.4	1.4
Totals for Broader Community	16,126	5,336,959	140,942	5,196,017	1.4	1.4
Totals - Community Benefit	87,911	132,358,513	71,377,778	60,980,735	16.2	16.9
Medicare	29,959	128,681,455	113,460,996	15,220,459	4.0	4.2
Totals Including Medicare	117,870	261,039,968	184,838,774	76,201,194	20.2	21.1

The uncompensated costs of providing services through financial assistance/charity care, Medicaid, Medicare and other means-tested programs are calculated utilizing a clinical cost accounting system.

Telling the Story

St. Joseph's Medical Center is the largest hospital and largest private employer in San Joaquin County. As such, the influence and benefit felt by residents extends not only to areas of highest need, but to the community in general. One goal has been to inform both staff and community partners of the programs available in the community so they can be a resource to their families, friends, clients, patients and neighborhoods.

SJMC has dedicated leadership and a Community Health Department 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 maximizing existing 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 committee it is sent to the hospital's 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 at www.dignityhealth.org under Who We Are/Community Health. The 2013 Community Health Needs Assessment executive summary and full report are available on both these websites as well as on a public website that is owned collectively by the Collaborative, www.healthiersanjoaquin.org.

The Community Benefit work of St. Joseph's Medical Center touches the lives of so many people. Hospitalized patients receive the highest quality care, and St. Joseph's continues to serve the uninsured and underinsured every day. The community health programs reach out into the neighborhoods where people live and provide them with the resources they need to have healthy lives. St. Joseph's also supports community partners who are bringing services to the most unreached parts of the service area. The impact that St. Joseph's makes can be measured in the large amount of money invested, the high number of people who participate in the programs, and in the positive health outcomes. It can also be shared through the experience of those who benefit the most. The following are a few examples.

"I just wanted to say when I first visited the CareVan I didn't know what to expect; but once I started explaining my situation to the provider and her staff they understood exactly what I was talking about and took care of my situation right away. I haven't been to doctor in a while. I really appreciate the empathy, patience and professionalism they demonstrated towards me as a patient." – *CareVan patient*

A 70 year old man with a history of Type 2 Diabetes has been able to achieve a hemoglobin A1C level of 6.5 and credits much of his success to the Diabetes Education program that St. Joseph's provides. He encourages other to become part of the program and says, "People can tell you what to do, but once you go and learn for yourself what it's doing to your body, then you can change." – *Diabetes class student*

"My chronic problems have been a part of my life for 30 years, and just this year they've begun to overwhelm me. Your program may be a life-saver for me as it has been for others." – *Participant in the Chronic Disease Self Management Program*

St. Joseph's Medical Center is proud to be a part of making San Joaquin County a healthier community.

Appendix A

ST. JOSEPH'S COMMUNITY BOARD

Michael Coughlan*	San Joaquin Superior Court Judge; former civil litigation attorney
Rudy Croce	Certified Public Accountant
Michael Herrera, D.O.	Chief of Staff, Emergency Medicine
Sister Raya Hanlon, O.P.	Member, Dominican Sisters of San Rafael
Kathleen Lagorio Janssen	CEO, Lagorio Family of Companies
Lisa Blanco Jimenez	Attorney, Neumiller & Beardslee
Ann Johnston	Owner, The Balloonery; former Mayor of Stockton
Sister Judy Lu McDonnell, OP	Member, Dominican Sisters of San Rafael
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
Linda Sakimura, M.D.	Pediatrician
Constance Fitzpatrick Smith	RN, Nurse Anesthetist; Educator
Thomas Sousa	President, IC Ink, Inc. and Legends Apparel
Donald J. Wiley	President & CEO, St. Joseph's Medical Center

* Board Chair

** Board Vice Chair

Appendix B

Community Health & Advocacy Committee

Kwabena Adubofour, M.D.	Family Practice
Barbara Alberson	Sr. Deputy Director, Policy & Planning San Joaquin County Public Health Services
Tom Amato	Director, PACT
Robin Asghar	Director, Community Partnership for Families of San Joaquin County
Occeletta Briggs	Community Member
Sister Terry Davis, SND de Namur	Catholic Diocese of Stockton
Edward Figueroa	Co-Director St. Mary's Dining Room
Mick Founts	Deputy Superintendent San Joaquin County office Of Education
Rich Good	Director, YMCA of San Joaquin
Sandy Haskins	Interim CEO, Community Medical Centers
Ann Johnston	Community Board Member
Robert Kavanaugh	Community Member
John Kendle	Director Support Services St. Joseph's Medical Center
Sister Abby Newton, OP	Vice President Mission Services St. Joseph's Medical Center
Elvira Ramirez	Director, Catholic Charities
Annette Sanchez	El Concilio
Don Sims	C.D. Program Manager St. Joseph's Behavioral Health Center
Constance Smith	Community Board Member & Chair, Community Health & Advocacy Committee
Petra Stanton	Manager, Community Health St. Joseph's Medical Center
Harvey Williams	University of the Pacific

Appendix C

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.