Dignity Health.
St. Joseph's Medical Center

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Community Benefit 2018 Report and 2019 Plan

Dignity Health
St. Joseph's Medical Center

A message from

Donald J. Wiley, president and CEO of St. Joseph's Medical Center, and Karl Si1berstein, Chair of the Port City Operating Company, LLC Board of Managers.

Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our multi-pronged initiatives to improve community health include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital and with community partners, and investing in efforts that address social determinants of health.

St. Joseph's Medical Center shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The Community Benefit 2018 Report and 2019 Plan describes much of this work. This report meets requirements in California state law (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health produces these reports and plans for all of its hospitals, including those in Arizona and Nevada. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2018 (FY18), St. Joseph's Medical Center provided $15,844,265 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. The hospital also incurred $23,685,120 in unreimbursed costs of caring for patients covered by Medicare.

Port City Operating Company, LLC Board of Managers reviewed, approved and adopted the Community Benefit 2018 Report and 2019 Plan at its October 25, 2018 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at (209) 467-6534.

Donald J. Wiley
President/CEO

Karl Silberstein
Chair, Port City Operating Company,
LLC Board of Managers

TABLE OF CONTENTS

At-a-Glance Summary

Community Served	Although San Joaquin County, and the City of Stockton, have many advantages such as an international deep water port, major interstate highways, farm fresh food and the Delta recreation and waterways, the residents of the county and city struggle with health issues such as poor oral health, obesity and mental illness, as well as the underlying social determinants of health such as poverty, violence, lack of affordable housing, low graduation rates and food insecurity. The county ranks as 46 out of 57 counties in California on overall health outcomes in the Robert Wood Johnson Foundation County Health Rankings report.
Economic Value of Community Benefit	$15,844,265 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits. $23,685,120 in unreimbursed costs of caring for patients covered by Medicare.
Significant Community Health Needs Being Addressed	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Those needs are: • Obesity/Diabetes • Violence and Injury • Substance Use • Access to Housing • Access to Care • Mental Health • Oral Health
FY18 Actions to Address Needs	• Diabetes Navigator – Linking patients and community members to resources that will help them manage the disease • Diabetes Empowerment Education Program (DEEP) – Information on self-care for those with pre-diabetes or diabetes and their family members. • Healthier Living: Chronic Disease Self-Management Program (CDSMP) – six week program to help people manage and cope with ongoing health issues and chronic diseases • One on One diabetes education with a Certified Diabetes Educator • Human Trafficking – Community awareness and education • Patient Navigator; ER Navigator Program – Linking hospital patients to a medical home • Reinvent South Stockton – Partnering with Public Health, other hospital systems and clinics, as well as community based organizations and residents to reduce violence and improve health in South Stockton • Friends of Seniors – Matching volunteers to seniors for friendly visiting and transportation assistance. • Homecoming Program – a hospital to home service that bridges the gap between a hospital discharge and a strong recovery • Smart Moves – Childhood obesity intervention • Eat Fit – Educational program for middle school adolescents to improve dietary choices and increase healthy behaviors

	• Compassionate Care Coalition – Coordination of a county-wide coalition focused on increasing the number of community members that complete Advance Care Directives • CareVan - mobile medical clinic offering free health services including health screenings, education, referral services, medical diagnoses and treatment. • Faith Nursing Program – support of faith based community health improvement efforts • Plan, Shop, Save, Cook – Educational series to increase access and affordability of healthy foods for low income families. • Community Events – engagement in community based health events at various partnering locations (i.e. senior or community centers, schools, etc.) • Multisector Countywide Collaboration – Community health staff participates in various collaborative groups to address specific health needs (i.e. Whole Person Care, Opioid Safety, Mental Health Consortium, Obesity and Chronic Disease Taskforce, etc.) • Community Benefit Investments – Strategic program and innovation funding to address community needs.
Planned Actions for FY19	For FY 18-19, the hospital plans to continue most of the existing programs with the following changes: • Smart Moves – The University of the Pacific We-Fit Club will take the lead role in facilitating the program, with limited technical assistance and education from the Community Health staff. • CareVan services were retired in August 2017. • Faith Community Health Partnership – In an effort to improve on the established Faith Nursing Program model, a new partnership with Public Health Advocates will create opportunities to support and strengthen existing population health initiatives in places of worship. • Community Events – With the Graduate Medical Education (GME) program established in 2018, Community Health will partner with resident students to deliver community based services in high disparity neighborhoods, in addition to the continuing other outreach and engagement events. • Patient Navigators – This program began with patient navigation in the emergency department exclusively, and has since expanded to assist all patients in need of a follow up appointment with a primary care provider post hospital visit. New efforts: • Taking Off Pounds Sensibly (TOPS) – In collaboration with Health Plan of San Joaquin, a Medi-Cal managed care contractor, a pilot TOPS weight-loss support program will be implemented. • Youth Development – Exploration into best practice programs that can be implemented for youth development and adolescent behavioral health skills to reduce anxiety, depression and to improve coping skills. • Sweet Journey 101- Due to low enrollment and retention in 6 week class sessions, this 2 hour workshop is designed to offer the diabetes basics and encouragement to pursue additional health education.

	• Sugar Fix Support Group – A monthly diabetes support group to provide ongoing education and encouragement for improved health outcomes of those with diabetes.

This report and plan is publicly available at http://dignityhealth.org/stjosephs-stockton/. It will be distributed to hospital leadership, members of the hospital's Community Transitional Council, community grants review committee, and to the Healthier Community Coalition, a group of leaders from local hospital systems, public health, and nonprofit organizations.

The 2013 and 2016 Community Health Needs Assessment executive summaries and full reports are available on this website as well as on a public website that is owned collectively by the local collaborative that conducts the Community Health Needs Assessment, www.healthiersanjoaquin.org. Executive summaries of the Community Health Needs Assessment will be published and distributed broadly to community groups and at public events.

Written comments on this report can be submitted to the St. Joseph's Medical Center Community Health Department, 1800 North California Street, Stockton, CA 95204 or by e-mail to Tammy.Shaff@dignityhealth.org.

MISSION, VISION AND VALUES

St. Joseph's Medical Center is a part of Dignity Health, a non-profit health care system made up of more than 60,000 caregivers and staff who deliver excellent care to diverse communities in 21 states. Headquartered in San Francisco, Dignity Health is the fifth largest health system in the nation.

At Dignity Health, we unleash the healing power of humanity through the work we do every day, in hospitals, in other care sites and the community.

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 healthcare 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.

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

Excellence - Exceeding expectations through teamwork and innovation.

OUR HOSPITAL AND THE COMMUNITY SERVED

About St. Joseph's Medical Center

St. Joseph's Medical Center is nationally recognized as a quality leader and consistently chosen as the "most preferred hospital" by local consumers. With 355 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 2,600 employees, St. Joseph's is also the largest private employer in Stockton. St. Joseph's Medical Center celebrates a history of 119 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.

Description of the Community Served

Located near the heart of downtown Stockton, St. Joseph's Medical Center primarily serves residents of Stockton along with members of neighboring communities within San Joaquin County. The overall service area is comprised of 24 ZIP Codes and in CY 2016, 90% of inpatient discharges originated from those zip codes. Approximately 50% of the Hospital's discharges originated from the top five ZIP Codes, and 83% from the top 11 ZIP codes, all of which are in the City of Stockton. In 2016, the Hospital's market share in the service area was 34%. The population of San Joaquin County is approximately 726,000, while the City of Stockton is home to roughly 307,000 residents.

St. Joseph's Medical Center lies in the midst of one of the most successful agricultural areas of the world, and at the same time is home to one of the largest cities in America to file for bankruptcy. The county is celebrated for its diverse communities of Latinos and African Americans as well as Asian immigrants; but there is also a big gap in health outcomes between ethnic groups. Some parts of the county have robust commuter neighborhoods with linkage to jobs in nearby counties, while other areas struggle with some of the highest homicide rates in the nation. There are some unique challenges such as access to care for the large undocumented immigrant population, the great need for substance use disorder treatment, and the high rates of asthma in the Central Valley.

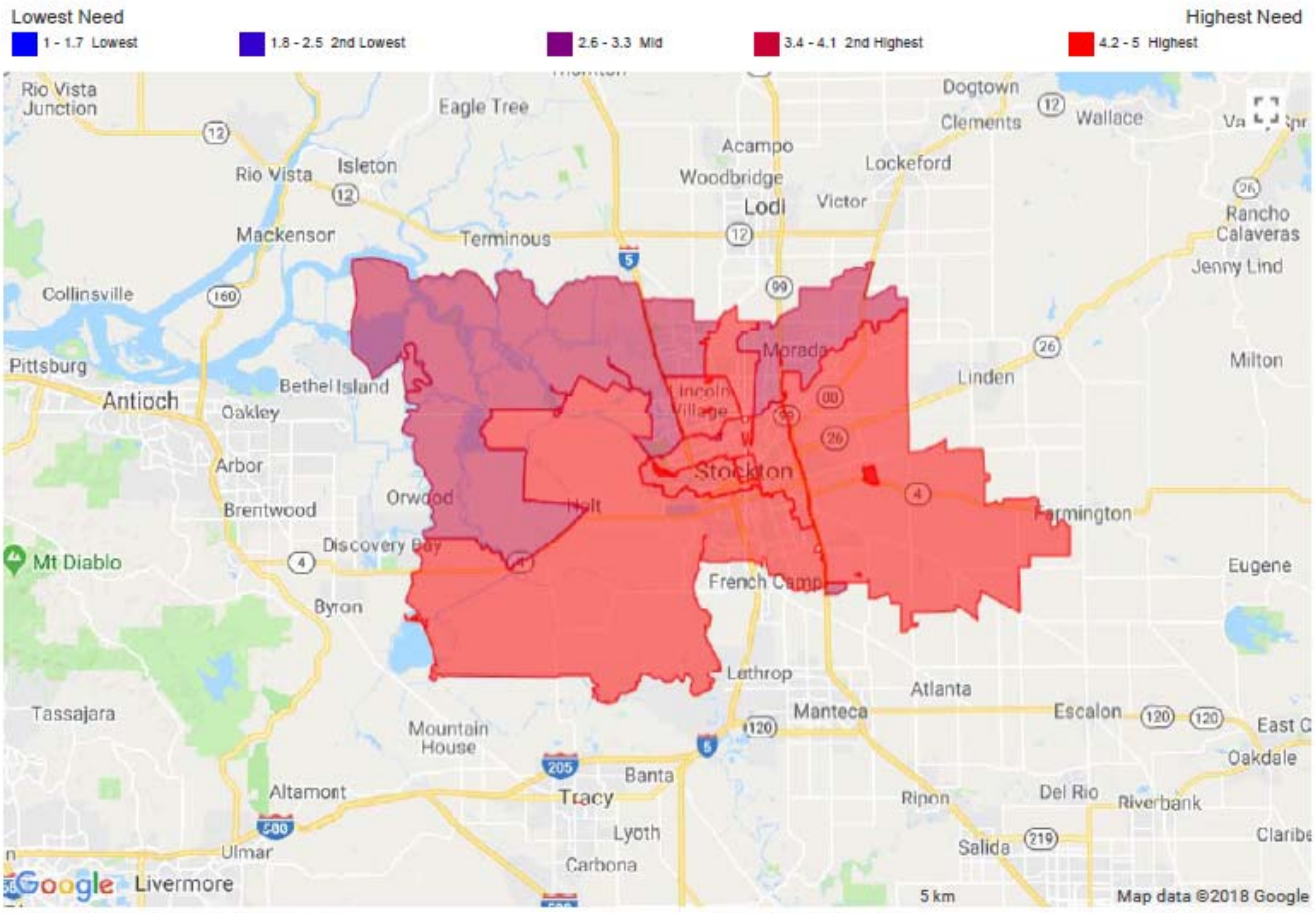
San Joaquin County also struggles with nationwide health issues such as rising obesity, poor oral health, and high rates of mental illness; but these issues are compounded by underlying social determinants of health including education, economic security and affordable housing. It is a county of contrasts, holding in one hand enormous challenges and in the other hand exciting new opportunities. On average, San Joaquin residents rate their health as poorer than the state overall, and there are notable disparities in health status between the county and the state.

Some key statistics for the area are in the table below.

St. Joseph's Medical Center's Service Area Demographics	SJMC Service Area	California
Total Population	382,593	39,695,753
Race		
White - Non-Hispanic	22.5%	36.7%
Black/African American - Non-Hispanic	9.4%	5.5%
Hispanic or Latino	45.7%	39.4%
Asian/Pacific Islander	18.2%	14.8%
All Others	4.1%	3.6%
Total Hispanic & Race	99.9%	100.0%
Median Income	$50,840	$77,277
Unemployment	7.6%	5.0%
No High School Diploma	26.2%	17.9%
Medicaid *	41.8%	27.8%
Uninsured	11.7%	7.4%
* Does not include individual's dually-eligible for Medicaid and Medicare.		
Source: © 2018 IBM Watson Health		

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and Truven Health Analytics. The CNI analyzes data at the zip code level on five factors known to contribute or be barriers to health care access: income, culture/language, education, housing status, and insurance coverage. Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores. The primary service area for St. Joseph's Medical Center has an average CNI score of 4.4, falling into the highest range of health needs.

Dignity Health.



Mean(zipcode): 4.4 / Mean(person): 4.4 CNI Score Median: 4.6 CNI Score Mode: 5

Zip Code	CNI Score	Population	City	County	State
95202	5	6671	Stockton	San Joaquin	California
95203	5	16527	Stockton	San Joaquin	California
95204	4.4	28860	Stockton	San Joaquin	California
95205	5	39764	Stockton	San Joaquin	California
95206	5	70243	Stockton	San Joaquin	California
95207	4.8	49601	Stockton	San Joaquin	California
95209	3.4	43017	Stockton	San Joaquin	California
95210	4.8	41807	Stockton	San Joaquin	California
95211	4	1528	Stockton	San Joaquin	California
95212	3.6	29221	Stockton	San Joaquin	California
95215	4.4	24239	Stockton	San Joaquin	California
95219	3.4	31115	Stockton	San Joaquin	California

TRUVEN HEALTH ANALYTICS

COMMUNITY ASSESSMENT AND PLANNING PROCESS

The hospital engages in multiple activities to conduct its community benefit and community health improvement planning process. These include, but are not limited to: conducting a Community Health Needs Assessment with community input at least every three years; using five core principles to guide planning and program decisions; measuring and tracking program indicators and impact; and engaging the Port City Operating Company, LLC Board of Managers and other stakeholders in the development of an annual community benefit plan and triennial Implementation Strategy.

Community Health Needs Assessment

The significant needs that form the basis of the hospital's community health programs were identified in the most recent Community Health Needs Assessment (CHNA), which was adopted in May 2016.

The hospital conducts a CHNA at least every three years to inform its community heath strategy and program planning. The CHNA report contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods, including: the data used; how the hospital solicited and took into account input from a public health department, members or representatives of medically underserved, low-income and minority populations; and the process and criteria used in identifying significant health needs and prioritizing them;
- Presentation of data, information and assessment findings, including a prioritized list of identified significant community health needs;
- Community resources (e.g., organizations, facilities and programs) potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

CHNA Significant Health Needs

The community health needs assessment identified the following significant community health needs:

Obesity and Diabetes: Diabetes is of particular concern as San Joaquin County has one of the highest rates in California for diabetes mortality.

Education: People with limited education tend to have much higher rates of disease and disability, whereas people with more education are likely to live longer, practice healthy behaviors, and experience better health outcomes for themselves and their children.

Youth Growth and Development: Primary and secondary data indicate that youth development tends to be undermined by trauma and violence, unhealthy family functioning, exposure to negative institutional environments and practices, and insufficient access to positive youth activities.

Economic Security: Concerns surrounding economic security were particularly important to community members, who highlighted the need for jobs that pay a living wage and the ability to afford decent and safe housing.

Violence and Injury: The homicide rate is much higher than California as a whole, particularly among men of color. Human Trafficking was also noted as a growing concern by interviewees.

Substance Use: San Joaquin County's rate of drug-induced deaths is 56% higher than average rate across California.

Access to Housing: In San Joaquin County, the foreclosure crisis, limited subsidized housing, rising rents, absentee landlords, and deteriorating housing stock are all significant contributing factors to the lack of safe and affordable housing.

Access to Medical Care: San Joaquin County has been successful in enrolling residents in Expanded Medi-Cal under the Affordable Care Act; however, learning how to use services, retention of coverage, and the shortage of primary care providers that will accept Medi-Cal patients remain challenges.

Mental Health: Interviewees noted that the psychology of poverty, including living day-to-day and struggling to provide basic needs, can negatively impact one's ability to make long-term plans, and can interfere with parenting abilities. In addition, poor mental health frequently co-occurs with substance use disorders.

Oral Health: Access to oral health services is a concern in all age groups, marked by limited dental visits and difficulty finding affordable and nearby care.

Asthma/Air Quality: Asthma and breathing problems are a health need in San Joaquin County, as marked by high prevalence of asthma in adults and youth.

Because of the hospital's limited resources and to avoid duplication of efforts by other stakeholders, the health needs that will not be addressed by the hospital at this time are education, economic security, and asthma/air quality.

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at https://healthiersanjoaquin.org or upon request at the hospital's Community Health office.

Creating the Community Benefit Plan

Rooted in Dignity Health's mission, vision and values, St. Joseph's Medical Center is dedicated to improving community health and delivering community benefit with the engagement of its management team, Board of Managers. The board and committee are composed of community members who provide stewardship and direction for the hospital as a community resource (see Appendix A). These parties review community benefit plans and program updates prepared by the hospital's community health director and other staff.

As a matter of Dignity Health policy, the hospital's community health and community benefit programs are guided by five core principles. All of our initiatives relate to one or more of these principles:

- Focus on Disproportionate Unmet Health-Related Needs
- Emphasize Prevention
- Contribute to a Seamless Continuum of Care

- Build Community Capacity
- Demonstrate Collaboration

The process used to identify, select and design the programs and initiatives described in this community benefit plan has been done in collaboration with the Healthier Community Coalition and is aligned with San Joaquin County Public Health's Community Health Improvement Plan (CHIP). The CHNA Core Planning Group provided guidance for the process that was led by Harder+Company consulting group. Participants included healthcare leaders from across the community, St. Joseph's Medical Center Management, CHNA stakeholders, county public health, and community members. Community input was obtained at a series of Healthier Community Coalition meetings to develop the CHIP.

Programs and initiatives were selected to address identified needs based on the following criteria:

- Evidence-based or promising practice
- Aligned with ongoing community efforts
- Feasible to make progress within 5 years
- Measurable via an objective and an indicator in the Community Health Needs Assessment.

2018 REPORT AND 2019 PLAN

This section presents strategies and program activities the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It summarizes actions taken in FY18 and planned activities for FY19, with statements on anticipated impacts, planned collaboration, and patient financial assistance for medically necessary care. Program Digests provide detail on select programs' goals, measurable objectives, expenses and other information.

This report specifies planned activities consistent with the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

Report and Plan Summary

Scheduled to be implemented in November 2018, the Coordinated Community Network Initiative™ (CCNI) of hospital care coordination and community partner agencies will work together to identify vulnerable patients' health and health-related social needs, and use a technology solution that streamlines the referral process and electronically links health care providers to organizations that provide direct services in their communities.

Health Need: Obesity/Diabetes			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Diabetes Navigation and Education Programs (DEEP, Presentations & One on One consultations)	Community classes provided in English, Spanish, and Hmong, as well as individual consultations with a registered nurse/Certified Diabetes Educator, along with resource and referrals for ongoing support.	☒	☒
Chronic Disease Self-Management Program	Evidenced-based, peer-led educational workshops to support effective self-management in English, Spanish & Hmong.	☒	☒
Eat Fit	Workshops designed to improve the eating and fitness choices of middle school adolescents.	☒	☒
Smart Moves	Childhood obesity intervention program.	☒	☒
TOPS	Weight loss program for adults.	☐	☒
Plan, Shop, Save, Cook	Class series to help increase nutrition when on a limited budget.	☒	☒
Collaboration	Community Health staff involvement in the following groups: • Chronic Disease and Obesity Prevention Taskforce including the Diabetes Workgroup • Healthier Community Coalition • Reinvent South Stockton Partnership • Faith Community Health Partnership	☒	☒
Anticipated Impact: Behavior change, leading to a decrease in obesity and diabetes rates and improved health outcomes for patients with chronic diseases. Increased knowledge regarding healthy eating and the			

importance of physical activity. An increase in fruit and vegetable consumption, and physical activity. A decrease in blood glucose and A1C levels for those with diabetes.

Health Need: Violence and Injury			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Reinvent South Stockton Partnership	Partnering with the City of Stockton, Public Health and several community based organizations build trust within the community and to bring mental health and other health and social services into low-income neighborhoods.	☒	☒
Human Trafficking Initiative	As part of the San Joaquin County Human Trafficking Taskforce, provides community education regarding the prevalence of human trafficking, identification of victims and reporting protocols and coordination of community volunteer efforts.	☒	☒
Anticipated Impact: Increase in the community's awareness of human trafficking, as well as an increase in the number of participants in the taskforce and in volunteer efforts throughout the county. Decrease in violence among the South Stockton Promise Zone.			

Health Need: Substance Use			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Behavioral Health Navigator	Community Grant to a local Federally Qualified Health Center to provide a Substance Use Services Peer Navigator as part of a mobile healthcare program focusing on those experiencing homelessness. The Navigator builds trust for those that need mental health or substance use services and connects them to ongoing care and support services.	☐	☒
Multisector Countywide Collaboration – San Joaquin County Whole Person Care	Through Whole Person Care, direct qualifying patient referrals to comprehensive care management for substance abuse and other coinciding issues. Community Health staff also participates in the San Joaquin County Opioid Safety and Prevention Coalition to develop innovative approaches to address the growing epidemic.	☐	☒
Anticipated Impact: Hospital patients and community members will be referred to health and social services, establish a medical home and ultimately improve overall health outcomes and decreasing substance abuse prevalence.			

Health Need: Access to Housing			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Homeless Recuperative Care Program	Community Grant to provide those experiencing homelessness with a safe place to recover upon discharge from a hospital stay. Participants also receive case management assistance to obtain permanent housing and referrals for substance use treatment.	☒	☒
Respite House	Community Grant for interim housing upon discharge from the medical center or behavioral health hospital for patients	☒	☒

	experiencing homelessness. Participants also receive case management assistance to connect patients to a medical home, outpatient mental health and substance use treatment, and assistance in locating permanent housing.		
Multisector Countywide Collaboration– San Joaquin County Whole Person Care	Through WPC, direct qualifying patient referrals to comprehensive care management for substance abuse and other coinciding issues. Community Health staff also participates in the San Joaquin County Homelessness Taskforce to increase access to shelters and affordable housing options.	☒	☒
Anticipated Impact: Homeless patients will recover in a sheltered location, improving health outcomes and reducing their chance of hospital readmissions. Increased number of patients discharged that initiate substance use treatment and increased number of patients that move into temporary or permanent housing. Decrease in homelessness for those at risk via comprehensive discharge planning and collaborative efforts.			

Health Need: Access to Care			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Financial Assistance for Uninsured/Underinsured and Low Income Residents	The hospital provides discounted and free health care to qualified individuals, following Dignity Health's Financial Assistance Policy.	☒	☒
Community Benefit Investment - St. Mary's Dining Room – Virgil Gianelli Medical Clinic and San Rafael Dental Clinic	Financial support for St. Mary's Dining Room health and dental clinics which provide free care for the uninsured, underinsured and those experiencing homelessness.	☒	☒
Friends of Seniors	Coordination of volunteers to provide friendly visiting and transportation assistance to medical appointments, supporting senior's ability to maintain independent living.	☒	☒
Homecoming Project	Providing transitional care services, including support for follow up physician appointments, obtaining medications, transportation assistance and access to other social and senior services and support.	☒	☒
Patient Navigator	Assist patients in establishing a medical home for primary care and preventive services.	☒	☒
Community Events	Community based screenings, resource and referrals	☒	☒
Anticipated Impact: Improved health outcomes and equitable care for vulnerable populations resulting from access to care.			

Health Need: Mental Health			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Reinvent South Stockton Partnership	Partnering in program to bring mental health services into low-income neighborhoods.	☒	☒

Respite House	Community Grant for interim housing upon discharge from the medical center or behavioral health hospital for patients experiencing homelessness. Participants also receive case management assistance to connect patients to a medical home, outpatient mental health and substance use treatment, and assistance in locating permanent housing.	☒	☒
Multisector Countywide Collaboration – San Joaquin County Whole Person Care	Through WPC, direct qualifying patient referrals to comprehensive care management for mental health care. Community Health staff also participates in the San Joaquin County Consortium for Mental Health, to increase access and high quality supportive services.	☒	☒
Friends of Seniors	Friendly visiting of home-bound seniors.	☒	☒
Anticipated Impact: An increase in treatment for mental health conditions, particularly those related to trauma. Decreased feelings of isolation for seniors living alone, or with limited family support.			

Health Need: Oral Health			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Community Benefit Investment - St. Mary's Dining Room – Virgil Gianelli Medical Clinic and San Rafael Dental Clinic	Financial support for St. Mary's Dining Room health and dental clinics which provide free care for the uninsured, underinsured and those experiencing homelessness.	☒	☒
Multisector Countywide Collaboration – TEETH	Staff participation in San Joaquin County Treatment, Education for Everyone on Teeth Health (TEETH) Collaborative to ensure continued expansion of dental care for vulnerable populations.	☒	☒
Anticipated Impact: Increased dental care for low income and uninsured individuals.			

Health Need: Youth Development			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Youth Development Program	Exploration of best practice programs to increase resiliency, coping, and positive self-image for youth.	☐	☒
Anticipated Impact: Decreased school explosions and truancies, decrease in self-harm and substance use, increased positive self-image and coping skills.			

Community Grants Program

One important way the hospital helps to address community health needs is by awarding financial grants to non-profit organizations working together to improve health status and quality of life in the communities we serve. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations.

In FY18, the hospital awarded three grants totaling $227,749. Below is a complete listing of FY18 grant projects; some projects may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Community Medical Centers, Inc.	Behavioral Health Navigator	$27,749
Gospel Center Rescue Mission	Recuperative Care Program	$100,000
Sacramento Self-Help Housing	Respite House	$100,000

Anticipated Impact

The anticipated impacts of some of the hospital's activities on significant health needs are summarized above, and select program initiatives are stated in the Program Digests on the following pages. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospital is committed to measuring and evaluating key initiatives. The hospital creates and makes public an annual Community Benefit Report and Plan, and evaluates impact and sets priorities for its community health program in triennial Community Health Needs Assessments.

Planned Collaboration

Healthier Community Coalition – St. Joseph's Medical Center serves as the fiscal agent for Healthier Community Coalition (HCC). HCC is a collaborative of the local hospitals, Medicaid managed care plans, County Public Health Department and community based organizations. The group works together to implement programs that address the needs identified in the previous Community Health Needs Assessment.

Reinvent South Stockton – Several partners have come together to focus on the needs of the underserved area of South Stockton. With over 120 community partners involved, below is a list of the members of the steering committee that serve alongside St. Joseph's Medical Center:

Authority of San Joaquin, Data Co-Op
Beyond Our Gates/University of the Pacific
Community Medical Centers
Community Partnership for Families
El Concilio
Fathers and Families of San Joaquin
San Joaquin Public Health Services, Housing
South Stockton Schools Initiative
Stocktonians Taking Action to Neutralize Drugs
Visionary Homebuilders

San Joaquin Homeless Task Force – Community Health department staff participate in the San Joaquin Homeless Task Force to develop innovative solutions to address the wide prevalence of homelessness in the county. Taskforce efforts are made publicly available at https://sjgov.app.box.com/v/HomelessnessTaskForce

Opioid Safety Coalition – This Coalition convenes a multisector group of leaders to improve treatment practices, Provider (Prescriber) and Dispenser (Pharmacist) education, and identify innovative approaches in order to reduce opioid use throughout the county. The Coalition is led by San Joaquin County Public Health Services, and includes representatives from hospitals, law enforcement, schools and several other organizations.

San Joaquin Emergency Services Task Force – Coordinated by the Hospital Council of Northern and Central California, this group convenes San Joaquin County area hospitals, first responders (Fire/EMS) and law enforcement leaders to improve the coordination and care of individuals with mental health issues.

Chronic Disease and Obesity Prevention Taskforce – The goal of the Taskforce is to decrease the incidence and prevalence of obesity, chronic disease, and the related risk factors through a combined and expanded effort of the members. In addition to St. Joseph's Medical Center, the taskforce includes representatives from county services, Medicaid managed care plans, local hospitals and school districts.

Human Trafficking Healthcare Workgroup – This subcommittee of the San Joaquin County Human Trafficking Taskforce is led by St. Joseph's Medical Center, and convenes medical providers to implement human trafficking initiatives, policies and procedures in all healthcare settings.

Adventist Health Lodi Memorial
Community Medical Centers
Planned Parenthood
San Joaquin Behavioral Health Services
San Joaquin General Hospital
San Joaquin County Public Health Services
Stockton Unified School District
Sutter Health

San Joaquin Human Trafficking Taskforce – A vast collaboration of agencies supporting victims of violence, working together to offer community outreach and education, advocacy. This taskforce ensures a safety network for victims and has made great strides in bringing forth community awareness and expanding interventions to identify, respond to, and save victims from continued abuse and exploitation.

San Joaquin TEETH - San Joaquin Treatment & Education for Everyone on Teeth & Health (SJ TEETH) is a coalition of health, education and nonprofit organizations collaborating to improve access to dental health for income-eligible children in San Joaquin County. St. Joseph's Medical Center participates alongside the following partners:

Catholic Charities
Community Medical Centers
Family Resource and Referral
Family Resource Network
First5 of California
San Joaquin County Public Health
University of the Pacific

Whole Person Care (WPC) – Led by San Joaquin County Health Care Services Agency, the WPC Pilot is designed to improve the health of homeless, high-risk, and high emergency room utilizers, through the coordinated delivery of critical community services such as physical and behavioral health, housing support, food stability, and additional social service needs. More information regarding the pilot and involved partners can be found at, http://caph.org/wp-content/uploads/2018/07/san-joaquin-wpc-pilots-7.12.2018.pdf

Financial Assistance for Medically Necessary Care

St. Joseph's Medical Center delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services. A plain language summary of the hospital's Financial Assistance Policy is in Appendix C. The amount of financial assistance provided in FY18 is listed in the Economic Value of Community Benefit section of this report.

The hospital notifies and informs patients and members of the community about the Financial Assistance Policy in ways reasonably calculated to reach people who are most likely to require patient financial assistance. These include:

- providing a paper copy of the plain language summary of the Policy to patients as part of the intake or discharge process;
- providing patients a conspicuous written notice about the Policy at the time of billing;
- posting notices and providing brochures about the financial assistance program in hospital locations visible to the public, including the emergency department and urgent care areas, admissions office and patient financial services office;
- making the Financial Assistance Policy, Financial Assistance Application, and plain language summary of the Policy widely available on the hospital's web site;
- provide paper copies of these documents available upon request and without charge, both by mail and in public locations of the hospital; and providing these written and online materials in appropriate languages.

The Financial Assistance Policy, the Financial Assistance Application, and plain language summary of the Policy are widely available on the hospital's web site. Paper copies are also available upon request and without charge, both by mail and in public locations of the hospital. Written notices, posted signs and brochures are printed and available online in appropriate languages. In addition, the plain language summary was shared with the Healthier Community Coalition, which consists of a broad collaborative of community representatives, and healthcare leaders, as well as St. Joseph's Foundation Board and Port City Operating Company, LCC Board of Managers, who were all asked to distribute the policy broadly to help raise awareness.

Bi-lingual signage that addresses the hospital's Patient Payment Assistance Program is posted in key areas of the hospital facility. Payment Assistance information can be found at www.dignityhealth.org/stjoseph's-stockton/paymenthelp.

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs in the most recent CHNA report. The digests include program descriptions and intervention actions, statements of which health needs are being addressed, any planned collaboration, and program goals and measurable objectives.

Community Diabetes Education (DEEP, CDSMP, 1:1, Eat Fit, Plan Shop Save Cook)	
Significant Health Needs Addressed	✓ Obesity/Diabetes ✓ Youth Development ❑ Violence and Injury ❑ Substance Use ❑ Access to Housing ✓ Access to Care ✓ Mental Health ✓ Oral Health
Core Principles Addressed	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	Community Health Educators from the hospital's Community Health Department deliver diabetes workshops at both the hospital campus and in community settings such as community centers, schools, and senior living complexes.
Community Benefit Category	A1a. Community Health Improvement Services, Lectures and Workshops
FY 2018 Report	
Program Goal / Anticipated Impact	Promote behavior and lifestyle changes, increase physical activity and healthy eating, reduce A1C levels, reduce barriers, and increase support for individuals with diabetes.
Measurable Objective(s) with Indicator(s)	Continue to develop data collection methods to efficiently and effectively measure and evaluate impact from all programs by the end of the fiscal year.
Intervention Actions for Achieving Goal	New leadership and new staff assignments led to the ability of assessing if program goals were being achieved. Prior to staff changes pre/post data collection was solely being reported up to the system level for workshops, and not collected nor manipulated for reporting at the local level.
Planned Collaboration	Ongoing collaboration with both internal and external audiences will lead to the awareness of classes, and ultimately an increase in class participants.
Program Performance / Outcome	119 students: Diabetes Empowerment Education Program (DEEP) 31 students: Chronic Disease Self-Management Program (CDSMP) 639 One-on-One consultations with Certified Diabetes Educator 76 Eat Fit participants (launched Q4 FY18) 16 Plan Shop Save Cook participants (launched Q4 FY18) Outcome data began being collected in May 2018 and below are results from the 3 month follow up calls post DEEP class sessions: 3 out of 16 people responded to 3 month follow up calls 66% - 2 out of 3 never felt overwhelmed by diabetes 66% - 2 out of 3 know ways to handle stress

	100% feel they can ask for support 100% feel comfortable asking their doctor questions 66% feel they can make a plan with goals On average, participants are eating vegetables 6 days per week On average, participants exercised 4.6 days per week On average, participants checked their blood sugar 5.6 days per week Of those taking medications, 100% are taking them as prescribed, 7 days/week On average, participants checked their feet 5 days per week.
Hospital's Contribution / Program Expense	$550,215 in staff and facility expenses
FY 2019 Plan	
Program Goal / Anticipated Impact	Continue promotion and outreach in order to enroll students and ultimately create behavior and lifestyle changes in the community.
Measurable Objective(s) with Indicator(s)	Increase physical activity and healthy eating, reduce A1C levels, reduce barriers and increase support for individuals with diabetes.
Intervention Actions for Achieving Goal	Strategic partnering with community and faith organizations to help recruit participants, and to increase delivery of classes in the community.
Planned Collaboration	Through the newly established Faith Community Health Partnership, along with identified successful site partners, it is anticipated that diabetes education classes will reach a significantly higher amount of residents than in prior years.

Diabetes Navigator	
Significant Health Needs Addressed	✓ Obesity/Diabetes ❑ Youth Development ✓ Violence and Injury ✓ Substance Use ✓ Access to Housing ✓ Access to Care ✓ Mental Health ✓ Oral Health
Core Principles Addressed	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ❑ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	Provide patients with resource, referral, and connection to diabetes education, and support available to them post discharge. Provide community members with guidance, enrollment and/or resource and referrals to diabetes education opportunities. The navigator will also assess and make appropriate referrals to address social determinants of health.
Community Benefit Category	A3e. Community Health Improvement Services, Information and Referral
FY 2018 Report	
Program Goal / Anticipated Impact	Increase referrals to Diabetes Navigator. Encourage individuals with diabetes or those with pre-diabetes to enroll in education to better manage condition and maintain good health. Connect individuals to community resources to address social determinants of health.

Measurable Objective(s) with Indicator(s)	Evaluate program metrics and develop a tool to measure program success by quarter 1 of FY18-19.
Intervention Actions for Achieving Goal	Ongoing internal and external outreach of diabetes navigator services in both the hospital and community. Development and strategic promotion of hospital's online diabetes assessment tool.
Planned Collaboration	Ongoing collaboration with both internal and external audiences will lead to the awareness of classes, and ultimately an increase in class participants.
Program Performance / Outcome	19 individuals assisted
Hospital's Contribution / Program Expense	$4,380, staff time
FY 2019 Plan	
Program Goal / Anticipated Impact	Continued promotion and outreach in order to create behavior and lifestyle changes in the community, and ultimately increase physical activity and healthy eating, reduce of A1C levels, reduce barriers and increase support for individuals with diabetes. Increase social determinants of health referrals.
Measurable Objective(s) with Indicator(s)	In 12 months, increase referrals to diabetes navigator services by 100%. Of those referred, 10% of individuals will attend a diabetes class.
Intervention Actions for Achieving Goal	Ongoing rounding with referring hospital departments and community based physicians to increase referrals, and ultimately improve health outcomes for those with diabetes.
Planned Collaboration	With the role of the navigator being to link individuals to community health education, ongoing collaboration with other hospitals, managed care plans, medical clinics, and other community based organizations will continue in order to provide effective referrals.

Human Trafficking (SJC Taskforce, Healthcare Workgroup, SJMC Taskforce)	
Significant Health Needs Addressed	❑ Obesity/Diabetes ✓ Youth Development ✓ Violence and Injury ✓ Substance Use ✓ Access to Housing ✓ Access to Care ✓ Mental Health ❑ Oral Health
Core Principles Addressed	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	Promote awareness and prevention of human trafficking in San Joaquin County. Develop policies and producers in healthcare settings, to recognize and respond to victims.
Community Benefit Category	A5. Community Health Improvement Services, Initiative: Human Trafficking Community Response

FY 2018 Report	
Program Goal / Anticipated Impact	Increase awareness and prevention of human trafficking. Maintain and expand education and training of hospital staff to know how to recognize and support victims.
Measurable Objective(s) with Indicator(s)	In 12 months, over 95% of St. Joseph's Medical Center staff will enroll in Human Trafficking 101 training. Provide a minimum of one community event to bring awareness, discuss county efforts, and increase engagement in efforts. Develop a workgroup to evaluate data collection to better inform community on impact and deliverables.
Intervention Actions for Achieving Goal	Ongoing convening of SJC Taskforce members, Healthcare Workgroup and Hospital Taskforce.
Planned Collaboration	Continued partnership with key stakeholders as listed in Planned Collaboration section.
Program Performance / Outcome	In response to SB 1193, the senate bill that mandates certain businesses to post Human Trafficking awareness posters, the Community Outreach Coordinator organized: 7 outreach events (4 in Stockton, 2 in Tracy and 1 in Lodi) 106 volunteers who visited 177 businesses, and resulting in 104 businesses that accepted information 72 locations that displayed the awareness posters. 97.65%% of staff enrolled in Human Trafficking 101: Dispelling the Myths training. 89.531% of those registered, completed the training. Data workgroup was established and is gathering data from all efforts to report impact at 2019 Summit scheduled 1/11/2019, as well as future reports.
Hospital's Contribution / Program Expense	$100,895, staff and facility expenses
FY 2019 Plan	
Program Goal / Anticipated Impact	Continue to expand education and awareness in San Joaquin County, and expand policies and procedures in our medical facilities. Explore opportunities to support labor trafficking victims.
Measurable Objective(s) with Indicator(s)	Develop a Healthcare Workgroup Charter by the end of 2018. Provide a minimum of two train-the-trainer events and acquire a minimum of 6 educators to expand interventions in both faith and community based organizations. Have local persons trained on Trauma Informed Care
Intervention Actions for Achieving Goal	Continued collaboration and sharing of resources and tools.
Planned Collaboration	Ongoing presentations, along with county taskforce and workgroup convening.

Homeless Recuperative Care Program	
Significant Health Needs Addressed	❑ Obesity/Diabetes ❑ Youth Development ✓ Violence and Injury ✓ Substance Use ✓ Access to Housing ✓ Access to Care ✓ Mental Health

	✓ Oral Health
Core Principles Addressed	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	Homeless patients that are medically cleared for discharge, but who need shelter for recovery are provided with a 24/7 bed for up to 30 days. Additional supportive services (substance abuse treatment, life/work training, and counseling) are available as well, and individuals can self-enroll at any time. A medical clinic is onsite to provide basic follow up care.
Community Benefit Category	E2a, Community Grants Program
FY 2018 Report	
Program Goal / Anticipated Impact	Provide shelter to homeless individuals needing recuperative care, and ultimately transition individuals to permanent housing.
Measurable Objective(s) with Indicator(s)	In 12 months, maintain an average hospital readmission rate of 20% or less.
Intervention Actions for Achieving Goal	Maintain strong partnership and communication with Gospel Center staff to ensure successful transition of care.
Planned Collaboration	Ongoing collaboration between Care Coordination, Community Health, and Recuperative Care staff.
Program Performance / Outcome	3,459 days of shelter was provided to a total of 96 individuals 12% of individuals readmitted to hospital 25% moved in with family/friends/or own place 9% enrolled into New Life Program 1% enrolled into Sober Living Program 13% transitioned into shelters 7% moved into Independent or Assisted living community 20% return to life on the streets 13% dismissed against medical advice
Hospital's Contribution / Program Expense	$100,000 Community Grant
FY 2019 Plan	
Program Goal / Anticipated Impact	Continue to provide shelter to homeless individuals needing recuperative care, and ultimately transition individuals to permanent housing.
Measurable Objective(s) with Indicator(s)	Increase the number of bed days by 1% and number of individuals served by 2%. Readmission rate for clients will be 15% or less.
Intervention Actions for Achieving Goal	Continue to educate care coordination staff from local hospitals and collaborate with the workgroup to overcome challenges and share/increase community resources needed for vulnerable individuals.
Planned Collaboration	Ongoing collaborative meetings to discuss challenges, barriers and success.

ECONOMIC VALUE OF COMMUNITY BENEFIT

The economic value of community benefit for patient financial assistance is calculated using a cost-to-charge ratio, and for Medicaid and other categories of community benefit using a cost accounting methodology.

St. Joseph's Medical Center Stockton
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2017 through 6/30/2018

	Persons Served	Net Benefit	% of Org. Expenses
Benefits for Living in Poverty			
Financial Assistance	**3,750**	**4,606,321**	**0.8**
Medicaid *	**62,602**	**2,323,105**	**0.4**
Means-Tested Programs	**4**	**7,942**	**0.0**
Community Services			
A - Community Health Improvement Services	5,032	1,096,907	0.2
C - Subsidized Health Services	280	11,595	0.0
E - Cash and In-Kind Contributions	5,622	2,609,725	0.5
G - Community Benefit Operations	0	564,355	0.1
Totals for Community Services	**10,934**	**4,282,582**	**0.8**
Totals for Living in Poverty	**77,290**	**11,219,950**	**2.1**
Benefits for Broader Community			
Community Services			
A - Community Health Improvement Services	862	108,678	0.0
B - Health Professions Education	2,290	3,558,796	0.7
D - Research	284	371,610	0.1
E - Cash and In-Kind Contributions	0	58,905	0.0
F - Community Building Activities	8	526,326	0.1
Totals for Community Services	**3,444**	**4,624,315**	**0.9**
Totals for Broader Community	**3,444**	**4,624,315**	**0.9**
Totals - Community Benefit	**80,734**	**15,844,265**	**2.9**
Medicare	**43,493**	**23,685,120**	**4.4**
Totals with Medicare	**124,227**	**39,529,385**	**7.3**

Net Benefit equals costs minus any revenue from patient services, grants or other sources.

* The hospital was required to record some Medicaid Provider Fee revenue in FY18 that was attributable to FY17 services. If all FY17 Medicaid Provider Fee revenue had been recorded in FY17, the hospital's FY18 net benefit for Medicaid would have been $21,940,488.

APPENDIX A: PORT CITY OPERATING COMPANY, LLC BOARD OF MANAGERS

Debra Cunningham	SVP, Strategy, Kaiser Permanente
Elsie Dempsey	VP, Nursing Research, Chief Nursing Informatics Dignity Health
Tom Hanenburg	SVP, Hospital & Health Plan Operations, Kaiser Permanente
Corwin Harper	SVP Central Valley Service Area, Kaiser Permanente
John Petersdorf	SVP Operational Effectiveness, Dignity Health
Karl Silberstein	SVP Financial Operations, Dignity Health
Jon VanBoening	Sr. Vice President, President Bakersfield Memorial Dignity Health

APPENDIX B: OTHER PROGRAMS AND NON-QUANTIFIABLE BENEFITS

The hospital delivers a number of community programs and non-quantifiable benefits in addition to those described elsewhere in this report. Like those programs and initiatives, the ones below are a reflection of the hospital's mission and its commitment to improving community health and well-being.

In June 2017, Dignity Health approved a 3-year renewal of a $500,000 revolving loan to STAND, a Community Housing Development Organization founded to create positive change in southeast Stockton communities that had been devastated by gang and drug activity. The funds help cover the costs of purchasing and refurbishing former drug houses, thereby creating homes for sale to low-income homebuyers.

Leaders from St. Joseph's serve as board members of numerous community organizations and collaboratives. The Director of Community Health serves as Secretary for the Women's Center Youth and Family Services Board of Directors and serves on the Human Resources Committee for the Community Partnership for Families of San Joaquin Board of Directors. Three hospital employees are part of the San Joaquin Human Trafficking Task Force, two of which co-chair the Healthcare Workgroup, while the other chairs the Outreach and Education Committee. Hospital staff also regularly attend collaborative meetings as noted in the Planned Collaboration section of this report.

The hospital is also a key partner in community building and ensuring environmental improvement through the ecology initiatives. Staff members from St. Joseph's Medical Center voluntarily operate a community garden that provides over 1,200 pounds annually of fresh vegetables which are donated to organizations that prepare free meals for low-income individuals. The Medical Center achieved 46.37% of waste being diverted from the landfill through our recycling efforts. The hospital achieved at 12.55% reduction in water consumption as a result of improved equipment installation. Continued efforts and focus to provide ongoing education and process improvement, has made St. Joseph's Medical Center a recognized community leader in the environmental stewardship arena.

In order to expand access to care, the hospital also pays for ancillary services such as X-Rays and laboratory tests for patients of St. Mary's Medical Clinic. The hospital also coordinates the Dobbins Under 40 Program, which is a source of financial assistance for uninsured or underinsured women ages19-39 years who are in need of a breast screening or further breast diagnostic testing.

Advancing access to medical care and developing a strong infrastructure of providers for future generations, is of great concern so that is why St. Joseph's Medical Center invests greatly in workforce development. Health profession education for students of nursing, pharmacy, physical therapy, paramedics, as well as respiratory and occupational therapy is offered. A Graduate Medical Education Program in partnership with Touro University has also been established to provide high quality training for Family Medicine, Emergency Medicine, OB/GYN, and Pediatric medical residents.

APPENDIX C: FINANCIAL ASSISTANCE POLICY SUMMARY

Dignity Health's Financial Assistance Policy describes the financial assistance programs available to uninsured or under-insured patients who meet certain income requirements to help pay for medically necessary hospital services provided by Dignity Health. An uninsured patient is someone who does not have health coverage, whether through private insurance or a government program, and who does not have the right to be reimbursed by anyone else for their hospital bills. An underinsured patient is someone who has health coverage, but who has large hospital bills that are not fully covered by their insurance.

Free Care

- If you are uninsured or underinsured with a family income of up to 200% of the Federal Poverty Level you may be eligible to receive hospital services at no cost to you.

Discounted Care

- If you are uninsured or underinsured with an annual family income between 200-350% of the Federal Poverty level, you may be eligible to have your bills for hospital services reduced to the highest amount reasonably expected to be paid by a government payer, which is usually the amount that Medicare would pay for the same services.
- If you are uninsured or underinsured with an annual family income between 350-500% of the Federal Poverty level you may be eligible to have your bills for hospital services reduced to the Amount Generally Billed, which is an amount set under federal law that reflects the amount that would have been paid to the hospital by private health insurers and Medicare (including co-pays and deductibles) for the medically necessary services.

If you are eligible for financial assistance under our Financial Assistance Policy you will not be required to pay more than the Amount Generally Billed described above. If you qualify, you may also request an interest-free extended payment plan. You will never be required to make advance payment or other payment arrangements in order to receive emergency services.

Free copies of the hospital's Financial Assistance Policy and financial assistance application forms are available online at your hospital's website listed below or at the hospital Admitting areas located near the main entrance. (Follow the signs to "Admitting" or "Registration"). Copies of these documents can also be mailed to you upon request if you call Patient Financial Services at the telephone number listed below for your hospital.

Traducción disponible: You may also obtain Spanish and other language translations of these documents at your hospital's website, in your hospital's Admitting area, or by calling your hospital's telephone number.

Dignity Health Financial Counselors are available to answer questions, provide information about our Financial Assistance Policy and help guide you through the financial assistance application process. Our staff is located in the hospital's Admitting area and can be reached at the telephone number listed below for your hospital.
1800 N. California St, Stockton, CA 95204 | Financial Counseling (209) 461-5271 | Patient Financial Services 866-549-7941 | www.dignityhealth.org/stjoseph's-stockton/paymenthelp.