DAMERON HOSPITAL

# YEAR ONE UPDATE, FY 2023 Community Health Implementation Strategy

2023

DAMERON HOSPITAL

Managed by:

Adventist Health

# Table of Contents

# Purpose & Summary

Non-profit health systems, community-based organizations, and public health agencies across the country all share a similar calling: to provide public service to help improve the lives of their community. To live out this calling and responsibility, Dameron Hospital conducts a Community Health Needs Assessment (CHNA) every three years, with our most recent report completed in 2022. Now that our communities' voices, stories, and priority areas are reflected in the CHNA, our next step is to complete a Community Health Improvement Plan (CHIP), or as we refer to it in this report, a Community Health Implementation Strategy (CHIS).

The CHIS consists of a long-term community health improvement plan that strategically implements solutions and programs to address our health needs identified in the CHNA. Together with the Dameron Hospital community benefit team, local public health officials, community-based organizations, medical providers, students, parents, and members of selected underserved, low-income, and minority populations, Dameron Hospital intentionally developed a strategic plan to address the needs of our community.

In this Year One Update, FY 2023 of the Community Health Implementation Strategy also known as the Community Health Plan Update, FY 2023, you will find strategies, tactics, and partnerships that address the following health needs identified in the 2022 Dameron Hospital CHNA:

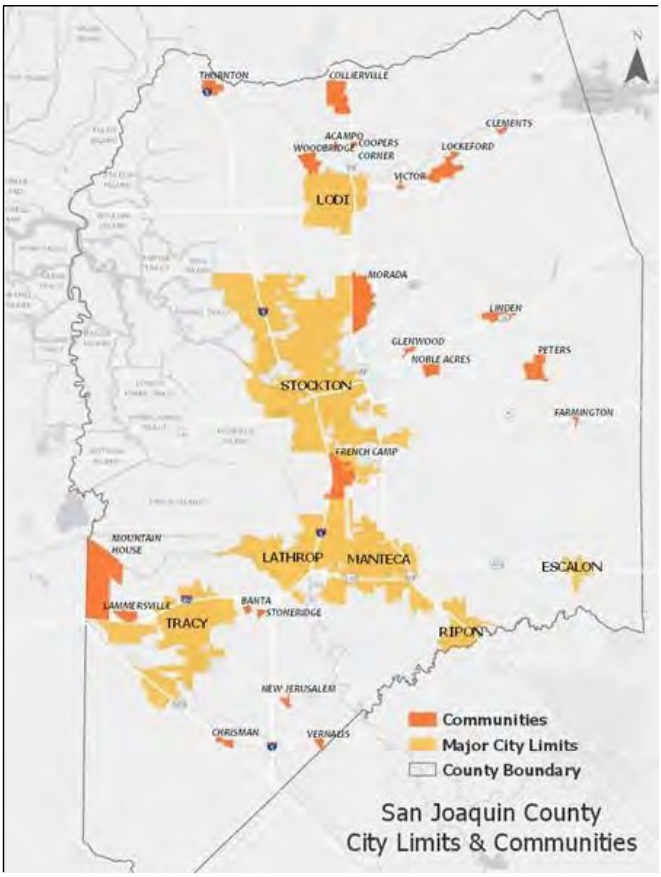
**Access to Care**

**Financial Stability**

**Mental Health**

# Definition of Community Served

Each hospital participating in our CHNA defines its hospital service area to include all individuals residing within a defined geographic area surrounding the hospital. Per the joint CHNA, the hospital partners chose San Joaquin County as the primary service area.




## GEOGRAPHIC DESCRIPTION OF THE COMMUNITY SERVED

San Joaquin County, in the Central Valley of California, is roughly 60 miles east of San Francisco and 35 miles south of Sacramento, with a total population of 742,603 (2019). Historically, agriculture has been a strong driver of our economy and many migrants and immigrants have settled here to work in the fields and help with agricultural processing or shipping. The County is mostly rural, with one large urban core (Stockton) and seven smaller cities, as well as many ranching and farming communities scattered across the County.

## DEMOGRAPHIC PROFILE OF THE COMMUNITY SERVED

San Joaquin County is home to a high concentration of residents at elevated risk for COVID-19 and who have experienced enormous impacts from the pandemic. A quarter of residents are foreign-born. Overall, 14.5% of residents live in poverty. Residents aged 65 years and older have a poverty rate of 9.9%. The educational attainment of San Joaquin County residents is much lower than California residents. Only 18.8% of County residents aged 25 and older have a bachelor's degree or higher, compared to 33.9% of Californians aged 25 and older that have a bachelor's degree or higher.

| Race/ethnicity | |
|---|---|
| Total Population | 742,603 |
| Asian | 15.2% |
| Black/African American | 6.7% |
| Latinx | 41.4% |
| Native American/Alaska Native | 0.2% |
| Pacific Islander/Native Hawaiian | 0.5% |
| Multiple races | 3.9% |
| White | 31.9% |

Source: US Census, 2019

| Socioeconomic Data | |
|---|---|
| Living in poverty (<100% Federal poverty level) | 14.5% |
| Children in poverty | 16.6% |
| Older adults (ages 65+) in poverty | 9.9% |
| Employed (ages 20-64 years) | 52.6% |
| Insured (ages 19-64 years) | 90.5% |
| Adults with no high school diploma | 20.7% |
| Bachelor's Education or higher | 18.8% |

Source: US Census, 2019

*For a more detailed look into community member comments, facts and numbers that are captured in the CHNA, please visit dameronhospital.org/chna. The following pages provide a closer look into our community demographic as well as our approach to the CHIS.*

# About Us

## Dameron Hospital

Dameron Hospital is a fully accredited, non-profit, 200+ bed community hospital providing acute and tertiary level care to San Joaquin County residents. Now managed by Adventist Health, our hospital remains committed to providing the high quality care that has earned various state and national recognitions, as well as numerous awards and accolades. The hospital has also been designated by Blue Shield of California as a Blue Distinction® Center for Bariatric Surgery and for Knee and Hip Replacements as part of the Blue Distinction® Centers for Specialty Care program. In addition to being a top-rated joint replacement center in the Stockton area, and the county's leading orthopedic hospital, Dameron has also been recognized as a Top Performer for its Quality Metrics by The Joint Commission.

The San Joaquin County Emergency Medical Services Agency has also named Dameron as a designated STEMI (heart attack) receiving center and certified stroke center. Thanks to Dameron's Lifeline technology and cardiac-prepared ER staff, emergency responders have a local care partner that also is a Certified Cardiac Care Hospital and a Cardiothoracic Surgery Center with an active Cardiac Catheterization Lab.

Dameron Hospital continues its leading-edge tradition, and we are continually enhancing our facilities and services to help fulfill our mission of delivering top-quality care to the community. Dameron services include cardiology and cardiac surgery, orthopedics, bariatric surgery, as well as general acute care, emergency, and intensive care services.

## Dameron Hospital's Approach to CHNA & CHIS

Dameron Hospital prioritizes well-being in the communities we serve across our system. We use an intentional, community centered approach when creating our hospital CHNA's to understand the health needs of each community. After the completion of the community assessment process, we address health needs such as mental health, access to care, health risk behaviors, and others through the creation and execution of a Community Health Implementation Strategy (CHIS) for each of our hospitals and their communities.

The following pages highlight the key findings that Dameron Hospital identified as top priority health needs, or as we refer to them in this report, 'High Priority Needs.' The High Priority Needs are addressed in the implementation strategy and are reported on a yearly basis through the Annual Community Health Plan Update.

This is year one, of a three-year strategy to improve the health of our community. We invite you to learn about the actions, activities ad programs that have been implemented in 2023.

# Action Plan for Addressing High Priority Needs

The following pages reflect the goals, strategies, actions, and resources That Dameron Hospitals provided in 2023 to address each selected High Priority Need.

**ADDRESSING HIGH PRIORITY: Access to Care**

| | |
|---|---|
| **GOAL** | Collaborate with partners to connect community members with health plan coverage to help ensure they have access to primary care and preventive health services. |

**Strategy 1:**

**Action:**
Program/Activity/Tactic/Policy

- Effectively enroll uninsured patients in appropriate health plan programs such as CalAIM.
- Refer uninsured and underinsured patients to community resources to help address their health and psychosocial needs.

**FY 2023 YEAR ONE**

Evaluate current processes for identifying and enrolling eligible patients in health coverage plans during ED intake process at Dameron.

Connect with internal stakeholders to determine benefits and identify barriers.

Meet with executive leadership with for approval.

**COMMUNITY IMPACT SUMMARY/ALL STRATEGIES:**

**CalAIM HEALTH NAVIGATORS**
Adventist Health established a partnership with a third-party service provider to connect our Medi-Cal patients who have complex health needs, are unhoused, or are high emergency room utilizers, with additional support and services. The program provides a whole-person approach to care and addresses clinical and non-clinical needs of enrollees.

As part of CalAIM's broader Enhanced Care Management initiative, the partnership is intended to close care gaps for patients with the most complex care needs by addressing the social barriers, such as homelessness, that influence a patient's health.

Emcara Health was selected to administer our CommunityConnect program in a number of counties in California which will include San Joaquin County. This partnership launched in 2023 and we began exploring how it will integrate operationally with our hospital care management and social work teams.

Emcara Health will deploy field-based care teams, consisting primarily of community health workers (CHW), to meet patients on their terms, whether that's at home, in a homeless encampment, or in the emergency department. Once engaged, CHWs conduct a social determinants of health assessment to understand the social impediments that may be impacting the patient's health, such as access to food, stress, transportation and more. As part of the agreement, Emcara Health nurses and social workers will connect and coordinate preventive care and clinical treatment through Adventist Health. Emcara Health will provide wraparound support, including transitions of care, providing member and family assistance, and coordinating and referring patients to community and social support services.

**STRATEGY THAT CHANGED DURING THE YEAR:**

***Update:*** *In 2024, Adventist Health made the decision to internalize this program and end the relationship with Emcara. We are currently in the process of negotiating the reimbursement contract with Health Plan of San Joaquin and hiring our local field agent.*

**ADDRESSING HIGH PRIORITY: Financial Stability**

| GOAL | Provide supportive environment for members of vulnerable populations to gain exposure and skills for employability in allied health professions. |
|---|---|

**Strategy 1:**

**Action:**
Program/Activity/Tactic/Policy

- Review existing training programs to determine opportunities to continue, enhance or revise.
- Collaborate with existing community high school and post-secondary institutional programs to identify eligible students.
- Review current learning partnerships in consultation with Health Force partners.
- Meet with executive leadership to discuss/approve changes/enhancements.

**FY 2023 YEAR ONE**

Review current learning partnerships and healthcare training needs in the community.

Review current eligibility and enrollment for inclusion of vulnerable populations in partnership with educational institutions.

Market and enroll students in the various nursing and allied health education programs currently offered at the hospital.

## COMMUNITY IMPACT Financial Stability SUMMARY

**PROVIDE INTERNSHIP OPPORTUNITIES IN HEALTH CARE PROFESSIONS AT DAMERON HOSPITAL**

- **INTERNSHIP AND RESIDENCY PROGRAMS**
  We continue to partner with educational institutions to offer internships and residency opportunities to their students in the area of nursing. In 2023, more than 11,300 nursing student hours were provided at Dameron and we are currently expanding the range of healthcare profession development opportunities.

- **DECISION MEDICINE PROGRAM**
  On July 17, 2023, Dameron Hospital hosted the San Joaquin Medical Society's Decision Medicine Program, comprised of 24 promising high school students interested in pursuing medical careers. These are students who are high achieving with an average GPA of 4.15, come from lower income households and underrepresented and would not otherwise have the opportunity to interact with medical professionals for pathway advice. The students participated in tours and interactive activities with staff that included the catheterization lab, CT imaging, MRI, ambulance/paramedic systems, and a laboratory personal blood typing exercise. They also engaged with general surgeons for advice on how to best achieve their career aspirations in medicine.

- **HOPE NURSING PROGRAM**
  In 2021, the Board of Registered Nursing approved 40 fast track (18-month associate degree in nursing) positions annually at San Joaquin Delta College (indefinitely). Half of them have been dedicated to the HOPE RN program. This enables partners to have a direct talent pool of nursing candidates to be employed at partnered employers.
    - The current cohort (Cohort #4) has 11 incumbent workers at Adventist Health Lodi Memorial, Dameron Hospital and Community Medical Centers. Cohort #3 graduated in 2023 and a total of 11 out of the 12 students passed their licensing examination and are transitioning over to the workforce. In

Cohort #3, 11 out of the 12 graduates were from Dameron Hospital or Adventist Health Lodi Memorial.

- **CNA PROGRAM DEVELOPED FOR 2024**
  Pending approval by the California Department of Public Health (CDPH), we are planning to participate in a 14-week program guided study program for participants to become certified nursing assistants (CNA). The program is geared towards the working adult so they can continue to support themselves and their family so the program will be held during nights and weekends. We are partnering with Vienna Nursing & Rehab Center in Lodi to provide the training environment for participants and California Preparatory College as our educational partner. We will need a minimum of 13 students to conduct the program and we may also explore the possibility of including high school student participation because the CDPH allows youth as young as 16 to take the CNA licensing exam.

| GOAL | Advocate for and collaborate with community partners to connect community members with services that will reduce the burden of childcare and make them available to acquire skills for employability. |
|---|---|

**Strategy 2:**

**Action:** Program/Activity/Tactic/Policy

- Determine whether case managers at Dameron Hospital will benefit from access to the Unite Us digital referral platform in order to connect eligible patients to relevant service providers.
- Increase use of Unite Us overall for better connection of patients with community services as appropriate.

**FY 2023 YEAR ONE**

Determine feasibility, value and cost for implementing the Unite Us system at Dameron.

Explore feasibility of incorporating system as part of the ED intake process for eligible

patients. Present recommendations to executive leadership for implementation approval.

**COMMUNITY IMPACT SUMMARY/ALL STRATEGIES:**

Unite Us is a closed loop referral software platform that allows community connections for food support, housing assistance, employment services and medical care referrals. In 2020, Adventist Health Lodi Memorial (AHLM) became a funding partner of the Unite Us platform to actively participate in San Joaquin County's Connected Community Network (CCN). In 2023, AHLM continued to actively support the Unite Us platform by disbursing the 3rd installment of the funding in the 3-year agreement.

In 2023, we evaluated the feasibility for case management and social workers to use the Unite Us software solution for making referrals for uninsured/underinsured patients for community services that also includes childcare services for single parents in need. The use of the Unite Us software in addition to our internal electronic medical record (EMR) to document each patient was identified as a barrier because it requires duplicate data entry, more work and time to process each discharge. There was also a perceived lack of timely responses from external agencies/organizations when referring patients. The established efficiency benchmark for this process has been phone referrals for live discussion and placement with receiving service providers.

Pursuing this further, we discovered:

- Unite Us has developed an EMR integration engine for other Adventist Health hospitals and it is fully functioning and integrated into their workflows. This allows the Unite Us program to run seamlessly with the Adventist Health EMR, utilizing a single set of patient information.
- The AHLM Care Management team confirmed that an integration engine is essential for adoption by their team and attempting a pilot.
- AHLM's EMR build is identical to other Adventist Health systems integrated with Unite Us so this solution was made available with no additional cost.
- The Unite Us referral system was successfully integrated in 2023 at AHLM.
- AHLM Care Management team continue to evaluate the enhanced functionality and develop streamlined workflows.
- The need to engage with San Joaquin United Way and Unite Us in adding community resources into the referral system as part of the Connected Community Network (CCN)

The social work team has also been partnering with Community Medical Centers to improve our patient follow up process, as they see many of our Medi-Cal/unfunded patients. We are working directly with their Unite Us referral coordinator to assist our patients who need follow up with a social worker or assistance with Medi-Cal enrollment.

**UNITE US FEASIBILITY AT DAMERON**

The Unite Us EMR integration solution was not feasible at Dameron Hospital because it relies on an entirely different EMR system and the timeframe for migration to the Adventist Health standard IT platform has not been determined. Once the EMR conversion occurs, implementation of the Unite Us solution will be pursued. This will build upon the progress made by the AHLM Care Management team and result in a faster and smoother transition.

*Background:*

*The CCN is built around a network of community partners working together to coordinate communication and implement processes to provide referrals and track outcomes for vulnerable populations. A key element of the CCN is Unite Us, a technology solution which streamlines the coordination of care in the community by electronically linking health care providers to organizations that provide direct services to their communities. A Community Advisory Group was also established that meets regularly to review utilization, discuss challenges, and decide how best to improve processes. CCN is essentially a social determinants of health referral system within our county. This platform can help connect our patients with mental health services, housing, food, and employment, which helps to address our top three community health needs.*

**ADDRESSING HIGH PRIORITY: Mental Health**

| GOAL | Collaborate with community partners in addressing workplace related stress as well as mental health concerns that employees may have in the workplace. |
|---|---|

| Strategy: |
|---|
| **Action:**<br>Program/Activity/Tactic/Policy |
| • Conduct semi-annual community workplace symposia addressing burnout prevention and available resources with a goal of creating a healthy workforce and sustainable productivity. |

| FY 2023 YEAR ONE |
|---|
| Co-create employer workshops and symposia with AHA.<br><br>Identify subject matter experts at Dameron.<br><br>Identify most effective venue: Virtual, in-person or hybrid.<br><br>Implement Program Evaluation processes and tools. |

**COMMUNITY IMPACT SUMMARY/ALL STRATEGIES:**

**COLLABORATE WITH COMMUNITY PARTNERS IN ADDRESSING WORKPLACE RELATED STRESS AS WELL AS EMPLOYEE MENTAL HEALTH CONCERNS AT WORK.**

- Utilize existing Adventist Health partnership with the American Heart Association to co-present educational outreach to the San Joaquin County workforce via their employers.
- Incentive for employer participation by helping them maintain a healthy, productive workforce.
- Completed first webinar, “Happy Half Hour” on Zoom, featuring medical experts providing tips and information on practicing healthy habits that helps maintain physical and mental well-being. We reached more than 18 employer organizations and 1000+ employees.
- Conducted an employer onsite learning seminar on substance abuse that reached more than 1000 employees.

**SAN JOAQUIN COUNTY CHIP COMMITTEE PROJECT 2023**

- The San Joaquin County Community Health Improvement Plan (CHIP) committee is a collaborative among all local health care organizations that participate in a joint triennial community health needs assessment to inform their respective community health improvement plan.
- This group is collaborating on a community improvement project within the county, targeting public park enhancement to support community usage, family and physical activity as ways to support physical and mental well-being.
- Several meetings have been held with the full group and a core team to discuss the process for park selection. The San Joaquin Public Health Services Department, is assisting with facilitating this collaborative effort. Public land trust consultants are assisting in the selection process, data analysis and proposal process.
- Once selection is made (in conjunction with the local municipality, e.g., City of Stockton, etc.) then partners will be participating in the improvement project by providing fiscal support, volunteers, in-kind services, etc.

**SAN JOAQUIN COUNTY COMMUNITY HEALTH LEADERSHIP COUNCIL - YOUTH WELLNESS ALLIANCE PROJECT 2023**

- The San Joaquin County Community Health Leadership Council, comprised of executive leadership from health care, government agencies and community organizations, is collaborating on efforts to address youth mental health needs in our county. The stated mission: Bringing together leaders across education, healthcare, and community organizations in San Joaquin County to improve accessibility to and utilization of safe and effective resources that promote youth wellness and resilience.
- An ongoing series of meetings are being held to identify existing mental health resources and resource gaps, that may reveal duplicative services or support taking a more holistic approach (e.g., educational setting youth intervention may reduce demand on Corrections System interventions).
- One objective is to implement a school-based pilot program over the next 18 months (CA Children and Youth Behavioral Health Initiative*). SJCOE has received a grant that is driving the implementation timeline.
- Goal is to measure effectiveness and tailor for expansion/replication. Listening sessions with youth and community members will influence the design.
- Once the projects/efforts are selected, all participating member organizations will develop effective ways to support the improvement of youth behavioral health well-being.
- The vision for the Alliance: A community in which all young people achieve physical, mental and social wellness.
-

**MENTAL HEALTH/BEHAVIORAL HEALTH INCLUDING SUBSTANCE USE**

Dameron Hospital has continued to utilize the funds from the Behavioral Health Pilot Project (BHPP) to support a Substance Use Navigator (SUN) in the emergency department (ED). In 2023, the SUN at Dameron Hospital provided services to 339 patients in emergency department/ inpatient care between February and December. Out of the 192 patients that accepted referral, 61 of them were for Medicated Assisted Treatment (MAT) treatment for opiates and alcohol with scheduled appointments as the patients were discharged from the emergency department or inpatient hospital setting. Out of the 61 patients, 29 attended their MAT Program scheduled appointments.

In 2023, a total of 49 Buprenorphine prescriptions were administered or written in the ED or inpatient settings. A total of 65 patients received a drug overdose diagnosis. Also, 106 patients were diagnosed with Opiate Use Disorder. Additionally, our SUN coordinated the direct transfer of at least six patients directly from the hospital inpatient setting to community residential treatment programs for a seamless course of care for their conditions.

The BHPP initiative was an important step toward reducing the severity of behavioral health issues impacting San Joaquin County, with a focus on substance use disorders (SUD) and specifically opioid use disorders (OUD). Dameron's 2022 Community Health Needs Assessment identified mental health disorders and SUD as priority health issues affecting all populations, which are also linked to higher levels of poverty, homelessness, and community violence

Deaths by suicide, drug overdose and alcohol poisoning per 100,000 residents are significantly higher in San Joaquin County (43) when compared to the state (34). Additionally, 69% of our interviewees and focus group participants identified mental health as a top priority in San Joaquin County. Specific outcomes to be achieved under this pilot project will include: decreasing deaths from opioid-related overdoses, combat stigma surrounding opioid and other substance use disorders, and to improve the quality of care provided to patients with SUD/OUD.

The SUN's role is to evaluate and assess individuals in the emergency department (ED) who may have a substance use disorder. The SUN establishes a referral network within the community with the different available resources for persons with substance use disorder, including outpatient medication-assisted treatment (MAT), residential care, housing/shelter needs, etc. The SUN then works closely with ED staff to support the comprehensive care of individuals with substance use disorders, including working with ED providers, nurses, case managers, social workers, and others. Through counseling and discussion with the individual and evaluation of their health insurance status, the SUN determines what outpatient treatment option will work best for each individual's specific needs. If the individual is on buprenorphine in the Emergency Department, the SUN will work with the ED provider to assure that the patient has a prescription for a sufficient amount of buprenorphine to last until their outpatient treatment clinic appointment.

# Significant Identified Health Needs

The Adventist Health Community Well-Being team and community partners collectively reviewed all relevant significant health needs identified through the CHNA process. Health needs are defined as including requisites for the improvement or maintenance of health status both in the community at large and parts of the community (such as specific neighborhoods or populations experiencing health disparities). Requisites may include addressing financial and other barriers to care as well as preventing illness, ensuring adequate nutrition, or addressing social, behavioral, and environmental factors that influence health in the community. Health needs were identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

**THE FOLLOWING CRITERIA WERE USED:**

- It fits the definition of a "health need" as described above.
- It was confirmed by multiple data sources (i.e., identified in both secondary and primary data).
- Indicator(s) related to the health need performed statistically significantly worse than the state average.
- It was chosen as a community priority. Prioritization was informed by the frequency with which key informants and focus groups mentioned the need. The final list included only those that informants and focus groups identified as a need.

Highest Priority needs are the focus of the Community Health Implementation Strategy and this accompanying Community Health Plan Update, FY 2023.

**NINE HEALTH NEEDS MET THE ABOVE CRITERIA:**

**HIGHEST PRIORITY**

- Mental Health/Behavioral Health Including Substance Use
- Access to Care
- Income and Employment/Financial Stability

**MEDIUM PRIORITY**

- Housing
- Chronic Disease/Healthy Eating, Active Living (HEAL)
- Community Safety

**LOWER PRIORITY**

- Family and Social Support
- Education
- Transportation

Medium and Lower priority needs will not be addressed directly by Dameron Hospital due to limited resources, expertise and feasibility of viable interventions but will likely benefit from the collective efforts defined in this report.

# Community Health Financial Assistance for Medically Necessary Care Commitment

Dameron Hospital understands that community members may experience barriers in paying for the care they need. That is why we are committed to providing financial assistance to those who may need support in paying their medical expense(s).

Community members can find out if they qualify for financial aid in paying medical bills by completing a financial assistance application. Applications can be filled out at the time care is received or after the bill has been administered. To access the financial assistance policy for more information, please visit: Financial Assistance | Dameron Hospital

Dameron Hospital
525 W. Acacia Street
Stockton, CA 95203
(209) 944-5550
www.dameronhospital.org


Thank you for reviewing our YEAR ONE UPDATE, FY 2023 of the Community Health Implementation Strategy.
We are proud to serve our local community and are committed to making it a healthier place for all.
To provide feedback on this community benefit report or other reports referenced, please email community.benefit@ah.org. You may also request a copy free of charge.

| Dameron Hospital Year 2023 | Community Benefit |
|---|---|
| Traditional Charity Care | $874,360 |
| Unpaid Cost of Medicaid | $33,005,931 |
| Unpaid Cost of Medicare | $18,656,564 |
| Community Health Improvement Services | - |
| Health Professions education | - |
| Non-billed and subsidized health services | - |
| Generalizable research | - |
| Cash and in-kind contributions for community benefit | - |
| Community building activities | - |
| **TOTAL COMMUNITY BENEFIT (excluding unpaid Medicare)** | $33,880,290 |
| **TOTAL COMMUNITY BENEFIT (including unpaid Medicare)** | $52,536,854 |

**The economic value of all community benefit is reported at cost. Patient financial assistance (charity care) reported in this report is reported to the California Department of Health Care Access and Information in Hospital Annual Financial Disclosure Reports, as required by Assembly Bill 204. The community benefit of charity care, Medicaid and other means-tested programs and other net community benefits is calculated using a cost accounting methodology. Where applicable, restricted offsetting revenue for a given activity is subtracted from total expenses to determine net benefit in dollars.**