

St. Elizabeth Community Hospital Community Benefit 2023 Report and 2024 Plan

Adopted November 2023



Dignity Health™
St. Elizabeth Community Hospital

A message from

Dear Community Members, Community Partners and Colleagues,

On behalf of St. Elizabeth Community Hospital, we'd like to thank you for your interest in the health of our community as we seek to improve the overall health in Tehama County. Our Mission is to make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all. We are excited to share our Community Benefit 2023 Report and 2024 Plan.

The COVID-19 global pandemic has caused extraordinary challenges for us all. Yet, in some ways this disruption has been a positive force of change and new beginnings. The ongoing pandemic taught us that improving the health of our community requires all of us to come together and bring our expertise, engagement and investment, only by working together in partnership, can we become a healthier, stronger community.

Dignity Health's approach to community health improvement aims to address significant health needs identified in the 2022 Community Health Needs Assessments (CHNA) that we conduct with community input, including from the local public health department. Our initiatives to deliver community benefit 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.

In fiscal year 2023 (FY23), St. Elizabeth Community Hospital provided \$15,732,573 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred \$17,074,436 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2022 Report and 2023 Plan at its November 9, 2023 meeting. We welcome any questions or ideas for collaborating that you may have, by reaching out to Laura Acosta, Community Health Director at 530-225-6114 or by email at laura.acosta900@commonspirit.org.

We look forward to partnering with you to continue building a stronger, more equitable future for all.

Sincerely,

Rodger Page
President/CEO

Riico Dotson
Chairperson, Board of Directors

Table of Contents

At-a-Glance Summary	Page 4
Our Hospital and the Community Served	Page 5
About the Hospital	Page 5
Our Mission	Page 5
Financial Assistance for Medically Necessary Care	Page 5
Description of the Community Served	Page 6
Community Assessment and Significant Needs	Page 8
Community Health Needs Assessment	Page 8
Significant Health Needs	Page 8
2023 Report and 2024 Plan	Page 10
Creating the Community Benefit Plan	Page 10
Community Health Strategic Objectives	Page 11
Report and Plan by Health Need	Page 11
Community Health Improvement Grants Program	Page 15
Program Highlights	Page 15
Other Programs and Non-Quantifiable Benefits	Page 17
Economic Value of Community Benefit	Page 18
Hospital Board and Committee Rosters	Page 19

At-a-Glance Summary

<p>Community Served</p> 	<p>St. Elizabeth Community Hospital (SECH) is located off of California Interstate 5 in Red Bluff, and serves a core service area population of 86,090 residents. Tehama County is a rural county with the residents being spread out over approximately 2,962 square miles. Due to the rural nature of the county, access to care is a consistent barrier for the many medically underserved residents, including those who may be low income and/or minorities. The majority of individuals served reside in Tehama County, however, these services extend to bordering communities in Glenn and Shasta counties. The following zip codes make up the core service area for St. Elizabeth Community Hospital: 95963, 96021, 96022, 96035, 96055, and 96080.</p>
<p>Economic Value of Community Benefit</p> 	<p>\$15,732,573 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits</p> <p>\$17,074,436 in unreimbursed costs of caring for patients covered by Medicare fee-for-service</p>
<p>Significant Community Health Needs Being Addressed</p> 	<p>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). Needs being addressed by strategies and programs are:</p> <ul style="list-style-type: none"> ● Access to Quality Primary Care Health Services ● Access to Specialty and Extended Care ● Safe and Violence Free Environment ● Access to Mental/Behavioral Health and Substance-Use Services
<p>FY23 Programs and Services</p> 	<p>St. Elizabeth Community Hospital delivered several programs and services to help address identified significant community health need. These included:</p> <ul style="list-style-type: none"> ● Medication for Indigent Patients ● Provide community grants to local non-profit organizations ● Transportation Services ● Community benefit investment
<p>FY24 Planned Programs and Services</p> 	<p>For FY24, St. Elizabeth Community Hospital plans to build upon many of the FY23 initiatives, explore new partnership opportunities with Tehama County community organizations, and intends to take actions and to dedicate resources to address these needs.</p>

This document is publicly available online at <https://www.dignityhealth.org/north-state/locations/stelizabethhospital/about-us/community-benefit>.

Written comments on this report can be submitted to the St. Elizabeth Community Hospital Community Health Office, 2550 Sister Mary Columba Dr., Red Bluff, CA 96080, Attn: Laura Acosta or by e-mail to laura.acosta900@commonspirit.org.

Our Hospital and the Community Served

About St. Elizabeth Community Hospital

St. Elizabeth Community Hospital (SECH) is a member of Dignity Health, which is a part of CommonSpirit Health.

SECH is located in Tehama County, which consists of 2,962 square miles and is approximately midway between Sacramento and the Oregon border and situated along the Interstate 5 corridor. The county is bordered by Glenn County to the south, Trinity and Mendocino counties to the west, Shasta County to the north, and Butte and Plumas counties to the east. The county is situated in the northern portion of the Sacramento Valley and is divided in half by the Sacramento River. The largest city is Red Bluff, both a Micropolitan Statistical Area and the County Seat with a population of just over 14,000 residents. A small portion of southern Shasta County is covered by the hospital's service area and includes the community of Cottonwood. Service area is defined by six ZIP codes. These included 96021, 96022, 96035, 96055, 96080, and 96090. The total population of the service area was 69,385.

Our Mission

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Our Vision

A healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

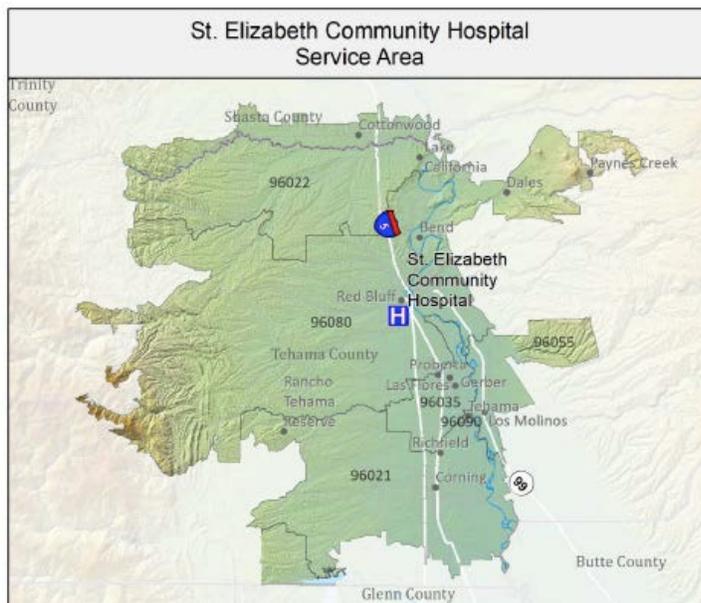
Financial Assistance for Medically Necessary Care

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay. This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

Description of the Community Served

St. Elizabeth Community Hospital serves service area includes large portions of Tehama County and a smaller portion of southern Shasta County. Both counties are located in Northern California, situated along the Interstate 5 corridor. Tehama County is a rural county with the residents being spread out over approximately 2,950 square miles. Due to the rural nature of the county, access to care is a consistent barrier for the medically underserved residents who experience low-income status and may be in a minority population of 69,385 residents.

Tehama County is situated in the northern portion of the Sacramento Valley and is divided in half by the Sacramento River. Red Bluff, the county seat, was established in 1856 and is located on the Interstate 5 corridor. While the majority of individuals served reside in Tehama County there are community health services available to bordering communities located in Glenn and Butte counties.



Population Groups Experiencing Disparities

Key informants were asked to identify population groups that experienced health disparities in the SECH service area. Interview participants were asked, “What specific groups of community members experience health issues the most?” Responses were analyzed by identifying all groups noted as one experiencing disparities. Groups identified by key informants are listed below. The groups are not mutually exclusive—one group could be a subset of another group. One of the purposes of identifying the sub-populations was to help guide additional qualitative data collection efforts to focus on the needs of these population groups. Additional details can be found in the CHNA report online.

- Low income
- Senior
- Disabled
- Hispanic
- Homeless
- Migrant farm workers
- Native Americans
- Severely mentally ill
- Those without internet
- Undocumented
- Caucasians

Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its 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, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospital’s community benefit plan and programs were identified in the most recent CHNA report, which was adopted in April 2022.

This document also reports on programs delivered during fiscal year 2023 that were responsive to needs prioritized in the hospital’s previous CHNA report.

The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at <https://www.dignityhealth.org/north-state/locations/stelizabethhospital/about-us/community-benefit> or upon request at the hospital’s Community Health office.

Significant Health Needs

The CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors and health care services, and also health-related social needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Access to Quality Primary Care Health Services	Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and other similar resources. Primary care services are typically the first point of contact when an individual seeks healthcare. These services are the front line in the prevention and treatment of common diseases and injuries in a community.	●
Access to Specialty and Extended Care	Extended care services, which include specialty care, are care provided in a particular branch of medicine and focused on the treatment of a particular disease. Primary and specialty	●

Significant Health Need	Description	Intend to Address?
	care go hand in hand, and without access to specialists, such as endocrinologists, cardiologists, and gastroenterologists, community residents are often left to manage the progression of chronic diseases, including diabetes and high blood pressure, on their own.	
Access to Functional Needs (Transportation)	Having access to transportation services to support individual mobility is a necessity of daily life. Without transportation, individuals struggle to meet their basic needs, including those needs that promote and support a healthy life.	
Access to Mental/Behavioral Health and Substance-Use Services	Access to mental, behavioral, and substance-use services is an essential ingredient for a healthy community where residents can obtain additional support when needed.	●
Access to Basic Needs Such as Housing, Jobs, and Food	Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, have a substantial impact on health behaviors and health outcomes. Addressing access to basic needs will improve health in the communities we serve.	
Increased Community Connections	Community connection is a crucial part of living a healthy life. Research suggests individuals who feel a sense of security, belonging, and trust in their community have better health. Assuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a healthy community. Furthermore, healthcare and community support services are more effective when they are delivered in a coordinated fashion to build a coordinated ecosystem.	
Safe and Violence-Free Environment (North State Market approach)	Feeling safe in one’s home and community is fundamental to overall health. Next to having basic needs met (e.g., food, shelter, and clothing) is having physical safety. Research has demonstrated that individuals exposed to violence in their homes, the community, and schools are more likely to experience depression and anxiety and demonstrate more aggressive, violent behavior.	●

Significant Needs the Hospital Does Not Intend to Address

St. Elizabeth Community Hospital met with internal and community members to review and determine the top priorities the hospital would address. SECH will continue to lean into the organizations who are addressing the needs and continue to build capacity by strengthening partnerships among local community-based organizations. Due to the magnitude of the need and the capacity of SECH’s to address the need the Implementation Strategy will not address Access to Functional Needs (Transportation), Access to Basic Needs Such as Housing, Jobs, and Food, and Increased Community Connections.

2023 Report and 2024 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 FY23 and planned activities for FY24, with statements on impacts and community collaboration. Program Highlights provide additional detail on select programs.

Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Creating the Community Benefit Plan

St. Elizabeth Community Hospital is dedicated to improving community health and delivering community benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

SECH leaders met with internal and community members to review and determine the top priorities the hospital would address over the next three years.



To aid in determining the priority health needs, the criteria below was used to consider when making a decision.

- Mission alignment
- Magnitude of the problem
- Severity of the problem
- Health disparities: The health need disproportionately impacts the health status of one or more vulnerable population groups.
- Need among vulnerable population
- Community's capacity and willingness to act on the issue
- Availability of hospital and community resources
- Ability to have measurable impact on the issue
- Existing Infrastructure: There are programs, systems, staff and support resources in place to address the issue.
- Established Relationships: There are established relationships with community partners to address the issue.
- Ongoing Investment: Existing resources are committed to the issue. Staff time and financial resources for this issue are counted as part of our community benefit effort.

Improving community health requires collaboration across community stakeholders and with community engagement. Each initiative involves research on best practice and is written to align with local resources, state or national health priorities and initiatives. The goals, objectives, and strategies contained in this document, where possible, intend to utilize upstream prevention models to address the social determinants of health. In addition, building and strengthening relationships with community-based providers that serve target populations for intended initiatives is critical to the success and sustainability to achieve impact.



Community Health Strategic Objectives

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources and engagement of participants both inside and outside of the health care delivery system.

CommonSpirit Health has established four core strategic objectives for community health improvement activities. These objectives help to ensure that our program activities overall address strategic aims while meeting locally-identified needs.



Create robust alignment with multiple departments and programmatic integration with relevant strategic initiatives to optimize system resources for advancing community health.



Scale initiatives that complement conventional care to be proactive and community-centered, and strengthen the connection between clinical care and social health.



Work with community members and agency partners to strengthen the capacity and resiliency of local ecosystems of health, public health, and social services.



Partner, invest in and catalyze the expansion of evidence-based programs and innovative solutions that improve community health and well-being.

Report and Plan by Health Need

The tables below present strategies and program activities the hospital has delivered or intends to deliver to help address significant health needs identified in the community health needs assessment.

They are organized by health need and include statements of strategy and program impact, and any collaboration with other organizations in our community.

 Health Need: Access to Quality Primary Care Health Services and Specialty and Extended Care			
Strategy or Program	Summary Description	Active FY23	Planned FY24
Provide services for vulnerable populations	Financial Assistance for uninsured/underinsured and low-income residents. Rural Health Clinics offering sliding fee scale for patients who do not qualify for insurance.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Increase Access to Care	Physician recruitment efforts. Rural Health Clinics eligible for federal and state student loan repayment programs for clinicians. Offer convenient appointments on the weekend acute care walk in or drive through clinic appointments. When appropriate, offer video and telephone visits to those who's health may limit their ability to drive to their appointment.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Community Support	Develop partnerships with Rolling Hills Clinic, Federally Qualified Indian Health Clinic; Greenville Rancheria; Tehama County Public Health; Tehama County Dental Health Program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Health Education Outreach	LIFT (Poor and the Homeless Health Fair); Latino Multicultural Health Fair; Greenville Rancheria Wellness Fair; Senior Health Fair; Corning Olive Festival; Bi National Health Fairs participation offering nutrition services consultation, blood pressure screenings, and high school sports physicals for all area high schools are offered supported by the clinics and hospital staff when appropriate.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Provide/facilitate funding and in-kind support for access to care to local community agencies	Funding directed towards access to health care programs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
CHW/Promotora Navigator (Proposed)	SECH will explore opportunities with Visión y Compromiso (VyC) to advance the community health worker/ promotora model. VyC promotes community well-being by supporting promotoras, trusted leaders known by diverse titles (CHW, navigator, advocate, outreach worker).	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Workforce Development	Identify and partner with community organizations who are leading workforce development efforts to increase access to a diverse and inclusive health care	<input type="checkbox"/>	<input checked="" type="checkbox"/>

workforce—both in clinical and nonclinical/corporate settings and improve health equity.

Goal and Impact:

Leverage SECH’s investments as an anchor institution to address Social Determinants of Health (SDOH) needs in our communities to improve access to quality health care services for vulnerable populations by coordinating and improving resources and referrals to services to improve access.

Goal (Anticipated impact)

- Reduce the utilization of Emergency Departments for “avoidable”, non-emergency visits
- Reduce the rates of uninsured people in the community

Collaborators: SECH currently partners with Tehama County Public Health, Lassen Medical Clinic, Solano Street Medical Clinic, Women’s Health Services but will continue to seek out partnerships with local organizations that respond to the health needs of our community. Community-based collaborations continue to be a priority in for the hospital and will continue to drive community benefit efforts.

 **Health Need: Access to Mental/Behavioral Health and Substance-Use Services**

Strategy or Program	Summary Description	Active FY23	Planned FY24
Substance Use Navigation	CA Bridge is a program of the Public Health Institute working to ensure that people with substance use disorder receive 24/7 high-quality care in every California health system by 2025. The CA Bridge Navigator program seeks to fully integrate addiction treatment into standard medical practice—increasing access to treatment to save more lives. Utilizing a Substance Use Navigator to build a trusting relationship with the patient and motivating them to engage in treatment. The hospital works to reduce the language that stigmatizes people who use drugs, treating substance use disorder like any other disease. Program is currently funded through Medication for Addiction Treatment (MAT) program.	☒	☒
Education and Awareness	Provide education and awareness and reduce stigma in the community.	☒	☒
Live Inspired for Tomorrow (LIFT) Tehama	One day event brings together community organizations such as Department of Motor Vehicles, Social Security office, behavioral and substance use services, housing, jobs, medical and dental care, animal services, vision services, and other community organizations to meet the needs of the community.	☒	☒

Goal and Impact:

Goal: Improved system for patient linkages to outpatient behavioral health services; provide a seamless transition of care, reduce mental health stigma and increase in resources in the community.

Anticipated Impact: Ensure equitable access to quality, culturally responsive and linguistically appropriate services.

Collaborators: SECH currently partners with Partnership HealthPlan, Tehama County Health Services Agency Behavioral Health, Solano Street Medical Clinic, Disability Action Center (DAC) but will continue to seek out partnerships with local organizations that respond to the health needs of our community. Community-based collaborations continue to be a priority in for the hospital and will continue to drive community benefit efforts.

 **Health Need: Safe and Violence Free Environment**
Market approach

Strategy or Program	Summary Description	Active FY23	Planned FY24
Mission and Ministry Fund, United Against Violence Planning Grant	Facilitate strategy sessions to develop violence prevention/human trafficking implementation plan encompassing in Shasta County. This plan will build upon and align existing work identified during planned activities.		☒
Provide trauma-informed care for patients	Explore ongoing opportunities to promote Trauma Informed Care practices within the behavioral health service line.	☒	☒
Prevent violence and intervene when it is suspected	Increase health system and community capacity to identify victims of human trafficking and respond appropriately.	☒	☒
Human Trafficking Taskforce	A revitalization of the Human Trafficking Taskforce made up of multidisciplinary leaders with a victim-centered approach on strategies, interventions and policies.	☒	☒
Human Trafficking/Violence Training led by the International Rescue Committee (IRC)	Anti-Trafficking Outreach and Training Specialist from IRC will provide trainings to bring awareness around human trafficking and its various forms and resources available at local and national level. Physicians, Physicians Assistants, Nurse Practitioners, Nurses, Social Workers, Pharmacists, Police, Fire, Hospitality, Government, and other Community Members will be invited.		☒

Goal and Impact:

Goal: Improved system for patient linkages to outpatient behavioral health services; provide a seamless transition of care, reduce mental health stigma and increase in resources in the community.

Anticipated Impact: Ensure equitable access to quality, culturally responsive and linguistically appropriate services.

Collaborators: SECH currently partners with Empower Tehama, Tehama County District Attorney, Health Alliance of Northern California, First 5 Tehama, International Rescue Committee (IRC) but will continue to seek out partnerships with local organizations that respond to the health needs of our community. Community-based collaborations continue to be a priority in for the hospital and will continue to drive community benefit efforts.

Community Health Improvement 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. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations related to CHNA priorities.

In FY23, the hospital awarded the grants below totaling \$70,500. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Family Service Agency of Tehama County – Family Counseling Center	Supporting Latino Mental Health	\$20,500
Poor and the Homeless Tehama County Coalition (PATH)	Transitional Care Program (TCP)	\$50,000

Program Highlights

The following pages describe a sampling of programs and initiatives listed above in additional detail, illustrating the work undertaken to help address significant community health needs.

 Transitional Care Program (TCP)	
Significant Health Needs Addressed	<ul style="list-style-type: none"> ● Access to Quality Primary Care Health Services ● Access to Specialty and Extended Care ● Access to Mental/Behavioral Health and Substance-Use Services
Program Description	TCP program provides short-term transitional housing and coordinated care for homeless adults who are recovering from a non-acute illness or injury and whose condition would be exacerbated by living unsheltered or in a place not suitable for recovery.
Population Served	Homeless male adults recovering from minor illness/injury who have no suitable place for recovery.
Program Goal /	Through effective and meaningful case management, PTC will provide knowledge and resources to PTC clients via community partner referrals to foster

Anticipated Impact	wellbeing and promote self-sufficiency. The program will graduate PTC clients to stable housing or connect them to family stability or offer a vacancy within the Pathways Transitional Housing program for up to two years. PTC will positively impact the community by reducing need for hospital beds for homeless individuals and provide hope and resources to those impacted.
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FY 2023 Report

Activities Summary	PTC performed patient assessments and intakes of referred homeless individuals and immediately began delivering case management services with a six-week emphasis on recovery and rehabilitation. PTC enrolled one hundred percent of referred patients into Coordinated Entry through 2-1-1 and began a housing search and assessment. PTC also provided transportation to and from medical appointments as well as weekly one-on-one case management based on an individualized patient program plan developed with patient input. Finally, PTC provides prepared meals or sufficient food for able patients to prepare their own meals.
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Performance / Impact	PTC reunited several individuals with families living out of state who were able to provide for or assist loved ones to establish financial stability and effective housing. PTC also enrolled most of the referred patients into the Pathways Transitional Housing program immediately following completion of the six-week PTC program. Many of those individuals are either currently enrolled and remain under case management or have moved out of the area. The individuals have benefited by continuing to work on their coordinated program goals and the community has benefited by reducing homelessness and reducing utilization of the emergency room or other hospital services.
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Hospital's Contribution / Program Expense	Community Health Grant support and Patient Navigator/Case Manager support and assistance to coordinate referral, intake, and assessment, and any on-going medical appointments established prior to discharge.
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FY 2024 Plan

Program Goal / Anticipated Impact	PTC will incorporate the PATH Plaza Navigation Center into the program with delivery of three homemade meals daily and expand services from partner agencies by offering a supportive remote information technology infrastructure aimed at bringing services to our clients.
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Planned Activities	The planned activities will remain the same as in previous years with emphasis on increasing quality of service.
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Other Programs and Non-Quantifiable Benefits

The hospital delivers community programs, services, 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. One of the most powerful ways is through partnerships. We recognize that no hospital facility can address all of the health needs present in its community, requires long-term focus and investment from all levels of community stakeholders. This includes:

- Red Bluff Farmers Market
- City of Red Bluff Fire Department to support the purchase of Automatic External Defibrillator (AED) to meet community needs.
- Community benefit investment to support senior and disable needs through the Disability Action Center
- Helen and Joe Chew Foundation – Increase cultural awareness to Chinese culture in Tehama County
- Childbirth preparation classes
- Stroke and trauma prevention and education at various community events, such as the Tehama County Farmers Market.
- Participation at the "Happy Healthy" event to bring awareness and education around water/pool safety in English and Spanish.

St. Elizabeth Community Hospital Administration and members of the hospital's leadership and management teams provide significant in-kind support and expertise to nonprofit health care organizations, civic, and service agencies such as:

- Tehama County Domestic Violence, CSEC
- Tehama County Public Health Advisory Board Meeting
- American Association of Diabetes Educators
- Tehama County Health Care Coalition
- Tehama County Economic Development
- First 5 Tehama Board
- Expect More Tehama
- Active 20-30 Club of Red Bluff
- Tehama County Cattlewomen
- Red Bluff Chamber of Commerce
- Red Bluff Rotary
- Soroptimist International of Red Bluff

In addition, annual sponsorships also support multiple programs, services and fund-raising events of organizations among them; Red Bluff Chamber, Active 20-30 Club of Red Bluff Turkey Trot, Tehama Cottonwood Community Park Inc, and Northern California Child Development Inc.

Economic Value of Community Benefit

153 St. Elizabeth Community Hospital					
Complete Summary - Classified (Programs) Including Non Community Benefit (Medicare)					
For period from 07/01/2022 through 06/30/2023					
	<u>Persons</u>	<u>Expense</u>	<u>Offsetting Revenue</u>	<u>Net Benefit</u>	<u>% of Expenses</u>
Benefits for Poor					
Financial Assistance	7,443	\$3,663,017	\$0	\$3,663,017	2.4%
Medicaid	30,343	\$63,721,917	\$52,138,039	\$11,583,878	7.5%
Community Services					
A - Community Health Improvement Services	79	\$27,687	\$0	\$27,687	0.0%
E - Cash and In-Kind Contributions	13	\$337,152	\$0	\$337,152	0.2%
G - Community Benefit Operations	1	\$36,521	\$0	\$36,521	0.0%
Totals for Community Services	93	\$401,360	\$0	\$401,360	0.3%
Totals for Benefits for Poor	37,879	\$67,786,294	\$52,138,039	\$15,648,255	10.2%
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	280	\$9,079	\$0	\$9,079	0.0%
E - Cash and In-Kind Contributions	150	\$70,441	\$0	\$70,441	0.0%
F - Community Building Activities	233	\$4,798	\$0	\$4,798	0.0%
Totals for Community Services	663	\$84,318	0	\$84,318	0.1%
Totals for Broader Community	663	\$84,318	\$0	\$84,318	0.1%
Totals - Community Benefit	38,542	\$67,870,612	\$52,138,039	\$15,732,573	10.2%
Medicare	22,564	\$45,568,864	\$28,494,428	\$17,074,436	11.1%
Totals Including Medicare	61,106	\$113,439,476	\$80,632,467	\$32,807,009	21.3%

The economic value of all community benefit is reported at cost. Patient financial assistance (charity care) reported here is as reported to the Office of Statewide Health Planning and Development in Hospital Annual Financial Disclosure Reports, as required by Assembly Bill 204. The community benefit of Medicaid and other means-tested programs is calculated using a cost-to-charge ratio to determine costs, minus revenue received for providing that care. Other net community benefit expenses are calculated using a cost accounting methodology. Restricted offsetting revenue for a given activity, where applicable, is subtracted from total expenses to determine net benefit in dollars.

Hospital Board and Committee Rosters

Dignity Health North State Service Area Community Board Members

Riico Dotson, M.D., Chairperson
Karolina DeAugustinis, M.D., Secretary
Amanda Hutchings
Irene DeLao
Keith Cool
Mary Rushka
Mike Davis
Nikita Gill, M.D,
Russ Porterfield
Sister Bridget McCarthy
Sister Sheila Browne

Any communications to Board Members should be made in writing and directed to:

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