Dignity Health™
Mercy Medical Center

Mercy Medical Center

Community Health Implementation Strategy
2015

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EXECUTIVE SUMMARY

Mercy Medical Center (MMC), a Dignity Health member, is a 186 acute care, religious-sponsored, not-for-profit hospital located in the city of Merced, California. The city of Merced is the County seat and is the largest of the six incorporated cities in the county. MMC opened on May 2, 2010 and employs over 1,300 people, making it one of the largest employees in Merced County. MMC has a professional relationship with more than 250 local physicians. Major programs and services include: one licensed acute care facility with a family birthing center, intensive care unit, emergency care and four floors housing, telemetry and medical/surgical nursing units. There are three outpatient facilities, Mercy UC Davis Cancer Center, Mercy Outpatient Center and the Mercy Medical Pavilion. Services at these outpatient centers include home care, physical and cardiac rehabilitation, ambulatory surgery, cancer care, laboratory, imaging and endoscopy. MMC primary service area includes Merced, Atwater, Winton and Planada for a total of 160,215 residents in Merced County. Secondary service areas include Los Banos, Livingston, Dos Palos, Chowchilla, Le Grand and Mariposa totaling 104,122 lives.

The significant community health needs that form the basis of this Implementation Strategy were identified in the hospital's 2015 Community Health Needs Assessment (CHNA), which is publicly available at mercymercedcares.org. Additional detail about identified needs, data collected, community input obtained, and prioritization methods used can be found in the CHNA report. The Implementation Strategy is aligned with the hospital's Community Benefit FY2015 Report and FY2016 Plan, created and adopted following the 2015 Community Health Needs Assessment.

The significant community health needs identified are:

- Access to Health Care Services
- Cancer
- Diabetes
- Infant Health & Family Planning
- Nutrition, Physical Activity and Weight
- Heart Disease & Stroke
- Respiratory Diseases

In FY15, Mercy Medical Center took numerous actions to help address identified needs. These included:

- Chronic Disease Self-Management (English and Spanish)
- Labor of Love & Lactation
- Live Well With Diabetes (English and Spanish)
- Mercy Cancer Center Support
- Mercy Yoga and Zumba Classes
- Mercy Cancer Center Community Programs
- Stroke Support Group
- Bi-National Week Activities
- Diabetes Self-Management Program
- Dignity Health Community Grant Program
- Anti-Human Trafficking Program
- Stroke Support and Education Program

For FY16, the hospital plans to expand the Diabetes Self-Management Program to include Spanish workshops and through the Stroke Support Group offer quarterly educational seminars. The Cancer Center is partnering with the Susan B. Komen Foundation to bring more breast cancer prevention and education to the community. A Human Trafficking Task Force has been formed to educate staff on what to do, should a victim of Human Trafficking be identified in the hospital. MMC is a member of the "Whole Health Partnership", a group of Merced health professionals working for the advancement of integrated behavioral health in Merced County. MMC is in the process of completing a contract with the local ambulance company to provide transportation for non-emergency low income patients, funding for this service will cost the hospital $70,000.

This Implementation Strategy is publicly available at mercymercedcares.org and on the Dignity Health website. The two local newspapers, The County Times and the Merced Sun Star, were issued a public service announcement announcing to the community that the Community Benefit FY2015 Report and FY2016 Plan had become available online. Hospital staff announced to the public at various service clubs that the report was available and gave a brief summary of the report. The Mercy Medical Center Foundation uses the report as a tool in their philanthropic community information packets.

MISSION, VISION AND VALUES

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.

Hello humankindness

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

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

OUR HOSPITAL AND OUR COMMITMENT

Mercy Medical Center (MMC) is a 186-bed acute care, religious-sponsored, not-for-profit hospital located in the city of Merced, California. MMC is a member of Dignity Health, a family of over 60,000 caregivers and staff. On May 2, 2010 MMC moved into a brand new 262,000 square foot facility on Mercy Avenue. MMC has a staff of more than 1,300 and professional relationships with more than 250 local physicians.

Major programs and services include: one licensed acute care facility with a family birthing center, intensive care unit, emergency care and four floors covering telemetry and medical/surgical nursing units. Two outpatient facilities that combined services include outpatient home care, physical and cardiac rehabilitation, ambulatory surgery, wound care, laboratory, imaging and a "Medical Assistance Program" pharmacy. There are three rural health clinics; Family Practice (32% of patients are uninsured), General Medicine Clinic (specialist clinic) and Kids Care (92% of the pediatric patients are on MediCal) that combined see over 4,000 patients a month. The clinics are highlighted in the "Program Digest" section of this report.

In response to identified unmet health-related needs in the community health needs assessment, during FY 2015 MMC focused on increasing access to health care for the broader and underserved disadvantaged members of the surrounding community. Major Community Benefit activities focused on increasing programming, Coalition Building and Health Education for those with disproportionate unmet health-related needs (DUHN).

Rooted in Dignity Health's mission, vision and values, Mercy Medical Center is dedicated to delivering community benefit with the engagement of its management team, Community Board and Community Advisory Committee. The board and committee are composed of community members who provide stewardship and direction for the hospital as a community resource.

The Community Board reviews health initiatives and the health needs of the medically under-served and the multicultural populations of Merced County. They provide assistance to administration in developing the strategic direction of the hospital. The Board participates in the process of establishing priorities, plans and programs for the Healthy Communities Initiatives based on an assessment of community needs and assets and monitors progress toward identified goals. They provide advice and consultation concerning the annual operating and capital budgets for the hospital as part of the budget development process and receive periodic reports from management comparing actual operations to budget.

The Community Advisory Committee (CAC) members assist and advise the community benefit planning process for MMC. The Chair of the committee is a member of MMC's Community Board. The CAC meets quarterly and represents diverse sectors of the community. They interact to raise issues and identify areas for community outreach opportunities. Special meetings may be arranged as needed. This committee oversees the Dignity Health Community Grant program selection process. The CAC is accountable to the Board and reports their activities after each meeting and on an annual basis.

CAC Committee Responsibility

- Support and implement Dignity Health's mission and core values related to health services
- Serve as a resource for MMC by bringing forward information relative to unmet needs of the medically under-served communities in Merced County
- Offer recommendations regarding health services needs of Merced County's medically under-served populations

- Serve as a link between MMC's Board of Directors and the Community Health Benefit planning process, coordinating and overseeing the development of the annual Health Benefit Plan
- Provide leadership for the Dignity Health Community Grant Program

For a roster of Community Board and the Community Advisory Committee members see Attachment A

Mercy Medical Center's community benefit program includes financial assistance provided to those who are unable to pay the cost of their care, unreimbursed costs of Medicaid, subsidized health services that meet a community need, and community health improvement services. Our community benefit also includes monetary grants we provide to not-for-profit organizations that are working together to improve health on significant needs identified in our Community Health Needs Assessment. Many of these programs and initiatives are described in this report.

DESCRIPTION OF THE COMMUNITY SERVED

Mercy Medical Center primary service area is comprised of the communities of Merced, Atwater, Winton and Livingston. There is only one other hospital in the county, Memorial Los Banos, a Sutter Health Affiliate, a 44-bed facility with basic emergency services.

Merced County is located in the heart of the San Joaquin Valley and spans from the coastal ranges to the foothills of Yosemite National Park. The county encompasses 1,934.46 square miles with a population density of 133.74 per square mile. The county is predominantly urban, with 85.7% of the population living in areas designated as urban.

The City of Merced is the County seat and is the largest of the six incorporated cities. County and City municipalities are a major source of employment along with agricultural related industries, retailing, manufacturing, food processing and tourism.

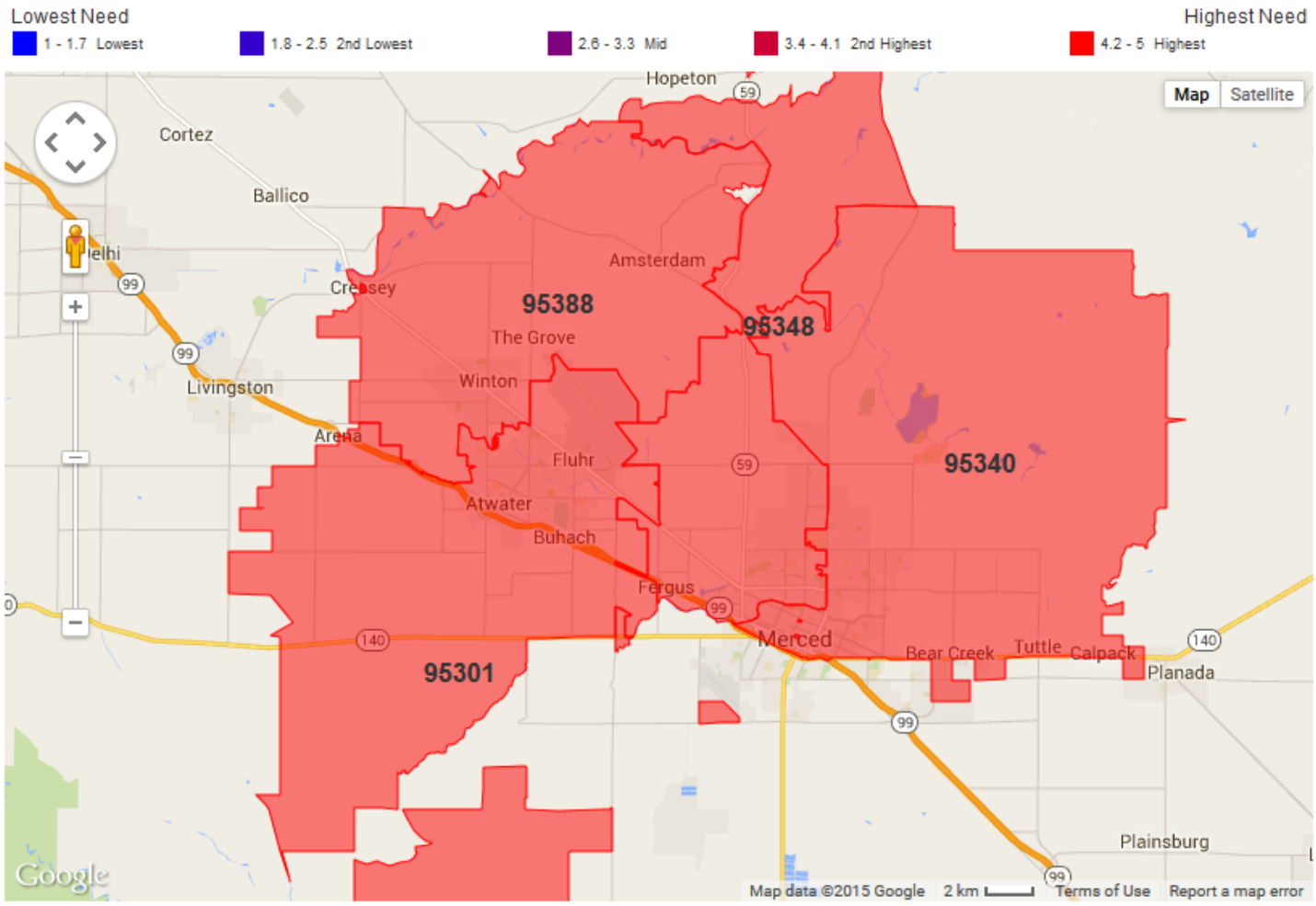
Merced County has been identified as 49th poverty stricken counties in California. Data gathering and reporting has shown poverty to be a chronic and pervasive reality affecting all aspects of healthy living. Merced County's poverty rate is significantly higher for persons under the age of 18. It is important to understand the age distribution of the population as different age groups have unique health needs which should be considered separately from other along the age spectrum. In Merced County, 31.0% of the population is infants, children, or adolescents (age 0-17); another 59.3% are age 18 – 64, while 9.7% are age 65 and older. The median age is "younger" than the state and the nation.

Merced County is designated as a ***medically underserved area***. This designation is based on an index of four variables – the ratio of primary care physicians per 1,000 populations, the infant mortality rate, the percent of the population with incomes below the poverty level and the percent of the population age 65 and over.

Population/Race/Ethnicity –

- Total Population: Merced County 258,707 – Primary Service Area population 160,215
- Diversity: Hispanic 48.2%, Caucasian 34.6%, Asian 9.40%, African American 4.4%, American Indian/Alaska Native 0.5%, 2+ Races 2.7%, Other 0.2%
- Median Income: $48,470
- Unemployment: 9.9%
- Uninsured: 12.0%
- No high school diploma: 26.0%
- CNI Score: 4.8
- Medicaid Patients: 38.4%
- Other Area Hospitals: In Merced County - Sutter Memorial Hospital, Los Banos

Source of demographic indicators: 2010 U.S. Census, 2015 The Nielsen Company, 2015 Truven Health Analytics Inc.



Mean(zipcode): 4.7 / Mean(person): 4.6 CNI Score Median: 4.7 CNI Score Mode: None

Zip Code	CNI Score	Population	City	County	State
95301	4.6	39310	Atwater	Merced	California
95340	4.4	35905	Merced	Merced	California
95348	4.8	32741	Merced	Merced	California
95388	5	13351	Winton	Merced	California

COMMUNITY BENEFIT 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 engaging the Community Advisory Committee and other stakeholders in the development and annual updating of the community benefit plan.

A. Community Health Needs Assessment Process

This assessment was conducted on behalf of Mercy Medical Center by Professional Research Consultants, Inc. completed report was published in the month of August 2015. It is a follow-up to a similar study conducted in 2012; it is systematic, data-driven approach to determining the health status, behaviors and needs of the residents in Merced County. A precise and carefully executed methodology is critical in asserting the validity of the results gathered. To ensure the best representation of the population surveyed, a telephone interview methodology – one that incorporates both landline and cell phone interviews was employed. The primary advantages of telephone interviewing are timeliness, efficiency and random-selection capabilities. There were 400 random surveys completed with individuals 18 and older in Merced County. PRC's preferred practice is to "weight" the raw data to improve the representativeness even further. This is accomplished by adjusting the results to match the geographic distribution and demographic characteristics of the population surveyed.

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of the process. Online surveys were sent to 12 community/business leaders, 119 physicians, 98 public health representatives, 15 social services providers and 5 other health providers; reminder emails were sent as needed to increase participation. In all, 73 community stakeholders took part in the Online Key Informant Survey. On pages 11 – 12 of the CHNA report is a list of the final representatives, their organizations and further description of the process.

A variety of existing data sources was consulted to complement the research quality of this assessment. A complete list of sources is included in the CHNA.

The final CHNA report can be found on the hospital website, mercymercedcares.org and the Dignity Health website. Community members were informed by two local newspapers that if they would like a copy sent to them, either electronically or hard copy, they are to make their request to the hospital's Community Benefit office by calling 209-564-5007.

While the assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. In terms of content, the assessment is designed to provide a comprehensive and broad picture of the health of the overall community.

B. CHNA Significant Health Needs

Prior survey results and historical data for secondary data indicators are also included for the purposes of trending. Statewide risk factor data was provided where available as an additional benchmark which to compare local survey findings; this data was reported in the most recent Behavioral Risk Factor Surveillance System prevalence and trend data published by Centers for Disease Control and Prevention and the US

Department of Health & Human Services. National risk factor data also provided in comparison charts was taken from 2013 PRC National Health Survey. Healthy People 2020 provided science-based, 10 year objectives for improving the health of all Americans.

The following "areas of opportunity" represent the significant health needs of the community, based on the information gathered through the CHNA and the guidelines set forth in Healthy People 2010.

Significant Health Needs Identified:

- **Access to Healthcare Services;** Insurance instability, barriers to access, primary care physician ratio.
- **Cancer;** Cancer deaths, Cancer incidence including lung and cervical, female breast cancer and colorectal cancer screening
- **Dementia, Including Alzheimer's deaths**
- **Diabetes**; diabetes ranked #2 as a major problem in the Online Key Informant Survey
- **Heart Disease & Stroke;** ranked #5 as a major problem in the Online key Informant Survey
- **Immunization & Infectious Diseases;** Hepatitis B vaccination
- **Infant Health & Family Planning;** prenatal care, teen births
- **Injury & Violence;** motor vehicle crash deaths, firearm-related deaths, homicide deaths and violent crime rate
- **Mental Health;** symptoms of chronic depression, suicide deaths, seeking help for mental health, ranked #1 as a major problem in the Online Key Informant Survey
- **Nutrition, Physical Activity and Weight;** low healthy food access, overweight & obesity adult and children, moderate physical activity, access to recreation/fitness facilities, ranked #3 as a major problem in the Online Key Informant Survey
- **Potentially Disabling Conditions;** sciatica/back pain, blindness/vision trouble
- **Respiratory Diseases;** CLRD, COPD
- **Substance Abuse;** cirrhosis/liver disease deaths, drug-induced deaths, seeking help for alcohol/drug issues, ranked #4 as a major problem in the Online Key Informant Survey

Health education was selected as a priority to address prevention of disease, to empower community members to assume responsibility for their health and to educate people about various medical conditions and the ability they have to make wise choices.

MMC is addressing, as indicated in the "Digest Progress" section of this report, the following identified "areas of opportunity": access to health services; cancer; diabetes; heart disease & stroke; immunization & infectious diseases; infant health; mental health; respiratory diseases; nutrition, physical activity and weight.

Areas of opportunity that are identified but not being addressed by MMC are: family planning, dementia including Alzheimer's death; injury and violence; potentially disabling conditions and substance abuse. Services for these health priorities are being provided in the community by other entities and MMC does not have expertise in these areas.

C. Community Benefit Plan Development Process

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

- **Disproportionate Unmet Health-Related Needs**: Seek to address the needs of communities with disproportionate unmet health-related needs.
- **Primary Prevention**: Address the underlying causes of persistent health problems through health promotion, disease prevention, and health protection.
- **Seamless Continuum of Care**: Emphasize evidence-based approaches by establishing operational linkages between clinical services and community health improvement activities.
- **Community Capacity**: Target charitable resources to mobilize and build the capacity of existing community assets.
- **Collaborative Governance**: Engage diverse community stakeholders in the selection, design, implementation, and evaluation of program activities.

Mercy Medical Center's community health programs reflect our commitment to improve the quality of life in the community we serve. The Community Advisory Committee (CAC), Community Board, Mercy Administration along with key management staff provides oversight and policy guidance for all charitable services and activities supported by the hospital. The people on these committees and boards represent a health professionals as well as community residents. This group reviews the CHNA to determine that MMC's community health programs are addressing identified needs. The CAC members meets on a quarterly basis and the Community Board meets monthly. Identified needs are also reviewed by the Mercy Foundation to determine their philanthropic strategies.

A roster of members in the CAC and Community Board is attached in Appendix A.

MMC is committed to the Dignity Health's annual community grant program which supports the continuum of care in the community offered by other not-for-profit organizations. In FY15 MMC awarded $112,674 in community grants. These not-for-profit organizations addressed one or more of the "areas of opportunity" identified in the 2015 CHNA. Health priorities being addressed are: access to health services; infant health; mental health; nutrition, physical activity and weight; and substance abuse.

D. Planning for the Uninsured/Underinsured Patient Population

The hospital offers patient financial assistance based on the Dignity Health Financial Assistance Policy, a summary of which is in the Appendix. This financial assistance information is given to our patients by the Financial Counselors who visit the patients before discharge. The Financial Counselors work with patients to assess whether they are eligible for government sponsored health programs. If the patient is eligible, the Financial Counselor will assist the patient with completing the application process. The policy and application is also available on the Mercy Medical Center website (mercymercedcares.org).

There are signs throughout the registration departments referring patients to the payment assistance programs. Brochures describing the program are distributed through the registration department. Information is also included in the patient admission packet.

The Dignity Health "Admitting Leadership" team in Sacramento has provided training as it related to the Affordable Care Act (ACA) and Covered California. MMC management is now responsible to train MMC staff on how to inform and direct patients to enroll in the Health Exchange plans.

2015 REPORT AND 2016 IMPLEMENTATION STRATEGY

This section presents programs and initiatives the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It includes both a report on activities for FY15 and planned programs with measurable objectives for FY16.

SUMMARY

Below are community benefit and community health programs and initiatives operated or substantially supported by the hospital FY15, and those planned to be delivered in FY16. Programs that the hospital plans to deliver in 2016 are denoted by *.

Poor Access to Primary and Preventive Care

- 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.*
- Family Practice Center, Kids Care and General Medicine Clinic – these are rural health care outpatient clinics providing primary health care, prenatal/infant and pediatric care and specialty physicians.*
- Emergency Department Physician Services for Indigent Patients*
- Community Grant Program - Hope Respite Care*
- Community Grant Program – Alpha Crisis Pregnancy Program
- Merced County Whole Health Partnership*

High Prevalence of and Disparities in Chronic Health Conditions

- Conversion of Mercy Medical Center, and Mercy Outpatient Center to a "Tobacco Free Campus" *
- Chronic Disease Self-Management Program*
- Diabetes Self-Management Program*
- Labor of Love*
- Mercy Yoga and Zumba Classes*
- Stroke Support Group and Education*
- Bi-National Week Health Activities*
- Mercy Cancer Center Community Programs*
- Stroke Support and Education*

Anticipated Impact

The anticipated impacts of specific program initiatives, including goals and objectives, 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 care; and help create conditions that support good health. The hospital is committed to monitoring key initiatives to assess and improve impact. The Mercy Medical Center Community Benefit/Health Committee, hospital executive leadership, Community Board, and Dignity Health receive and review program updates. In addition, the hospital evaluates impact and sets priorities for its community benefit program by conducting Community Health Needs Assessments every three years.

Planned Collaboration

MMC has engaged community-based partners representing the spectrum of agencies providing services vital to Merced County residents include: Merced Rescue Mission, Merced County Department of Public Health, Merced County Department of Mental Health, Central California Alliance for Health, Golden Valley Health Clinics and the Livingston Community Health Center.

This community benefit plan specifies significant community health needs that the hospital plans to address in whole or in part, in ways consistent with its mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in other community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

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.

PROGRAM DIGESTS

Mercy UC Davis Cancer Center Community Program	
Significant Health Needs Addressed	❑ Maternal/Infant Health ❑ Diabetes ❑ Mental Health ❑ Nutrition, Physical Activity and Weight X Cancer
Program Emphasis	X Disproportionate Unmet Health-Related Needs ❑ Primary Prevention X Seamless Continuum of Care ❑ Build Community Capacity ❑ Collaborative Governance
Program Description	The community programs offered at the Mercy UC Davis Cancer Center are funded through the Mercy Foundation as well as through the cancer center itself. The hospital provides a team of staff from all disciplines to help coordinate, facilitate and raise awareness of the program for patients as well as the community at large. The program provides to the community information, education, location and staffing.
Planned Collaboration	Collaboration with this program occurs within our internal resources to include the physicians, nursing staff, radiation therapists, case management, social workers, marketing, community education and outreach. In addition there is collaboration with the other cancer centers in our community for cancer awareness events, seminars and programs
Community Benefit Category	A1-d Community Health Education
FY 2015 Report	
Program Goal / Anticipated Impact	Address the need in the community for supportive programs, education and resources with regards to cancer patients. Create a support group that is lacking and much needed in our service area. Increase access to support, education, and resources for both cancer patients and their family/caregivers.
Measurable Objective(s) with Indicator(s)	Track the number of attendees in our program including the new massage therapy program as part of the cancer support group. Continue to provide opportunity for feedback from patients and the community on needed resources and programs. Keep track of new Cancer Center Drive as a resource for patients with daily radiation therapy needing to be transported from outlying service areas.
Baseline / Needs Summary	Cancer, as identified in the most recent CHNA is a leading health concern and need in our service area. In addition, there are no other cancer centers in our community that offers educational and supportive services to all in need.
Intervention Actions for Achieving Goal	Offer a community support group for those battling cancer, caregivers, family and friends and survivors. In addition, collaborating with groups such as the ACS and the LLS to bring more services and resources to our community. Partner with local physicians to increase the awareness of these programs and to increase access to those that are most in need rather than having to travel to Stanford or Fresno etc.
Program Performance / Outcome	Allowed for patients and community members increased access to resources and services they need in the midst of their care and foster more positive outcomes.
Hospital's Contribution / Program Expense	The hospital contributed funding as well as Mercy Foundation in the amount $9,254.00.
FY 2016 Plan	
Program Goal / Anticipated Impact	Continue to provide the community with supportive services that address emotional, spiritual, and care related needs to help address the patients, caregivers and family and friends. Enhance existing partnerships and seek new partners to combine resources and create a more impactful program and positive outcomes.
Measurable Objective(s)	Track and collect date and information of number of encounters/sessions and attendance.

with Indicator(s)	Collect data on the newly implemented programs and those that will be implemented later this fiscal year.
Baseline / Needs Summary	This program will continue to be offered and grow to address the needs identified in our latest CHNA that found cancer as the second leading cause of death in Merced County. The age-adjusted death rate for cancer in Merced County is 163.3 per 100,000 which is above the state rate of 149.9.
Intervention Actions for Achieving Goal	Enhance and strengthen relationships with ACS, LLS and other community based organizations addressing cancer in our community. Implement new wig bank program in the cancer center for patients and community members with cancer. Continue and increase participation in Look Good Feel Better program at the cancer center New partnership with Susan G. Komen Circle of Hope California and bring preventive screenings and education to the broader community Increase attendance of cancer support group by 15% by increasing access and awareness.

Live Well With Diabetes	
Significant Health Needs Addressed	❑ Maternal/Infant Health X Diabetes ❑ Mental Health ❑ Nutrition, Physical Activity and Weight ❑ Cancer
Program Emphasis	X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care ❑ Build Community Capacity ❑ Collaborative Governance
Program Description	This is a weekly program that teaches strategies for understanding, managing and living with diabetes. It's a multi-purpose support program that features medical professional guest speakers, interactive educational experiences and develops personal actions plans. Program is offered in English and Spanish.
Planned Collaboration	The Living Well With Diabetes program collaborates with community partners in recruiting participants such as local physicians and clinics. There is also a process in place for referral from our inpatient to this community program. There is also collaboration with faith based organizations on providing diabetes education off-site, directly in the community
Community Benefit Category	A1 Community Health Services
FY 2015 Report	
Program Goal / Anticipated Impact	To help prevent health complications of diabetes and help diabetes patients to manage their diabetes. To strengthen program by offering more professional speakers in English, Spanish and Hmong. Continue tracking the inpatient diabetic patients with the Meditech link and establish a follow-up for the frequent readmitted diabetic patients.
Measurable Objective(s) with Indicator(s)	Enrollment increased in the "Living with Diabetes" Spanish and English classes. A Hmong Shaman four hour diabetes education class was presented. Increased number of patients being tracked in Meditech and tracked the frequent readmitted diabetic patients. Expanded community awareness by having a community diabetes educator moved to the "Center for Diabetes".
Baseline / Needs Summary	There are no other ongoing community (free of charge) educational diabetes classes in Merced County that offer English, Hmong and Spanish instructions. Between 2006 and 2008 there was an

	annual average age-adjusted diabetes mortality rate of 25.8 deaths per 100,000 populations Merced County. This is less favorable than that found statewide and that of the national rate. 25.8 also fail to satisfy the Healthy People 2020 target of 19.6 or lower.
Intervention Actions for Achieving Goal	Diabetic patients were tracked in Meditech and referred for enrollment into the program. Current weekly diabetes class will be modeled to be more of a diabetes support group. Community Health Diabetes Education will begin to encompass the "Center for Diabetes" in our General Medicine Clinic. Collaborate with the Mercy rural health clinics to reach more diabetic patients.
Program Performance / Outcome	Enrollment has continued to rise in our Community Health Diabetes Education program through the use of Meditech to identify those patients in need of a referral to the program and multiple admissions due to uncontrolled diabetes and it's complications. We have seen a steady increase of participants in the English program by 55% and the Spanish program by 75%. In addition, we are in the process of adding a service line upon seeking accreditation of our DSME program that will further develop our Community Health Diabetes Education program and create a true community center for all diabetics as well as those at risk of developing diabetes.
Hospital's Contribution / Program Expense	Hospital's contribution was $25,500 for educational materials, supplies and instructors.
FY 2016 Plan	
Program Goal / Anticipated Impact	The Community Health Diabetes Education program plans to expand and offer 5 educational programs to be offered throughout the year in addition to the diabetes support group. Completion of the accreditation process and addition of the DSME as a new service line to our service area. Collaborate with local physicians, FQHC's and RHC's as well as the Merced County Health Department and the Central California Alliance for Health managed care. The expected outcome is to address the rates of age-adjusted deaths in Merced County and the overall health of our community. In addition to see a positive impact on the readmission rates fir diabetes related admissions.
Measurable Objective(s) with Indicator(s)	Maintain the increase in attendance to both the English and Spanish Diabetes programs. Increase the number of classes offered to the community and the number of community members accessing the educational intervention. Continue to track the number of diabetes referrals from inpatient and number of readmissions within 30 days.
Baseline / Needs Summary	There are no other ongoing community (free of charge) educational diabetes classes in Merced County that offer English, Hmong and Spanish instructions. Between 2011 and 2013 there was an annual average age-adjusted diabetes mortality rate of 29.0 deaths per 100,000 populations in Merced County. This is less favorable than that of the statewide rate of 20.7 deaths and national rate of 21.3 deaths. The statewide and national rates both declined from 25.8 in previous reports, while the rates in Merced County rose. These numbers also fail to satisfy the Healthy People 2020 target of 20.5 or lower.
Intervention Actions for Achieving Goal	Addition of 5 new diabetes educational programs Accreditation of our DSME program and addition of the service line to Community Health Education Increase the number of educational sessions offered to the community and include offsite sessions through collaboration with community partners Increase the number of attendees of community programs by 15% in both English and Spanish programs

Childbirth Preparation Course – Labor of Love	
Significant Health Needs Addressed	X Maternal/Infant Health ❑ Diabetes ❑ Mental Health ❑ Nutrition, Physical Activity and Weight ❑ Cancer
Program Emphasis	X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care ❑ Build Community Capacity ❑ Collaborative Governance
Program Description	This program prepares expectant mothers for the childbirth experience, including the stages of labor, what to expect during pregnancy and delivery, covers the importance of prenatal care, breastfeeding and infant health care.
Planned Collaboration	The Childbirth preparation Course addresses a community need and as a result there is collaboration within the community with local groups as well as local Federally Qualified Health Centers and the Merced County Department of Public Health.
Community Benefit Category	A1 Community Health Education
FY 2015 Report	
Program Goal / Anticipated Impact	• Increase enrollment by more community outreach especially to pregnant teenager by contacting a local high school that enrolls the pregnant teens. • Add a Saturday class. • Encourage enrollment in the breastfeeding class. FY 14 saw an increase by 30% looking for a 50% increase in FY15. • In partnership with Sierra Vista Children's Services a new post partum depression support group will be offered to the community, due to a very low census in FY14 the program is on hold. A memorandum of understanding was signed with Castle Family Health Centers to add a class at the Castle facility.
Measurable Objective(s) with Indicator(s)	Increase enrollment – achieve by getting more physician and high school referrals. Collaborate with other organizations that have lost their funding for childbirth classes. Expand the distribution of educational materials in the community. A new child birth class to be offered at Castle Family Health Centers.
Baseline / Needs Summary	Merced County continues to lack any other resource or program that addresses the needs of mothers to be. Our program is the only one available due to lack of funding of our community partners.
Intervention Actions for Achieving Goal	Increase enrollment by more community outreach especially to pregnant teenager by contacting a local high school that enrolls the pregnant teens. Add a Saturday class. Encourage enrollment in the breastfeeding class. FY 14 saw an increase by 30% looking for a 50% increase in FY15. In partnership with Sierra Vista Children's Services a new postpartum depression support group will be offered to the community, due to a very low census in FY14 the program is on hold. A memorandum of understanding was signed with Castle Family Health Centers to add a class at the Castle facility
Program Performance / Outcome	We continue to have a steady flow of young/teenage mothers to be enrolled in our program and the numbers have been constant. In addition, we were able to add a Saturday class offered each month with excellent results in enrollment and completion of program. The program now has a 55% enrollment in the breast feeding course as compared to the childbirth preparation enrollments. We continue to work on building partnerships with local clinics and are exploring offering the program offsite at local FQHC's. There was also an addition of a monthly Spanish program this FY.

Hospital's Contribution / Program Expense	Hospital provided space, refreshments, educational materials and instructors. Cost $24,200.00
FY 2016 Plan	
Program Goal / Anticipated Impact	Continue to increase the number of women enrolled in program, especially targeting the Spanish classes and young/teenage mothers. In addition, continue to increase the number of women enrolled in the breastfeeding portion of the program. Lastly, work towards establishing and additional component of the program with the Merced County Human Services Agency Daddy Boot Camp Program. Growth of our Spanish Childbirth Preparation Program.
Measurable Objective(s) with Indicator(s)	The measurable objective is the total number of participants enrolled in the program and number of completions. In addition we will track the referral sources
Baseline / Needs Summary	Merced County continues to lack any other resource or program that addresses the needs of mothers to be. Our program is the only one available due to lack of funding of our community partners.
Intervention Actions for Achieving Goal	Provide increased number of both Spanish program enrollees as well was breastfeeding program. Increase Spanish program enrollment by 35% from current status. Continued growth in our breastfeeding program from to increase by another 15% per class. Establish a Daddy Boot Camp program as part of the preparation for new parents.

Chronic Disease Self-Management, CDSMP	
Significant Health Needs Addressed	❑ Maternal/Infant Health X Diabetes X Mental Health X Nutrition, Physical Activity and Weight X Cancer
Program Emphasis	X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care ❑ Build Community Capacity ❑ Collaborative Governance
Program Description	This is a six-week comprehensive, outcomes-based program developed by Stanford University which includes education and action planning for participants living with a chronic disease. Management tools help to control symptoms such as pain and difficult emotions; improving nutrition, physical activity, health literacy and communication with physicians; managing medications and making appropriate plans that work with their lifestyle.
Planned Collaboration	Collaboration is planned to include the following community partners: Merced County Department of Public Health, Central California Alliance for Health, FQHC's, RHC's, and local physician groups.
Community Benefit Category	A-1 Community Health Education
FY 2015 Report	
Program Goal / Anticipated Impact	Expand the CDSMP by offering more workshops and increase the number of participants to reduce readmissions and improve quality of life and self- management skills. Complete one Leader Training class for community health care professionals and or community members. Continue the "Tomando" workshop. Staff to increase referrals of inpatients for the CDSMP workshops. We are working on including the order entry in the EMR.
Measurable Objective(s) with Indicator(s)	Maintain the current number of workshops in English and Spanish. Complete a Leader Training workshop. Staff will use the new referral form for inpatients. Will increase community knowledge about workshops.
Baseline / Needs Summary	As reported in the Community Needs Assessment, Merced County's mortality rates are worse than national rates for diseases of the heart, stroke, CLRD (chronic lower respiratory disease), diabetes mellitus and cirrhosis/liver disease. In Merced County a total of 17.2% adults report their overall mental health as fair to poor. This is a less favorable percentage than the national 11.7%. Lung cancer death rates are higher than the state rate and female breast cancer is higher than

	both the California and US rates.
Intervention Actions for Achieving Goal	Collaborate with local partners, recruit and retain leaders, secure additional funding, and expand program into other areas.
Program Performance / Outcome	Leader Training workshop was completed for CDSMP in collaboration with community groups and organizations. The referral form was completed and implemented for use with inpatients.
Hospital's Contribution / Program Expense	Hospital's contribution is and expense for the CDSMP program is $ 9,612.00
FY 2016 Plan	
Program Goal / Anticipated Impact	This program will address each and every identified chronic condition ranging from obesity, asthma, COPD, high blood pressure, heart disease, kidney disease etc. Our goal is to provide resources and tools to those in the community either dealing with a chronic condition or supporting someone with a chronic condition. Provide education and tools that help with making healthier food choices and living an active life to help control and manage weight.
Measurable Objective(s) with Indicator(s)	Number of enrollees in workshops provided will be collected as well as completion of program. In addition there will be follow-ups post intervention on how well participants have maintained their weight and changes to their lifestyle.
Baseline / Needs Summary	According to the most recent CHNA 32% of deaths in Merced County are caused by a chronic condition, the need is present in our community
Intervention Actions for Achieving Goal	Schedule workshops throughout the year and at various locations in the community to increase access to these sessions. Develop partnerships with community partners that have the same goal to enhance our impact. Additional certified leaders to help build capacity of program and workshop offerings. Build stronger relationships with local physician groups to increase referrals and awareness of program to the broader community.

Pediatric Clinic (Family Care)	
Significant Health Needs Addressed	X Maternal/Infant Health ❑ Diabetes ❑ Mental Health ❑ Nutrition, Physical Activity and Weight ❑ Cancer
Program Emphasis	X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care ❑ Build Community Capacity ❑ Collaborative Governance
Program Description	• Family Care was established in 1967 and became a Rural Health Clinic in 1978 • Training clinic for the Family Practice Residency Program in affiliation with UC Davis • Training for nurse practitioner students via contract with the hospital, 3 per semester • Twenty one exam rooms, includes EKG, Colposcopy, fetal monitor and ultrasound machine • X-ray and laboratory services are on site and part of the hospital • Employee registration staff, LVN's and Nurse Practitioners • Comprehensive Perinatal Services (CPSP); nutrition, psychosocial, health counseling
Planned Collaboration	• Collaborate with hospital maternity department to see Bili babies regardless of which clinic they are assigned to so we can assure post discharge Bili levels are rising • Manager and one MA completed breast feeding support class so we can assist patients who might have difficulty post-partum breast feeding this support the breastfeeding hospital initiative • UC Davis for residency program • NP programs; Walden University, Sonoma State, Fresno State, Fresno Pacific, Grand Canyon University

	• Part of Healthcare Consortium with Public Health Department • CPSP program with State of California
Community Benefit Category	C3. Subsidized Health Services: Hospital Outpatient Services
FY 2015 Report	
Program Goal / Anticipated Impact	• Complete implementation of the Retasure machine (takes a picture of a diabetic patient's retina and sends photo to a local optometrist to be read) • Add one (1) Nurse Practitioner or Physician Assistant to the team • Residency program recruit two (2) second year residents (program is short 2) • Increase the patient visits by 10%
Measurable Objective(s) with Indicator(s)	• Retasure ✓ Every LVN trained to use the Retasure machine ✓ Contract completed with Dr. Jeffery Lee & Dr. Matt Lee ✓ Providing screening to diabetic patients and other high risk clients • Monitor the volume of pediatric visits for FPC monthly • Resident volume at 24
Baseline / Needs Summary	• 26.551 visits FY14 with an average of 2,186 patients a month (excludes lab & radiology tests) • No current in-house screening of patients retina's • 22 residents for a 24 resident program
Intervention Actions for Achieving Goal	• Retasure ✓ Training to begin November for LVN's to use the Retasure machine ✓ Contract completed with Dr. Jeffery Lee & Dr. Matt Lee ✓ Providing screening to diabetic patients and other high risk clients • Local recruiting and the use of a recruiting company for a FT NP/PA • Volume ✓ Increasing providers to full complement ✓ Implement Primary Care Medical Home techniques to increase volume • Work with Marketing to advertise the clinic and services
Program Performance / Outcome	• Retasure contract is incomplete. Working with legal for final part. Equipment is on site • Recruited one PA and NP • Fill both second year resident slots; 24 again • Recruited one OB/GYN • Flyers placed identifying from the lights in parking lot we are part of Dignity Health and Mercy Medical Center • We saw a growth in GYN procedures and pediatrics. The pediatric clients were those lost from Kids Care • Overall 1% decrease in volume form FY 14. The small decrease is related to the fact that we moved workers comp to Human resources
Hospital's Contribution / Program Expense	• 2.77% of the clients have no insurance. • Saw a rise in HMO Seniors 158%, ACA exchange 1900% and Medi/Medi 7%. We are reaching more of the those in the poverty level due the Affordable Health Care Act • The team provided 6 Sports physical events throughout the valley; average 3 hours at a time • Management participates in the following grant projects with the PHD and other community partners ✓ Whole Health Partnership; Blue Shield funding for primary care and behavioral health (BH) integration to expand BH access and services for the county. Monthly for 2 hours ✓ Community Capacity Assessment; Behavioral Health needs and capacity in the community. Attended two (2) workshops at two (2) hours each and one four (4) hour work shop ✓ Merced County Health Care Consortium; clinics, PHD and CCA update on what opportunities are out there and what we are doing for capacity in the county. There are presentations exp: Sirum presentation on "unused medicine donations" program so we can see if they might work in our community. Every two (2) months for 2 hours ✓ Community HIE Round-Table Meeting; Health Information Exchange through a common medical release form and some integrated data. Attended three (3) two (2) hour meetings

FY 2016 Plan	
Program Goal / Anticipated Impact	• Retasure contract and program completed • Local recruiting for a PD NP/PA to prepare for flu season and cover vacations • Volume ✓ Apply for Practice Coaching Grant from CCA for coaching QTR 3 or of FY16 to be a PCMH. It is a 12 month coaching process ✓ Implement Primary Care Medical Home techniques to increase access • Work with marketing to advertise the clinic and services
Measurable Objective(s) with Indicator(s)	Goal 5% increase, stretch 10% of the number of patients seen at FPC
Baseline / Needs Summary	With the vast increase of clients on managed medical there is a shortage of services in the county.
Intervention Actions for Achieving Goal	• Work with staff on looking a flow of clinic to see how we can streamline processes • Implement Care Coordinators to assist in get clients there health maintenance screening and follow up with PCP • Work towards PCMH certification

General Medicine Clinic (GMC)	
Significant Health Needs Addressed	❑ Maternal/Infant Health X Diabetes ❑ Mental Health X Nutrition, Physical Activity and Weight ❑ Cancer
Program Emphasis	X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care ❑ Build Community Capacity ❑ Collaborative Governance
Program Description	• GMC was established in 1967 as a Family Care Clinic the name was changed in 1992 when specialist were added to the clinic, became a Rural Health Clinic in 1978 • To provide specialty clinics to cover services that are not available to the poor, underinsured and working poor individuals in the community. • Specialty physicians rotate through the clinic to provide orthopedic, podiatry, neurology nephrology, cardiology, urology, gastroenterology, pulmonary and surgery. • Educational opportunity working with specialist for residents and medical students
Planned Collaboration	• Collaborate with community specialty physicians to provide services at GMC to the under served
Community Benefit Category	C3. Subsidized Health Services: Hospital Outpatient Services
FY 2015 Report	
Program Goal / Anticipated Impact	• Increase patient visits to Center for Diabetes (CFD) by 10% • Recruit a Nurse Practitioner (NP) • Recruit another Cardiologist
Measurable Objective(s) with Indicator(s)	• Increase CFD patient visits by 10% • Hiring a full-time (FT) NP • One (1) Cardiologist added to schedule to see patients at a minimum of once a month • Monitor the volume of pediatric visits for GMC monthly; specifically CFD and Cardiology
Baseline / Needs Summary	• 13,238 visits FY14 with an average of 1,103 patients a month (excludes lab & radiology tests) • CFD visits for FY 14 were 2,761 • Cardiology visits for FY 14 were 239
Intervention Actions for Achieving Goal	• Local recruiting and the use of a recruiting company for a FT NP • Work with Mercy Medical Center physician Recruiter for Cardiologist
Program Performance / Outcome	• Increase patient visits to Center for Diabetes by 10%

	• Unable to recruit a Nurse Practitioner (NP) • Recruited one Cardiologist • Growth for Cardiology 42%, Endocrinology 21% and CFD 9%
Hospital's Contribution / Program Expense	• 2.99% of the client visits have no insurance; there was a 57% drop in uninsured. This means that more of those in need are receiving benefits from the Affordable Health Care Act. • Saw a rise in ACA exchange 1228% and Medi/Medi 11%. Medi/Medi is 85% of the visits at GMC. • CFD nurses participated in the CMSP training and setting up the piolet diabetic version of the CMSP and continue to support the CMSP
FY 2016 Plan	
Program Goal / Anticipated Impact	• Recruit for a neurologist • Local recruiting for a PD NP/PA to add family care services to GMC • GMC visits for FY 16 to increase
Measurable Objective(s) with Indicator(s)	GMC visits for FY 16 to grow by 5%, stretch of 10%
Baseline / Needs Summary	With the vast increase of clients on managed medical there is a shortage of services in the county.
Intervention Actions for Achieving Goal	• Work with staff on looking a flow of clinic to see how we can streamline processes • Continue to recruit new specialty physicians who come to Merced or may want to return to GMC

Family Care Clinic (FPC)	
Significant Health Needs Addressed	X Maternal/Infant Health X Diabetes ❑ Mental Health ❑ Nutrition, Physical Activity and Weight ❑ Cancer
Program Emphasis	X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care ❑ Build Community Capacity ❑ Collaborative Governance
Program Description	• Family Care was established in 1967 and became a Rural Health Clinic in 1978 • Training clinic for the Family Practice Residency Program in affiliation with UC Davis • Training for nurse practitioner students via contract with the hospital, 3 per semester • Twenty one exam rooms, includes EKG, Colposcopy, fetal monitor and ultrasound machine • X-ray and laboratory services are on site and part of the hospital • Employee registration staff, LVN's and Nurse Practitioners • Comprehensive Perinatal Services (CPSP); nutrition, psychosocial, health counseling
Planned Collaboration	• Collaborate with hospital maternity department to see Bili babies regardless of which clinic they are assigned to so we can assure post discharge Bili levels are rising • Manager and one MA completed breast feeding support class so we can assist patients who might have difficulty post-partum breast feeding this support the breastfeeding hospital initiative • UC Davis for residency program • NP programs; Walden University, Sonoma State, Fresno State, Fresno Pacific, Grand Canyon University • Part of Healthcare Consortium with Public Health Department • CPSP program with State of California
Community Benefit Category	C3. Subsidized Health Services: Hospital Outpatient Services
FY 2015 Report	
Program Goal / Anticipated Impact	• Complete implementation of the Retasure machine • Add one (1) NP or PA to the team

	• Residency program recruit two (2) second year residents (program is short 2) • Increase the patient visits by 10%
Measurable Objective(s) with Indicator(s)	• Retasure ✓ Every LVN trained to use the Retasure machine ✓ Contract completed with Dr Jeffery Lee & Dr Matt Lee ✓ Providing screening to diabetic patients and other high risk clients • Monitor the volume of pediatric visits for FPC monthly • Resident volume at 24
Baseline / Needs Summary	• 26.551 visits FY14 with an average of 2,186 patients a month (excludes lab & radiology tests) • No current in-house screening of patients retina's • 22 residents for a 24 resident program
Intervention Actions for Achieving Goal	• Retasure ✓ Training to begin November for LVN's to use the Retasure machine ✓ Contract completed with Dr Jeffery Lee & Dr Matt Lee ✓ Providing screening to diabetic patients and other high risk clients • Local recruiting and the use of a recruiting company for a FT NP/PA • Volume ✓ Increasing providers to full complement ✓ Implement Primary Care Medical Home techniques to increase volume • Work with Marketing to advertise the clinic and services
Program Performance / Outcome	• Retasure contract is incomplete. Working with legal for final part. Equipment is on site • Recruited one PA and NP • Fill both second year resident slots; 24 again • Recruited one OB/GYN • Flyers placed identifying from the lights in parking lot we are part of Dignity Health and Mercy Medical Center • We saw a growth in GYN procedures and pediatrics. The pediatric clients were those lost from Kids Care • Overall 1% decrease in volume form FY 14. The small decrease is related to the fact that we moved workers comp to Human resources
Hospital's Contribution / Program Expense	• 2.77% of the clients have no insurance. • Saw a rise in HMO Seniors 158%, ACA exchange 1900% and Medi/Medi 7%. We are reaching more of the those in the poverty level due the Affordable Health Care Act • The team provided 6 Sports physical events throughout the valley; average 3 hours at a time • Management participates in the following grant projects with the PHD and other community partners ✓ Whole Health Partnership; Blue Shield funding for primary care and behavioral health (BH) integration to expand BH access and services for the county. Monthly for 2 hours ✓ Community Capacity Assessment; Behavioral Health needs and capacity in the community. Attended two (2) workshops at two (2) hours each and one four (4) hour work shop ✓ Merced County Health Care Consortium; clinics, PHD and CCA update on what opportunities are out there and what we are doing for capacity in the county. There are presentations exp: Sirum presentation on "unused medicine donations" program so we can see if they might work in our community. Every two (2) months for 2 hours ✓ Community HIE Round-Table Meeting; Health Information Exchange through a common medical release form and some integrated data. Attended three (3) two (2) hour meetings
FY 2016 Plan	
Program Goal / Anticipated Impact	• Retasure contract and program completed • Local recruiting for a PD NP/PA to prepare for flu season and cover vacations • Volume ✓ Apply for Practice Coaching Grant from CCA for coaching QTR 3 or of FY16 to be a PCMH. It is a 12 month coaching process ✓ Implement Primary Care Medical Home techniques to increase access

	• Work with marketing to advertise the clinic and services
Measurable Objective(s) with Indicator(s)	Goal 5% increase, stretch 10% of the number of patients seen at FPC
Baseline / Needs Summary	With the vast increase of clients on managed medical there is a shortage of services in the county.
Intervention Actions for Achieving Goal	• Work with staff on looking a flow of clinic to see how we can streamline processes • Implement Care Coordinators to assist in get clients there health maintenance screening and follow up with PCP • Work towards PCMH certification

Dignity Health Community Grants Program	
Significant Health Needs Addressed	X Maternal/Infant Health X Diabetes X Mental Health X Nutrition, Physical Activity and Weight X Cancer
Program Emphasis	X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Program Description	The grants program objective is to award grants to organizations that partner together and whose proposals respond to the priorities identified in the health assessment and/or the community plans of the hospital. Grant funds are to be used to provide services to underserved populations (economically poor; women and children; mentally or physically disabled; or other disenfranchised populations). Funding is from $10,000 up to $75,000.
Planned Collaboration	Any not-for-profit organization that is in Merced County partnering with other not-for-profit organizations in Merced County, to improve the health priorities identified in the CHNA. Grant recommendations are made by the Community Advisory Committee (CAC) to the Dignity Health BOD Investment Committee for final approval.
Community Benefit Category	E1 Financial Contributions: Grants
FY 2015 Report	
Program Goal / Anticipated Impact	To distribute grants in the total of $115,888 to organizations or agencies meeting the grant requirements and whose proposal is approved by the Community Advisory Committee and the Dignity Health BOD Investment Committee. The grant recipients will improve the health status and quality of life of residents in need of their services who reside in Merced County.
Measurable Objective(s) with Indicator(s)	The approved grant recipients will complete an 18 month accountability report to measure objectives and indicators.
Baseline / Needs Summary	Baselines and needs are summarized in the 2015 CHNA. Grant recipients must be servicing the population in need of one or more of the health priorities identified in the CHNA. The organization must meet one or more of these program emphasis; focus on disproportionate unmet health related need; emphasize primary prevention and address underlying causes of health problems; contribute to a seamless continuum of care; and build community capacity and emphasize collaborative governance.
Intervention Actions for Achieving Goal	Once the Community Advisory Committee has reviewed the identified health need/opportunities reported in the 2015 CHNA, they will announce to the community that they will be accepting letters of intent. Emails were distributed to not-for-profit organizations in Merced County. A total of eleven letters of intent were received. The CAC reviewed the LOI's and voted to allow five of the eleven to submit a full proposal. Once the CAC received the proposals they voted to recommend five of the proposals to the Dignity Health BOD Investment Committee for final approval.
Program Performance / Outcome	All four recommended proposals were approved by Dignity Health. $115,888 was awarded to the

	following not-for-profit organizations. • **Alpha Crisis Pregnancy Center - $15,000** Mobil Clinic Program providing prenatal care to women in rural, impoverished and at-risk communities. • **Merced County Rescue Mission "Merced Homeless Respite Care" - $75,000** Respite care for homeless persons, to allow them to rest and recover in a safe environment while receiving medical care and supportive services. • **Girl Scouts Heart of Central CA - $5,000** Funds for a summer day camp for 60 girls to receive interactive nutrition and fitness lessons. • **Boys & Girls Clubs of Merced County - $20,888** Funds for a summer program addressing child and family fitness.
Hospital's Contribution / Program Expense	Awarded grants in the amount of $115,888, plus MMC's operational of $4750, totals $120,638.
FY 2016 Plan	
Program Goal / Anticipated Impact	2015 grant awardees to submit an accountability report on their program. The CAC will determine the 2016 grant focus from the 2015 CHNA. The grant program announcement will be made to not-for-profit organizations in Merced County in the early Spring. CAC will review LOI's and proposals and make grant recommendations to Dignity Health. Grant awards will total $112,674.
Measurable Objective(s) with Indicator(s)	Four or five community not-for-profit organizations will receive the community grant allocations. The approved grant recipients will complete an 18 month accountability report to measure objectives and indicators.
Baseline / Needs Summary	Baselines and needs are summarized in the 2015 CHNA. Grant recipients must be servicing the population in need of one or more of the health priorities identified in the CHNA. The organization must meet one or more of these program emphasis; focus on disproportionate unmet health related need; emphasize primary prevention and address underlying causes of health problems; contribute to a seamless continuum of care; and build community capacity and emphasize collaborative governance.
Intervention Actions for Achieving Goal	Dignity Health will send out allocations announcement. MMC will receive $112,674 in grant funds to distribute to Merced County not-for-profits meeting the grant requirements. The CAC to review the letters of intent, recommend organizations to submit a full proposal and then vote on the final proposals. Recommendations will be sent to Dignity Health BOD Investment Committee for final vote and then organizations will receive their grant monies.

APPENDIX A: COMMUNITY BOARD AND COMMITTEE ROSTERS

Hospital Administration

A six-member senior management team operates the hospital administration.

- Chuck Kassis, President
- Mike Strasser, CFO/VP Finance
- Gregory Rouleau, VP Nursing Services/CNE
- Robert Streeter, M.D., VP Medical Affairs
- Kathy Kohrman, VP/Strategy and Business Development

Community Board

A fourteen-member board supports the vision, mission, values, charitable and philanthropic goals of the hospital and Dignity Health. Members are regarded in their community as respected and knowledgeable in their field, are contributing citizens in their community and are knowledgeable about or willing to become educated about hospital and healthcare matters.

- Walter Adams, III – Retired Branch Manager/Crop Consultant
- Michelle Allison - Retired
- Benjamin Duran – Retired MJ College President
- Doug Fluetsch – President, Fluetsch Insurance Company
- Sr. Katherine Hamilton, OP St. Joseph's Medical Center – *Board Secretary*
- Paul C. Lo, Superior Court Judge, *Board Vice Chair*
- Lee Lor, Assistant to Merced Co. Supt. Schools
- Barry McAuley – Auto Dealership Owner, *Board Chair*
- Leslie McGowan, CEO Livingston Health Services
- Sr. Mary Cornelius O'Conner, RSM VP/Mission Integration Mercy Hospital Folsom
- Atulkumar Roy, M.D. – Nephrology/Internal Medicine
- Eduardo Villarama, M.D. MMC Chief of Staff
- Janet Young – Retired Associate Chancellor and COS, UC Merced
- Chuck Kassis – Hospital President (Ex-Officio)

APPENDIX B: OTHER PROGRAMS AND NON-QUANTIFIABLE BENEFITS

MMC works collaboratively with community partners. The hospital provided leadership and advocacy, stewardship of resources, assisted with local capacity building, and participated in community-wide health planning.

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.

- MMC staff raised funds and walked in the Merced and Atwater's Cancer Society's "Relay for Life" weekend event.

- MMC staff raised funds and walked in Merced's Hinds Hospice "Angel Babies" walk. Angel Babies is a program that MMC's Family Birthing Center partners with Hinds Hospice to provide support for parents that have had a fetal demise.

- In December 2014 hospital departments participate in the Spiritual Services "Christmas Sharing Project" by adopting needy families and providing non-profit agencies with needed resources (toys, food, clothing).

- Participated in the Samaritan's Purse, "Operation Christmas Child" project by donating 30 shoeboxes filled with items appropriate for specific ages of children living in poverty stricken areas around the world.

- The St. Mary's Orthodox Church uses the hospital chapel for their weekly worship services and uses the hospital multipurpose room for weekly parish gatherings.

- Mercy has donated to local physicians many pieces of medical equipment and supplies to be taken to third world countries.

- Mercy staff represents MMC by being members of the Merced/Mariposa Cancer Society, Merced Rotary, Merced Kiwanis, Merced Greater Chamber of Commerce, Tobacco Coalition, Asthma Coalition, the Bi-National Committee, Central CA Health Alliance, and the Hinds Hospice "Angel Babies" committee.

- Mercy Emergency Cardiac Care Committee partners with the American Heart Association to present to the Merced/Fresno Area Task Force and Western Territory Region ECC Committee so that goals that impact health-care BLS, ACLS and PALS courses and the chain of survival initiatives are met.

- Mercy is a member of the Asthma Coalition helping to control asthma through awareness and education and flies the daily air pollution level flag.

- Mercy is part of the Merced County Health Care Consortium steering committee initiating the Children's Health Initiative to create Healthy Kids health coverage.

- The Mercy Cancer Center started a "Cancer Support Group" in FY2013. An average of 30 people attend the monthly cancer support meetings. The group is expanding to include community health presentations and now offers, "Look Good, Feel Better" programs.

- A Mercy Music Program was started in FY13. It is composed of musicians who volunteer their time to visit patients and minister to them through their music.

- MMC Pet Therapy Program has dogs that are certified through "Share A Pet". The dogs along with their owners, visit patients, staff and visitors.