Mercy San Juan Medical Center

Community Benefit 2021 Report and 2022 Plan

Adopted October 2021

Dignity Health™
Mercy San Juan Medical Center

A message from

Michael Korpiel, President and CEO of Mercy San Juan Medical Center, and Linda Ubaldi, Chair of the Dignity Health Sacramento Service Area Community Board.

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

Mercy San Juan Medical Center (Mercy San Juan) shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The Community Benefit 2021 Report and 2022 Plan describes much of this work. This report meets requirements in California state law (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health hospitals in Arizona and Nevada voluntary produce these reports and plans, as well. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2021 (FY21), Mercy San Juan provided $72,833,371 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $64,649,149 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2021 Report and 2022 Plan at its October 28, 2021 meeting.

Thank you for taking the time to review our report and plan. We welcome any questions or ideas for collaborating that you may have, by reaching to out to us at DignityHealthGSSA_CHNA@dignityhealth.org.

Sincerely,

Michael Korpiel
President/CEO

Linda Ubaldi
Chairperson, Board of Directors

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At-a-Glance Summary

Community Served

Mercy San Juan Medical Center is located in Carmichael and has 2,480 employees, 580 active medical staff, 384 licensed acute care beds, and 31 emergency department beds. The hospital serves the areas of north Sacramento and south Placer County.

Economic Value of Community Benefit

$72,833,371 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits

$64,649,149 in unreimbursed costs of caring for patients covered by Medicare

Significant Community Health Needs Being Addressed

The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are:

1. Access to Quality Primary Care Health Services
2. Access to Mental, Behavioral, and Substance Abuse Services
3. Access to Basic Needs, Such as Housing, Jobs, and Food
4. System Navigation
5. Injury and Disease Prevention and Management
6. Safe and Violence-Free Environment
7. Access to Active Living and Healthy Eating
8. Cultural Competency
9. Access to Specialty and Extended Care

FY21 Programs and Services

The hospital intends to take several actions and to dedicate resources to these needs, including:

- Housing with Dignity Homeless Program: In partnership with Lutheran Social Services, this stabilization program aims to assist homeless individuals with severe chronic health and mental health issues obtain and retain housing, care and services designed to achieve stability in their lives.
- Interim Care Program: This collaborative engages other Dignity Health hospitals and health systems in the region, the Salvation Army, Sacramento County and Federally Qualified Health Center, WellSpace Health, and provides a respite care shelter for homeless patients with available physical and mental health, and substance abuse treatment.
- ReferNet Intensive Outpatient Mental Health Partnership: The hospitals works in collaboration with community-based nonprofit mental health provider, El Hogar, to provide a seamless process for patients admitting to the emergency department with mental illness to receive immediate and

	ongoing treatment and other social services they need for a continuum of care when they leave the hospital. • SPIRIT Project: The Sacramento Physicians' Initiative to Reach Out, Innovate and Teach (SPIRIT) operated under the Sierra Sacramento Valley Medical Society exists as a vehicle to involve physicians in the community. SPIRIT recruits physician volunteers to provide free specialty medical care to the uninsured and coordinates and case manages surgical procedures donated at local hospitals and ambulatory surgery centers. • Patient Navigator Program: Patient navigators in the hospital's emergency department connect patients seen and treated at the hospital to medical homes at community health centers and provider offices throughout the region. The Patient Navigator Program represents a unique collaboration between Dignity Health, Sacramento Covered, a community-based nonprofit organization, and community clinics in the region. • Congestive Heart Active Management Program (CHAMP®): Establishes a relationship with patients who have heart disease after discharge from the hospital through regular phone interaction to support and education to help manage this disease and monitoring of symptoms or complications. • Community Based Violence Prevention Program: Focuses on educating staff to identify and respond to victims within the hospital; provide victim-centered, trauma-informed care; and collaborate with community agencies to improve quality of care.
FY22 Planned Programs and Services	Mercy San Juan plans to continue to build upon many of previous years' initiatives and explore new partnership opportunities with Sacramento County, the different cities, health plans and community organizations. Efforts to enhance navigation services in partnership with Sacramento Covered, Bay Area Community Services and Turning Point will continue with specific focus on improving the linkages to community resources and the number of real-time referrals. In FY22, Mercy San Juan will continue to play an active role in developing innovative strategies to address the growing number of individuals experiencing homelessness including: the Interim Care Program; Housing with Dignity; active engagement with the sunset of City of Sacramento's Pathways to Health + Housing (Whole Person Care) and transition to CalAIM Enhanced Care Management (ECM) and In Lieu of Services (ILOS); Homelessness and Healthcare Pilot Project; and working in partnership with both the city and county to improve our relationship with the shelters.

This document is publicly available online at https://www.dignityhealth.org/sacramento/about-us/community-health-and-outreach/health-needs-assessment.

Written comments on this report can be submitted to the Mercy San Juan Community Health and Outreach Department at 3400 Data Drive, Rancho Cordova, CA 95670 or by e-mail to DignityHealthGSSA_CHNA@dignityhealth.org.

Our Hospital and the Community Served

About Mercy San Juan Medical Center

Mercy San Juan is a member of Dignity Health, which is a part of CommonSpirit Health.

Founded in 1967, Mercy San Juan Medical Center is a nationally recognized not-for-profit tertiary care hospital located at 6501 Coyle Avenue, in Carmichael, CA, and serves the areas of north Sacramento and south Placer County. The hospital has 2,480 employees, 580 active medical staff, 384 licensed acute care beds, and 31 emergency department beds. Mercy San Juan Medical Center is a designated Comprehensive Stroke facility and is known for their quality neuroscience program. Mercy San Juan Medical Center is also Dignity Health's only level II trauma center in the Sacramento market treating 1,564 trauma patients in CY2020. Mercy San Juan Medical Center's Trauma Prevention and Outreach program provides community education and outreach efforts to decrease preventable death and injuries through a number of programs from newborn safety car seat checks to teen driving and fall prevention for seniors. Additionally, the hospital offers hyperbaric oxygen (HBO) treatment and OP wound care, providing much needed services in a hospital setting, thus offering patients added safety and comfort, knowing they are surrounded by a team of highly trained nurses, physicians and HBO therapists. The new 40-bed, level III Neonatal Intensive Care Units (NICU) has long been a leader in caring for the smallest of newborns and is ranked in the top 1-2% throughout Dignity Health in regards to quality of care and safe patient outcomes. The NICU is equipped to provide specialized care including invasive monitoring, conventional ventilation, surgery, transport service, inhaled nitric oxide and high frequency oscillator ventilation and offers a state-of-the-art milk preparation room staffed 24/7 with a certified NICU Dietitian specialist and certified milk technicians through a robust breast milk donor program where all babies who qualify can receive donor breast milk to help support their nutritional needs.

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

Mercy San Juan is dedicated to creating healthier communities by providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay. Advocating for the poor and vulnerable is both our mission and our passion. The hospital has financial assistance available to help pay for medically necessary services provided to those patients who meet certain income requirements. The financial assistance policy, a plain language summary of the policy, and a financial assistance application are on the hospital's web site.

Description of the Community Served

Mercy San Juan is one of the area's largest and most comprehensive medical centers. Mercy San Juan's community or hospital service area (HSA) is defined as the geographic area (by ZIP code) in which the hospital receives its top 75% of discharges. The hospital's primary service area is comprised of 14 zip codes (95608, 95660, 95842, 95621, 95610, 95841, 95628, 95843, 95821, 95670, 95838, 95673, 95662, and 95815). A summary description of the community is below. Additional details can be found in the CHNA report online.

The hospital is part of the region historically known for its lack of safety net providers to serve low-income and vulnerable residents; nearly 30 percent of residents are Medi-Cal-insured. While the Medi-Cal population struggles to access care due to a lack of local Medi-Cal providers, the result has been an increasing trend of Medi-Cal-insured admissions to the hospital's emergency department seeking primary care treatment for their basic health needs. In response to this growing trend, Mercy San Juan has made it a priority to provide patient navigation services to this population which helps to educate patients on how to access care in the appropriate healthcare setting. The hospital must balance its responsibility for caring for the acutely ill with an increasing role as a safety net provider for the vulnerable.

Demographics within the Mercy San Juan hospital service area are as follows, derived from 2021 estimates provided by Strategy's SG2 Analytics Platform (*Source: Claritas Pop-Facts® 2021)*:

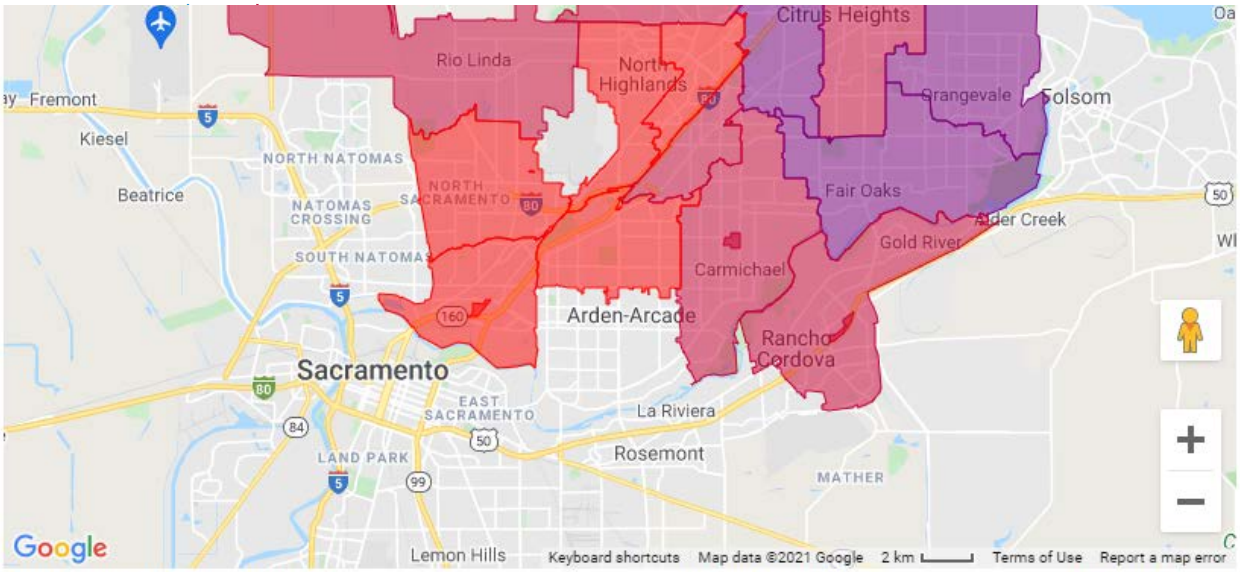
- Total Population: 537, 573
- Race/Ethnicity: Hispanic or Latino: 22.3%; White: 56.7%, Black/African American: 6.9% Asian/Pacific Islander: 8.4%, All Other: 5.7%.
- % Below Poverty: 11.4%
- Unemployment: 5.8%
- No High School Diploma: 11.0%
- Medicaid (household): 10.3%
- Uninsured (household): 5.2%

Community Need Index

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and IBM Watson Health. The CNI analyzes data at the zip code level on five factors known to contribute or be barriers to health care access: income, culture/language, education, housing status, and insurance coverage.

Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI

scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.



Mean(zipcode): 3.9 / Mean(person): 3.8 CNI Score Median: 3.8 CNI Score Mode: 3.8

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 June 2019.

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/sacramento/about-us/community-health-and-outreach/health-needs-assessment or upon request at the hospital's Community Health office.

Significant Health Needs

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

1. **Access to Quality Primary Care Health Services**: Encompasses access to primary care resources which include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and similar.
2. **Access to Mental, Behavioral, and Substance Abuse Services**: Includes access to prevention and treatment services.
3. **Access to Basic Needs, Such as Housing, Jobs, and Food**: Includes economic security, food security/insecurity, housing, education and homelessness.
4. **System Navigation**: The ability to traverse the fragmented social-services and healthcare systems; especially for more vulnerable populations and those with limited resources such as transportation access, English proficiency, etc.
5. **Injury and Disease Prevention and Management**: Contains health outcomes that require disease prevention and/or management and treatment including: cancer, cardiovascular disease/stroke, HIV/AIDS/STDs and asthma.
6. **Safe and Violence-Free Environment**: Consists of safety from violence and crime including violent crime, property crimes and domestic violence.
7. **Access to Active Living and Healthy Eating**: Encompasses all components of active living and healthy eating including health behaviors, associated health outcomes and aspects of physical environment/living conditions.
8. **Access to Meeting Functional Needs – Transportation and Physical Disability**: Includes the need for transportation options, transportation to health services and options for person with disabilities.
9. **Cultural Competency:** The ability of those in health and human services, including healthcare, social services, and law enforcement, to deliver services that meet an individual's social, cultural, and language needs.
10. **Access to Specialty and Extended Care**: Encompasses access to specialty care and extended services including skilled nursing facilities, hospice care, in-home healthcare, etc.

Significant Needs the Hospital Does Not Intend to Address

Mercy San Juan does not have the capacity or resources to address all priority health issues identified in Sacramento County, although the hospitals continue to seek opportunities that respond to the needs that have not been selected as priorities. The hospital is not addressing access to meeting functional needs as this priority is beyond the capacity and expertise of Mercy San Juan.

2021 Report and 2022 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 FY21 and planned activities for FY22, with statements on anticipated impacts, planned collaboration, and patient financial assistance for medically necessary care. Program Digests provide detail on select programs' goals, measurable objectives, expenses and other information.

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

The anticipated impacts of the hospital's activities on significant health needs are summarized below, and for select program initiatives are stated in Program Digests. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospital works to evaluate impact and sets priorities for its community health programs in triennial Community Health Needs Assessments.

Creating the Community Benefit Plan

Mercy San Juan 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.

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

- Focus on Disproportionate Unmet Health-Related Needs
- Emphasize Prevention
- Contribute to a Seamless Continuum of Care
- Build Community Capacity
- Demonstrate Collaboration

The following outlines the approach taken when planning and developing initiatives to address priority health issues. At the outset, Community Health and Outreach staff engages a core internal team that may include clinical staff, care coordinators and social workers, members of the Mercy San Juan leadership team, and Dignity Health leaders at the regional and local levels from Mission Integration, IT, Legal, Administration, and Finance. These core teams help shape initiatives, provide internal perspective on issues (i.e. utilization trends relative to the issue, gaps experienced in available follow-up or wraparound care for patients, etc.) and help define appropriate processes, procedures and methodologies for measuring outcomes.

The planning and development of each initiative also involves research on best practices to identify existing evidence-based programs and interventions, and relationship strengthening with community-based providers that serve target populations for intended initiatives. Once identified, community-based partners become part of the hospital's core project team. Core project teams for all initiatives meet quarterly, or as needed, to evaluate program progress and outcomes, and to make program changes and/or improvements. When target populations and priority health issues are shared by other Dignity Health hospitals in the Greater Sacramento region, initiatives are often regionalized in order to leverage resources, extend reach and achieve greater impact.

Impact of the Coronavirus Pandemic

The COVID-19 pandemic has globally resulted in millions of confirmed cases and deaths numbering hundreds of thousands. It has caused an unprecedented challenge for our Greater Sacramento Market Hospitals and health care systems worldwide. In particular, the risk to health care; considering most health care workers are unable to work remotely, strategies had to be developed around early deployment of viral testing for asymptomatic and/or frontline health care staff. High health care costs, shortages of protective equipment, and low numbers of ICU beds and ventilators have been major challenges for our hospitals in the delivery of patient care. In communities across our Market, there is concern regarding uninsured individuals, who may work in jobs predisposing them to viral infection which may lead to significant financial consequences in the event of illness.

In response to this pandemic, our Market hospitals have had to implement immediate relief measures and engage in short, medium and longer term planning to re-balance and re-energize our communities in the midst of this crisis. Many of our hospitals have been engaging in collaborative efforts focusing on development of a broad clinical and socioeconomic plans with multi-disciplinary partners from health care, business, social services, government, community based organizations and wider society.

In FY21, Mercy San Juan took the following actions to respond to the needs created or exacerbated by COVID-19:

- The Community Health team partnered with our grant partners on adapting programs, where needed, to respond to COVID-19 or divert grant funding to support urgent needs arising due to the pandemic.
- Partnered with Sacramento County on Project Room Key referring in homeless patients to the designated quarantine motels for shelter and follow-up care.
- Collaborated with American Heart Association on the – 'Don't Die of Doubt' - Campaign, which encouraged community members to not delay care out of fear of coming to the hospital.
- Partnered with Sacramento County, Hospital Council and our community wide EMS/Fire Departments in the deployment of Sacramento Mobile Integrated Health (SacMIH), to specifically respond to COVID-19 with community by providing mobile testing at congregate

care sites. Congregate Care Sites (such as Skilled Nursing Facilities, Board and Cares, etc.) had significant outbreaks of COVID-19 in our community.

- Through employee philanthropic contributions made through Mercy Foundation, we are offering up to eight free telehealth services with a clinical provider and/or therapist to any new parents, regardless of their health system affiliation or medical home.
- Mobilized market leadership, physicians, and clinical experts within the Dignity Health system through media outlets and social media to answer questions and assuage concerns of our community around COVID-19.
- Our media relations strategy consistently aims to include proactive and reactive media opportunities that promote, protect, and elevate Dignity Health's reputation. As we moved into a 'recovery' phase of the pandemic, with vaccine authorizations in sight, our storytelling focused on demonstrating our leadership in the region as a leading health care provider, showcasing COVID-19 survivor stories, recognizing our health care heroes, commemorating critical milestones and drive conversations around race and health care. From June 2021-December 2021, 303 unique stories were placed, resulting in more than 2.2 billion impressions.
- Alongside Kaiser Permanente, Sutter Health, and UC Davis Health, participated in and supported Sacramento County's Health Equity Task Force to devise strategies for an equitable distribution of vaccines, with particular emphasis on vulnerable communities disproportionately impacted by COVID-19.
- Sacramento County Department of Public Health in partnership with Dignity Health and UC Davis Health hosted a series of community-based COVID-19 vaccination clinics that ran February – June, 2021. Additional key partners included Kaiser Permanente, Sutter Health, Asian Resources Inc. and Sacramento City Unified School District. The clinics were part of an effort to provide opportunities for Sacramento area residents, with a special focus on those most vulnerable, to receive COVID-19 vaccines at convenient and accessible locations. Together we were able to immunize nearly 17,000 individuals.

In addition to continuing many of the actions identified above, Mercy San Juan plans to take the following actions in FY22 to continue helping alleviate pandemic-induced needs:

- Alongside Kaiser Permanente, Sutter Health, and UC Davis Health, Dignity Health continues to participate in and support Sacramento County's Health Equity Task Force to devise strategies for an equitable distribution of vaccines, with particular emphasis on vulnerable communities disproportionately impacted by COVID-19.
- Launching new pilot programs focusing on homelessness, which is a particularly vulnerable population in light of COVID-19, including children and older adults.
- Dignity Health's Sacramento Hospitals will continue to partner with Sacramento County and City of Sacramento on Project Room Key and other efforts to provide coordination of care and safe shelter for those experiencing homelessness in our community.
- Continue to advocate with the County proper utilization of federal funding to support ongoing programs exacerbated by the pandemic (e.g., homelessness, food insecurity, behavioral health).
- Alongside Health Systems, County Partners and other providers offering behavioral health services, we will continue to participate in the regional Behavioral Health Facilities call, convened bi-weekly by the Hospital Council, to identify gaps in the system of care and devise strategies for behavioral health across a multi-county region.
- The hospital and community physicians are continuing to utilize telemedicine where appropriate, which allows us to keep patients home and safe, especially as we move into flu season.

- Continuing to mobilize Division leadership, physicians, and clinical experts within the Dignity Health system through media and social media to answer questions and assuage concerns of our community around COVID-19.
- Dignity Health is strongly encouraging community members to get their COVID-19 vaccine and flu shot throughout the coming fiscal year and educating patients regarding the importance.
- As a broader community health and community benefit strategy, we will be looking for future opportunities to continue to support programs and initiatives that seek to address issues related to COVID-19.

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

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
School Nurse Program	In partnership with the Catholic Diocese of Sacramento, Dignity Health supports a school nurse program at three catholic schools in the community serving low income neighborhoods. Services include first aide, chronic disease management and care plans, mandated health screenings and education for students, families and school staff.	☒	☒
Care for the Undocumented	Dignity Health hospitals in Sacramento County partner with Sacramento County, other health system and the Sierra Sacramento Valley Medical Society on an initiative to provide primary and specialty care, including surgery, to the region's undocumented immigrants who currently have no insurance or access to care. The hospital continues to advocate for expanded enrollment and increasing the age range to	☒	☒

	ensure more individuals could access primary care and limited specialty care services.		
Salud con Dignidad (Health with Dignity)	Supported through the Community Grants Program, a partnership between La Familia Counseling Center, Latino Coalition for Health California, Sacramento Native American Health Center and Dr. David Nylund, Salud con Dignidad connects and navigates low-income, under-insured/uninsured, predominantly Latino, Sacramento youth and residents with health education and social service resources. SCD will utilize a holistic, coordinated-care approach to well-being by providing behavioral health, COVID education and prevention, health education, youth engagement and leadership development services, but will also include access to primary, vision, and oral health services.	☒	☒
CREER En Tu Salud (Believe in your Health)	Supported through the Community Grants Program, a partnership between Latino Leadership Council Inc, United Latinos, Stanford Settlement Neighborhood Center, Gardenland Natomas Neighborhood Association and Elica Health Center, CREER En Tu Salud is a culturally appropriate program that bridges the access gap between Latino/a adults and the health, dental, vision, nutrition, behavioral and social supports that are often inaccessible to them. Through our partnership, Promotores will triage, connect, case manage and support adults in the Northwest and Northeast regions of Sacramento to reduce the access gaps to (1) quality health care; (2) mental/behavioral services and (3) basic needs.	☒	☒

Impact: The hospital's initiatives to address access to high quality health care and services are anticipated to result in: increased timely access and services; increased knowledge about how to access and navigate the health care system; increased primary care "medical homes" among those reached by navigators; reduce barriers to care; and improve collaborative efforts between all health care providers.

Health Need: Access to Mental, Behavioral, and Substance Abuse Services

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
ReferNet Intensive Outpatient Mental Health Partnership	In collaboration with community-based nonprofit mental health provider, El Hogar, the program provides a seamless process for patients admitting to the emergency department with mental illness to receive immediate and ongoing treatment and other social	☒	☒

	services they need for a continuum of care when they leave the hospital.		
Sacramento County Triage Navigation	In partnership with Sacramento County and Bay Area Community Services, the Triage Navigator Program serves Sacramento County residents who are experiencing a mental health crisis resulting in functional impairment that interferes with primary activities of daily and independent living. Triage Navigators respond to hospital emergency departments as well as the county jail and Loaves & Fishes to assist patients in accessing outpatient mental health services and other resources.	☒	☒
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 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 a Behavioral Health Pilot Program grant.	☒	☒
Mental Health Consultations and Conservatorship Services	The hospital provides psychiatric consultations at no cost for all patients who require evaluations while hospitalized, as well as patient conservatorship services to those who lack capacity or family help to make decisions.	☒	☒
Tele-Psychiatry	Psychiatrists are able to provide early evaluation and psychiatric intervention via remote consultations with patients, improving access to timely quality care. Access is available to both the ED and inpatient setting.	☒	☒
Crisis Stabilization Unit	In partnership with Sacramento County, the Behavioral Health Crisis Services Collaborative provides an innovative model of integrated emergency medical and emergency mental health care in one location that aims to set a standard in Sacramento and across the state for behavioral health crisis stabilization services. The Program serves adults, 18 years and older, who present in the Emergency Department, are medically stabilized, and would benefit from multi-disciplinary mental health evaluation and crisis stabilization services for up to 23 hours.	☒	☒

#RAGE Healing	Supported through the Community Grants Program, a partnership between The Race and Gender Equity Project, RocSolid Logistics LLC, Sacramento Unified School District Foster Youth Services, and Monroe Howard Transformational Coaching, #RAGE Healing serves to increase the capacity of a youth-driven community wellness hub to provide individual support and increase youth-led healing practices (peer-to-peer support) both virtually and in-person. Project components include: Direct healing services, development of a RAGE Healing Youth Collaborative (including building capacity among youth social entrepreneurs) and Training & Trauma Stewardship for those serving Black youth.	☒	☒
Education Response& Access (ERA)	Supported through the Community Grants Program, a partnership between Harm Reduction Services, Gender Health Center, and Lighthouse of Hopeful Hearts, this community grant collaboration offers access to a broad array of co-occurring treatment options for a population with numerous challenges, including those experiencing homelessness. The program provides substance use disorder assessments, group and individual treatment onsite, and education for program staff around all forms of Medication-Assisted Treatment (MAT) options.	☒	☒
Behavioral Health Recuperative Care	Supported through the Community Grants Program, a partnership between Sacramento Covered, Sacramento Native Health Center and Legal Services of Northern California provides recuperative care for clients experiencing homelessness that also have a behavioral health diagnosis, with housing and supportive services for approximately 10 -15 people over the course of one year.	☒	☒
Innovative Pilot to address Methamphetamine use in the Homeless Population	Supported through the Community Grants Program, a partnership between Hope Cooperative, WellSpace Health and Sacramento Loaves and Fishes, this pilot program offers greater access to essential mental health and substance use prevention and treatment services for the homeless or those at risk of homelessness, and addresses head-on the methamphetamine epidemic that is ravaging our community.	☒	☒
CREER En Tu Salud (Believe in your Health)	Supported through the Community Grants Program, a partnership between Latino Leadership Council Inc, United Latinos, Stanford Settlement Neighborhood Center, Gardenland Natomas Neighborhood Association and Elica Health Center, CREER En Tu Salud is a culturally appropriate program that bridges the access	☒	☒

	gap between Latino/a adults and the health, dental, vision, nutrition, behavioral and social supports that are often inaccessible to them. Through our partnership, Promotores will triage, connect, case manage and support adults in the Northwest and Northeast regions of Sacramento to reduce the access gaps to (1) quality health care; (2) mental/behavioral services and (3) basic needs.		
Truth Sets you Free: Healing our Neighborhood of Generational Trauma, Stigma and Shame	Supported through the Community Grants Program, a partnership between Neighborhood Wellness Foundation, Jubilare Evangelistic Ministries, Del Paso Union Baptist Church and Sacramento Regional Family Justice Center, this program formalizes a structural framework for mental wellness that is culturally engaging, relevant and sustainable by addressing Adverse Childhood Experiences at the base. By leveraging generational roots (>4 decades) in 95838/95815, the program teach families the impact of ACEs on health outcomes through healing circles with mental/physical learning tools and reference guides. The impact is improvement in disease management, violence suppression and literacy.	☒	☒

Impact: The hospital's initiative to address access to behavioral health services are anticipated to result in: improve patient linkages to outpatient behavioral health services; provide a seamless transition of care; and improve care coordination to ensure individuals are connected to appropriate care and can access necessary services.

Health Need: Access to Basic Needs, Such as Housing, Jobs, and Food

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Interim Care Program	The hospital is an active partner in the Interim Care Program (ICP). This collaborative engages other Dignity Health hospitals and health systems in the region, Sacramento County and Federally Qualified Health Center, WellSpace Health, and provides a respite care shelter for homeless patients with available physical and mental health, and substance abuse treatment. The program provides case management services to assist participants in connecting with outpatient services and community resources.	☒	☒
Housing with Dignity	In partnership with Lutheran Social Services and Centene, the hospital aims to assist homeless individuals with severe chronic health and mental	☒	☒

	health issues obtain and retain housing, care and services designed to achieve stability in their lives. Hospital case managers work directly with Lutheran Social Services staff to identify participants who will be housed in supportive stabilization apartments and receive intensive case management and supportive services.		
Whole Person Care/ Pathways to Health + Housing	The Pathways to Health + Housing is the City of Sacramento's Whole Person Care (WPC) which is a statewide pilot program administered by the State Department of Health Care Services, under the federal authority of the Centers for Medicare and Medicaid Services. Launched in late 2018, Pathways is an opportunity to increase the level and scope of services provided to homeless and at-risk Medi-Cal beneficiaries who are frequent users of emergency health care and who have complex medical, behavioral health and/or substance abuse challenges.	☒	☒
Resources for Low-Income Patients	The hospital partially or fully subsidizes cost of transportation, prescription medication, medical supplies and equipment, and short term room and board in the community for patients unable to pay for or access these resources after being discharged from the hospital.	☒	☒
Resources for Homeless Patients	The hospital provides clothing, meals, prescription medication, transportation, room and board, information and referrals to available community resources to homeless patients being discharged from the hospital, with the intent to help prepare them for return to the community.	☒	☒
Healthcare and Homelessness Pilot Program	Supported through the Homeless Health Initiative, and led by Community Solutions and Institute for Healthcare Improvement (IHI), the healthcare and homeless pilot seeks to understand the most meaningful, measurable and transformative contribution health care can make to ending chronic homelessness. Over the course of the 2 year initiative, the Health Systems alongside the homeless Continuum of Care partners in Sacramento, will have made measurable progress toward ending chronic homelessness, with a focus on building racially equitable systems.	☒	☒
Keeping Communities Connected Together	Supported through the Community Grants Program, a partnership between Boys and Girls Clubs of Greater Sacramento, Always Knocking, Impact Sac and Sacramento State University School of Psychology, this collaborative effort brings health, wellness, and continued learning to 350 new Sacramento youth and	☒	☒

	families. This program aims to be a comprehensive health and wellness program serving low-income and at-risk communities who need it the most.		
Behavioral Health Recuperative Care	Supported through the Community Grants Program, a partnership between Sacramento Covered, Sacramento Native Health Center and Legal Services of Northern California provides recuperative care for clients experiencing homelessness that also have a behavioral health diagnosis, with housing and supportive services for approximately 10 -15 people over the course of one year.	☒	☒
CREER En Tu Salud (Believe in your Health)	Supported through the Community Grants Program, a partnership between Latino Leadership Council Inc, United Latinos, Stanford Settlement Neighborhood Center, Gardenland Natomas Neighborhood Association and Elica Health Center, CREER En Tu Salud is a culturally appropriate program that bridges the access gap between Latino/a adults and the health, dental, vision, nutrition, behavioral and social supports that are often inaccessible to them. Through our partnership, Promotores will triage, connect, case manage and support adults in the Northwest and Northeast regions of Sacramento to reduce the access gaps to (1) quality health care; (2) mental/behavioral services and (3) basic needs.	☒	☒
My Mom, My 1st Teacher	Supported through the Community Grants Program, a partnership between Community Against Sexual Harm, Bishop Gallegos Maternity Home and City of Refugee, this program provides intensive case management, housing, focused educational programming, community support, and wrap around services to commercially sexually exploited pregnant women and at-risk transition aged young women to improve the long-term health and well-being of families in our community.	☒	☒
Innovative Pilot to address Methamphetamine use in the Homeless Population	Supported through the Community Grants Program, a partnership between Hope Cooperative, WellSpace Health and Sacramento Loaves and Fishes, this pilot program offers greater access to essential mental health and substance use prevention and treatment services for the homeless or those at risk of homelessness, and addresses head-on the methamphetamine epidemic that is ravaging our community.	☒	☒

Impact: The initiative to address basic needs are anticipated to result in: improved coordination of homeless services; increasing access to services including successful completion of referrals to outpatient services; and creating a safe discharge for individuals without a permanent housing option.

Health Need: System Navigation

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Patient Navigator Program	The Patient Navigator program focuses on assisting patients who rely on emergency departments for non-urgent needs. The navigators help patients by connecting them to a medical home in an appropriate setting and assisting them with scheduling a follow up appointment along with any other barriers that may create obstacles with accessing care. The Patient Navigator Program represents a unique collaboration between Dignity Health, Sacramento Covered, a community-based nonprofit organization, and community clinics in the region.	☒	☒
CREER En Tu Salud (Believe in your Health)	Supported through the Community Grants Program, a partnership between Latino Leadership Council Inc, United Latinos, Stanford Settlement Neighborhood Center, Gardenland Natomas Neighborhood Association and Elica Health Center, CREER En Tu Salud is a culturally appropriate program that bridges the access gap between Latino/a adults and the health, dental, vision, nutrition, behavioral and social supports that are often inaccessible to them. Through our partnership, Promotores will triage, connect, case manage and support adults in the Northwest and Northeast regions of Sacramento to reduce the access gaps to (1) quality health care; (2) mental/behavioral services and (3) basic needs.	☒	☒
Proactive and Healthy Living Project	Supported through the Community Grants Program, a partnership between Hmong Youth and Parents United, Iu-Mien Community Services and Hmong Nurses Association, this program educates the Hmong and Iu-Mien community, including their health care providers, on a variety of health related areas and topics to improve the concerning health status and disparity in both communities.	☒	☒

Impact: The hospital's initiatives to address system navigation are anticipated to result in: increased timely access and services; increased knowledge about how to access and navigate the health care system; increased primary care "medical homes" among those reached by navigators; reduce barriers to care; and improve collaborative efforts between all health care providers.

Health Need: Injury and Disease Prevention and Management

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Healthier Living Program	The Healthier Living program allows participants to learn about and practice a wide variety of tools to help them become better self-managers of their ongoing health conditions. Workshops are open to anyone with a chronic health condition, as well as those who care for persons with chronic health conditions. They are offered at the community level in partnership with medical clinics, food banks, affordable housing developments and others to ensure the underserved have access to these peer led health education classes. Provided in both English and Spanish.	☒	☒
Falls Prevention Program	Matter of Balance (MOB) is specifically designed to reduce the fear of falling and improve activity levels among community-dwelling older adults. The program enables participants to reduce the fear of falling by learning to view falls as controllable, setting goals for increasing activity levels, making small changes to reduce fall risks at home, and exercise to increase strength and balance.	☒	☒
Congestive Heart Active Management Program (CHAMP®)	This unique program keeps individuals with heart failure connected to the medical world through symptom and medication monitoring and education. CHAMP® establishes a relationship with patients who have heart disease after discharge from the hospital through: 1) Regular phone interaction to help support and educate patients in managing their disease; 2) Monitoring of symptoms or complications and recommendations for diet changes medicine modifications or physician visits.	☒	☒
Mercy Faith and Health Partnership	This interfaith community outreach program supports the development of health ministry programs including healthcare professionals, clergy and other interested members who have a desire to focus on health promotion and disease prevention programs within their congregations. Providing education, advocacy and referrals for available resources within the congregation, health ministry teams do not duplicate available services, such as nursing or medical care, but seek to creatively bridge gaps in healthcare.	☒	☒

Disease-Specific Support Groups	Education and support are offered monthly to those affected by specific diseases in the community. Current groups include: cancer; and stroke. Program transitioned to phone based support due to COVID concerns.	☒	☒
Keeping Communities Connected Together	Supported through the Community Grants Program, a partnership between Boys and Girls Clubs of Greater Sacramento, Always Knocking, Impact Sac and Sacramento State University School of Psychology, this collaborative effort brings health, wellness, and continued learning to 350 new Sacramento youth and families. This program aims to be a comprehensive health and wellness program serving low-income and at-risk communities who need it the most.	☒	☒
Truth Sets you Free: Healing our Neighborhood of Generational Trauma, Stigma and Shame	Supported through the Community Grants Program, a partnership between Neighborhood Wellness Foundation, Jubilare Evangelistic Ministries, Del Paso Union Baptist Church and Sacramento Regional Family Justice Center, this program formalizes a structural framework for mental wellness that is culturally engaging, relevant and sustainable by addressing Adverse Childhood Experiences at the base. By leveraging generational roots (>4 decades) in 95838/95815, the program teach families the impact of ACEs on health outcomes through healing circles with mental/physical learning tools and reference guides. The impact is improvement in disease management, violence suppression and literacy.	☒	☒

Impact: The initiative to address this health need by the hospital is anticipated to result in: reduction of hospital admissions for chronic disease related; improve the health and quality of life for those who suffer from chronic illness; enable participants to better manage their disease; and create a supportive environment for individuals to learn critical skills and enhance their knowledge on self-management.

Health Need: Safe and Violence-Free Environment

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Community Based Violence Prevention	The Community Based Violence Prevention Program initiative focuses on: • Educating staff to identify and respond to victims of violence and human trafficking within the hospital; • Provide victim-centered, trauma-informed care;	☒	☒

	• Collaborate with community agencies to improve quality of care; • Access critical resources for victims; and • Provide and support innovative programs for recovery and reintegration. • Public policy initiatives • Community-based programs • Research on best practices • Resources for education and awareness • Partnerships with national, state and local organizations • Socially responsible investing and shareholder advocacy		
Initiative to Reduce African American Child Deaths	Dignity Health hospitals in Sacramento County have all implemented the program which creates a consistent method for assessing safe sleep environments, ensuring children have a safe sleeping environment by providing appropriate cribs and providing consistent education partnership with the Sacramento County Child Abuse Center.	☒	☒
Safe Kids Program	Child death due to vehicle accidents is one of the leading causes of death in Sacramento County for families living in poverty, particularly within the Russian, Hmong and Spanish immigrant communities, largely due to lack of appropriate car restraints and education. The Safe Kids program provides free car seats and educational classes in the community and to all leaving the hospital with a newborn infant.	☒	☒
Education Response & Access (ERA)	Supported through the Community Grants Program, a partnership between Harm Reduction Services, Gender Health Center, and Lighthouse of Hopeful Hearts, this community grant collaboration offers access to a broad array of co-occurring treatment options for a population with numerous challenges, including those experiencing homelessness. The program provides substance use disorder assessments, group and individual treatment onsite, and education for program staff around all forms of Medication-Assisted Treatment (MAT) options.	☒	☒
My Mom, My 1st Teacher	Supported through the Community Grants Program, a partnership between Community Against Sexual Harm, Bishop Gallegos Maternity Home and City of Refugee, this program provides intensive case management, housing, focused educational programming, community support, and wrap around services to commercially sexually exploited pregnant women and at-risk transition aged young women to improve the long-term health and well-being of families in our community.	☒	☒

Impact: The initiative to address safe, crime, and violence free communities are anticipated to result in: prevent unsafe environments; improve safety for the patient population served; provide education to all hospital staff on trauma informed care; increase the awareness of services available; and improve care coordination to ensure individuals are connected to appropriate care and can access necessary services.

Health Need: Active Living and Healthy Eating

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Food Exploration and School Transformation (FEAST)	Supported through the Community Grants Program, a partnership between Food Literacy Center, Soil Born Farms and Health Education Council, FEAST's objective is to create a full circle connection for students in which they can grow their food, consume healthy produce at home, learn to cook or prepare this food, & practice healthy habits with their families.	☒	☒
Keeping Communities Connected Together	Supported through the Community Grants Program, a partnership between Boys and Girls Clubs of Greater Sacramento, Always Knocking, Impact Sac and Sacramento State University School of Psychology, this collaborative effort brings health, wellness, and continued learning to 350 new Sacramento youth and families. This program aims to be a comprehensive health and wellness program serving low-income and at-risk communities who need it the most.	☒	☒

Impact: The anticipated result is to improve the knowledge of the community about healthy eating through increased exposure to new foods. In addition, the community will be exposed to more services and resources to help achieve these goals.

Health Need: Cultural Competency

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Healthier Living Program	The Healthier Living program allows participants to learn about and practice a wide variety of tools to help them become better self-managers of their ongoing health conditions. Workshops are open to anyone with a chronic health condition, as well as those who care for persons with chronic health conditions. They are offered	☒	☒

	at the community level in partnership with medical clinics, food banks, affordable housing developments and others to ensure the underserved have access to these peer led health education classes. Provided in both English and Spanish.		
Salud con Dignidad (Health with Dignity)	Supported through the Community Grants Program, a partnership between La Familia Counseling Center, Latino Coalition for Health California, Sacramento Native American Health Center and Dr. David Nylund, Salud con Dignidad connects and navigates low-income, under-insured/uninsured, predominantly Latino, Sacramento youth and residents with health education and social service resources. SCD will utilize a holistic, coordinated-care approach to well-being by providing behavioral health, COVID education and prevention, health education, youth engagement and leadership development services, but will also include access to primary, vision, and oral health services.	☒	☒
#RAGE Healing	Supported through the Community Grants Program, a partnership between The Race and Gender Equity Project, RocSolid Logistics LLC, Sacramento Unified School District Foster Youth Services, and Monroe Howard Transformational Coaching, #RAGE Healing serves to increase the capacity of a youth-driven community wellness hub to provide individual support and increase youth-led healing practices (peer-to-peer support) both virtually and in-person. Project components include: Direct healing services, development of a RAGE Healing Youth Collaborative (including building capacity among youth social entrepreneurs) and Training & Trauma Stewardship for those serving Black youth.	☒	☒
Proactive and Healthy Living Project	Supported through the Community Grants Program, a partnership between Hmong Youth and Parents United, Iu-Mien Community Services and Hmong Nurses Association, this program educates the Hmong and Iu-Mien community, including their health care providers, on a variety of health related areas and topics to improve the concerning health status and disparity in both communities.	☒	☒
CREER En Tu Salud (Believe in your Health)	Supported through the Community Grants Program, a partnership between Latino Leadership Council Inc, United Latinos, Stanford Settlement Neighborhood Center, Gardenland Natomas Neighborhood Association and Elica Health Center, CREER En Tu Salud is a culturally appropriate program that bridges the access gap between Latino/a adults and the health, dental,	☒	☒

	vision, nutrition, behavioral and social supports that are often inaccessible to them. Through our partnership, Promotores will triage, connect, case manage and support adults in the Northwest and Northeast regions of Sacramento to reduce the access gaps to (1) quality health care; (2) mental/behavioral services and (3) basic needs.		

Impact: A culturally competent health care system can help improve health outcomes and quality of care, and can contribute to the elimination of racial and ethnic health disparities.

Health Need: Access to Specialty and Extended Care

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Sacramento Physicians' Initiative to Reach Out, Innovate and Teach (SPIRIT)	Operated under the Sierra Sacramento Valley Medical Society, the program exists as a vehicle to involve physicians in the community. SPIRIT recruits and places physician volunteers in local clinics to provide free specialty medical care to the uninsured and coordinates and case manages surgical procedures donated at local hospitals and ambulatory surgery centers. This collaboration is between the Sierra Sacramento Valley Medical Society, Mercy Folsom, sister Dignity Health hospitals, Sacramento County, and other health systems in the region.	☒	☒
Oncology Nurse Navigator	The Oncology Nurse Navigation program offers one-to-one support and guidance to patients diagnosed with cancer from the day of diagnosis onwards. The Oncology navigators provide interventions that address patient's immediate concerns and barriers to care such as difficulties with insurance, financial burden, lack of transportation and addressing the knowledge deficit of around their diagnosis and treatment options. The Navigation program also provide referrals for nutritional and psycho-social support as well hosting multiple cancer support groups across the region.	☒	☒
School Nurse Program	In partnership with the Catholic Diocese of Sacramento, Dignity Health supports a school nurse program at three catholic schools in the community serving low income neighborhoods. Services include first aide, chronic disease management and care plans, mandated health screenings and education for students, families and school staff.	☒	☒

Care for the Undocumented	Dignity Health hospitals in Sacramento County partner with Sacramento County, other health system and the Sierra Sacramento Valley Medical Society on an initiative to provide primary and specialty care, including surgery, to the region's undocumented immigrants who currently have no insurance or access to care. The hospital continues to advocate for expanded enrollment and increasing the age range to ensure more individuals could access primary care and limited specialty care services.	☒	☒
My Mom, My 1st Teacher	Supported through the Community Grants Program, a partnership between Community Against Sexual Harm, Bishop Gallegos Maternity Home and City of Refugee, this program provides intensive case management, housing, focused educational programming, community support, and wrap around services to commercially sexually exploited pregnant women and at-risk transition aged young women to improve the long-term health and well-being of families in our community.	☒	☒

Impact: The hospital's initiatives to address access to specialty and extended care and services are anticipated to result in: increased timely access and services, and increased knowledge about how to access and navigate the health care system for specialty and extended care, specifically to those that are uninsured or underinsured.

Community Grants Program

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

In FY21, Dignity Health's Sacramento county hospitals awarded grants totaling $856,980. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Food Literacy Center	FEAST- Food Exploration and School Transformation	$50,000
The Race and Gender Equity Project	#RAGE Healing	$100,000
Boys & Girls Clubs of Greater Sacramento (BGC)	Keeping Communities Connected Together!	$22,240
Latino Leadership Council Inc.	Creer En Tu Salud (Believe in your Health)	$94.326
Hmong Youth and Parents United	Proactive and Healthy Living Project	$75,000

Community Against Sexual Harm (CASH)	My Mom, My 1st Teacher	$75,000
La Familia Counseling Center	Salud Con Dignidad en Communidad	$85,000
Hope Cooperative	Innovative Pilot to Address Methamphetamine Use in the homeless Population	$100,000
Harm Reduction Services	Education, Response, and Access (ERA)	$75,000
Neighborhood Wellness Foundation	Truth Sets You Free: Healing Our Neighborhood of Generational Trauma, Stigma, and Shame	$68,414
Sacramento Covered	Behavioral Health Recuperative Care	$55,000
Crime Victims Assistance Network I-CAN	Coronavirus Pandemic Community Benefit Support Grant	$5,000
Hmong Youth and Parents United	Coronavirus Pandemic Community Benefit Support Grant	$10,000
Law Enforcement Chaplaincy	Coronavirus Pandemic Community Benefit Support Grant	$10,000
NorCAL Resist	Coronavirus Pandemic Community Benefit Support Grant	$10,000
EveryONE Matters Ministries	Coronavirus Pandemic Community Benefit Support Grant	$10,000
Wellspring Women's Center	Coronavirus Pandemic Community Benefit Support Grant	$12,000

Program Digests

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

Interim Care Program (ICP)

Significant Health Needs Addressed	✓ Access to Quality Primary Care Health Services ✓ Access to Mental, Behavioral and Substance Use Services ✓ Access to Basic Needs ❑ System Navigation ✓ Injury and Disease Prevention and Management ✓ Safe and Violence-Free Environment ✓ Access to Active Living and Healthy Eating ❑ Cultural Competency ❑ Access to Specialty and Extended Care

Program Description	The Interim Care Program (ICP) provides homeless men and women a safe environment for recovery when they are ready to be discharged from the hospital. Participants receive mental health care, substance use treatment, and social services support to transition to a healthier lifestyle.
Community Benefit Category	A2 - Community Based Clinical Services - Ancillary/other clinical services
FY 2021 Report	
Program Goal / Anticipated Impact	Increase access to a continuum of care and social support services to meet the special needs of homeless individuals necessary to improve their health status, and reduce their need to admit/readmit to the hospital.
Measurable Objective(s) with Indicator(s)	Increase the number of successful ICP referrals, improve housing outcomes, and provide additional supportive services while patients are in the program such as substance use.
Intervention Actions for Achieving Goal	Work with all partners to improve the number of successful referrals. Emphasis will be focused on improving communication between hospital and ICP staff. The hospital will continue to meet with WellSpace Health and Sacramento County to build stronger relationships and increase successful referrals.
Collaboration	ICP is a partnership with Mercy General, sister Dignity Health Hospitals, other health systems, Sacramento County, and WellSpace Health which is a Federally Qualified Health Center (FQHC).
Performance / Impact	73 persons served with an average length of stay of 122 days, which otherwise would have been days spent in hospital.
Hospital's Contribution / Program Expense	$500,000, a shared expense by Dignity Health Hospitals in Sacramento County.
FY 2022 Plan	
Program Goal / Anticipated Impact	Continue to increase access to a continuum of care and social support services to meet the special needs of homeless individuals necessary to improve their health status, and reduce their need to admit/readmit to the hospital
Measurable Objective(s) with Indicator(s)	Increase the number of successful ICP referrals, improve housing outcomes, and provide additional supportive services while patients are in the program such as mental health substance use resources. Ensure patients are connected to a medical home while in interim care.
Intervention Actions for Achieving Goal	Continue to work with all partners to improve the number of successful referrals. Emphasis will be focused on improving communication between hospital and ICP staff. The hospital will continue to meet with WellSpace Health and Sacramento County to build stronger relationships and increase successful referrals. Emphasis will be placed on coordinating ICP referrals with other referrals such as Housing with Dignity and Pathways to Health + Housing to improve coordination of services. Explore opportunities to increase bed capacity.

Planned Collaboration	ICP is a partnership with Mercy General, sister Dignity Health Hospitals, other health systems, Sacramento County, and WellSpace Health which is a Federally Qualified Health Center (FQHC).

Healthier Living Program

Significant Health Needs Addressed	❑ Access to Quality Primary Care Health Services ❑ Access to Mental, Behavioral and Substance Use Services ❑ Access to Basic Needs ❑ System Navigation ✓ Injury and Disease Prevention and Management ❑ Safe and Violence-Free Environment ✓ Access to Active Living and Healthy Eating ✓ Cultural Competency ❑ Access to Specialty and Extended Care
Program Description	The Healthier Living program allows participants to learn about and practice a wide variety of tools to help them become better self-managers of their ongoing health conditions. Workshops are open to anyone with a chronic health condition, as well as those who care for persons with chronic health conditions. They are offered at the community level in partnership with medical clinics, food banks, affordable housing developments and others to ensure the underserved have access to these peer led health education classes.
Community Benefit Category	A1 - Community Health Education – Lectures/Workshops.
FY 2021 Report	
Program Goal / Anticipated Impact	Provide education and skills management to help those with chronic disease manage their symptoms and lead healthier and more productive lives; thus reducing their need to admit to the hospital. Specifically, achieve maximum target metric goal or better – 70% of all participants avoid admission post program intervention
Measurable Objective(s) with Indicator(s)	Meet/exceed the metric goal. Develop new lay leaders and community partners to expand workshop offerings at community clinics and other agencies; increase the number of participants
Intervention Actions for Achieving Goal	Outreach to the community clinics and other nonprofits. Build community partnerships to expand workshops and identify community lay leaders and partnerships for growth.
Collaboration	Workshops are conducted in collaboration with a variety of community organizations and are held in locations accessible to the residents, such as senior housing communities and organizations that serve a high percentage

	of residents that have or are caring for family members with chronic illnesses.
Performance / Impact	13 Healthier Living workshops were conducted, including a reach of 169 community members and 134 participants completing the program. There are now 14 active leaders who can facilitate A Matter of Balance, Diabetes Empowerment Education Program, and/or Chronic Disease Self-Management Program.
Hospital's Contribution / Program Expense	$44,557 which is a shared expense by Dignity Health hospitals in Sacramento, Yolo and Nevada Counties.
FY 2022 Plan	
Program Goal / Anticipated Impact	Continue providing education and skills management to help those with chronic disease manage their symptoms and lead healthier and more productive lives; thus reducing their need to admit to the Hospital. Specifically, achieve maximum target metric goal or better – 70% of all participants avoid admission post program intervention.
Measurable Objective(s) with Indicator(s)	Meet/exceed the metric goal. Develop new lay leaders and ensure current lay leaders are up to date on current trainings. Develop new community partners to expand workshop offerings at community clinics and other agencies; increase the number of participants.
Intervention Actions for Achieving Goal	Outreach to the community clinics and other nonprofits. Continue to build community partnerships to expand workshops. Continue to identify community lay leaders and partnerships for growth including strategies to recruit and train Hmong, Russian, and Spanish speaking lay leaders.
Planned Collaboration	Workshops are conducted in collaboration with a variety of community organizations and are traditionally held in locations accessible to the residents, such as senior housing communities and organizations that serve a high percentage of residents that have or are caring for family members with chronic illnesses. Due to the ongoing COVID-19 pandemic and safety measures, workshops for the time being will be held virtually. In Partnership with Dignity Healthy, community organizations will ensure Healthier Living Workshop participants have access to the technology needed to actively engage these classes.

Education, Response, and Access (ERA)

Significant Health Needs Addressed	✓ Access to Quality Primary Care Health Services ✓ Access to Mental, Behavioral and Substance Use Services ✓ Access to Basic Needs ❑ System Navigation ✓ Injury and Disease Prevention and Management ❑ Safe and Violence-Free Environment

	❑ Access to Active Living and Healthy Eating ❑ Cultural Competency ❑ Access to Specialty and Extended Care
Program Description	Through community grants, this program allows for a seamless continuum of care for individuals experiencing homelessness or at-risk struggling with co-occurring substance use disorder and in need of mental health services. By partnering with Harm Reductions Services, Safer Alternatives Through Networking and Education (SANE), and Lighthouse of Hopeful Hearts (LOHH) program resources and linkages are able to be co-located with mental health service and achieve a new level of integration.
Community Benefit Category	E2- Grants- program grants
FY 2021 Report	
Program Goal / Anticipated Impact	Decrease the overutilization of hospital services by individuals with co-occurring substance use and behavioral health problems through the use of an integrated treatment specialist that understands the complexities of interactions between disorders, supports the individual on discharge planning and provides linkages to public and general mental health services, harm reduction services, and medication assisted treatment (MAT).
Measurable Objective(s) with Indicator(s)	Individuals who were not linked to services or unaware of resources will be linked, decreasing inappropriate ED utilization or inpatient services dealing with co-occurring substance use disorder. Improved access to outpatient mental health and substance use services and resources.
Intervention Actions for Achieving Goal	Build the program to identified patients in the hospital setting and appropriately refer, successful linkages to community resources and create training and engagement opportunities for program staff.
Collaboration	The co-occurring substance use disorder program is a partnership between Harm Reduction Services, Safer Alternatives Through Networking and Education (SANE), and Lighthouse of Hopeful Hearts (LOHH) through the Dignity Health Community Grants.
Performance / Impact	55 ERA participants reported a greater knowledge of treatment modalities in Sacramento County after accessing Substance Use Disorder treatment through the program. Each participant was provided with case management services and overdose prevention training.
Hospital's Contribution / Program Expense	$75,000, a shared expense by Dignity Health Hospitals in Sacramento County.
FY 2022 Plan	
Program Goal / Anticipated Impact	Decrease the overutilization of hospital services by individuals with co-occurring substance use and behavioral health problems through the use of an integrated treatment specialist that understands the

	complexities of interactions between disorders, supports the individual on discharge planning and provides linkages to public and general mental health services, harm reduction services, and medication assisted treatment (MAT).
Measurable Objective(s) with Indicator(s)	Individuals who were not linked to services or unaware of resources will be linked, decreasing inappropriate ED utilization or inpatient services dealing with co-occurring substance use disorder. Improved access to outpatient mental health and substance use services and resources
Intervention Actions for Achieving Goal	Continue to strengthen the program to identified patients in the hospital setting and appropriately refer, successful linkages to community resources and create training and engagement opportunities for program staff.
Planned Collaboration	The co-occurring substance use disorder program is a partnership between Harm Reduction Services, SANE, and LOHH through the Dignity Health Community Grants.

Housing with Dignity

Significant Health Needs Addressed	✓ Access to Quality Primary Care Health Services ✓ Access to Mental, Behavioral and Substance Use Services ✓ Access to Basic Needs ❑ System Navigation ✓ Injury and Disease Prevention and Management ✓ Safe and Violence-Free Environment ✓ Access to Active Living and Healthy Eating ❑ Cultural Competency ❑ Access to Specialty and Extended Care
Program Description	The program partners hospital care coordination with Lutheran Social Services to identify individuals who are chronically homeless and chronically disabled and place them in stabilization housing units. Wrap-around supportive services are provided by Lutheran Social Services to help achieve stability. Once stable, individuals are transitioned into to permanent/permanent supportive housing.
Community Benefit Category	A2 - Community Based Clinical Services - Ancillary/other clinical services
FY 2021 Report	
Program Goal / Anticipated Impact	Housing with Dignity aims to assist homeless individuals with severe chronic health and mental health issues obtain and retain housing, care and services designed to achieve stability in their lives.
Measurable Objective(s) with Indicator(s)	Address the social determinants of health by providing up to six months of transitional supportive housing for homeless individuals and provide

	additional services to enable participants to move toward stable and healthier lifestyles, while reducing hospital admissions.
Intervention Actions for Achieving Goal	Lutheran Social Services (LSS) works with hospital care coordinators to improve referral processes and engage additional hospital staff in identifying patients who meet eligibility requirements. LSS will also work with all community clinics and support services to ensure follow up medical care is obtained upon hospital discharge along with linkages to additional resources.
Collaboration	Housing with Dignity is a collaborative between the Dignity Health Sacramento County hospitals, LSS and Health Net that assisted in expanding the program.
Performance / Impact	38 patients were referred from Dignity Health hospitals and received program services.
Hospital's Contribution / Program Expense	$525,000, a shared expense by Dignity Health Hospitals in Sacramento County.
FY 2022 Plan	
Program Goal / Anticipated Impact	Housing with Dignity aims to assist homeless individuals with severe chronic health and mental health issues obtain and retain housing, care and services designed to achieve stability in their lives.
Measurable Objective(s) with Indicator(s)	Continue to address the social determinants of health by providing up to six months of transitional supportive housing for homeless individuals and provide additional services to enable participants to move toward stable and healthier lifestyles, while reducing hospital admissions
Intervention Actions for Achieving Goal	LSS works with hospital care coordinators to improve referral processes and engage additional hospital staff, including the Cancer Center, in identifying patients who meet eligibility requirements. LSS will also work with all community clinics and support services to ensure follow up medical care is obtained upon hospital discharge along with linkages to additional resources. Additional focus will be placed on establishing a medical home once patients move into permanent housing, and ensuring program participants are complying with the program's policies and procedures to reach program goals.
Planned Collaboration	Housing with Dignity is a collaborative between the Dignity Health Sacramento County hospitals, LSS and Health Net

Sacramento Physicians Initiative to Reach Out, Innovate, and Teach (SPIRIT)

Significant Health Needs Addressed	❑ Access to Quality Primary Care Health Services ❑ Access to Mental, Behavioral and Substance Use Services ❑ Access to Basic Needs

	✓ System Navigation ✓ Injury and Disease Prevention and Management ❑ Safe and Violence-Free Environment ❑ Access to Active Living and Healthy Eating ❑ Cultural Competency ✓ Access to Specialty and Extended Care
Program Description	This program is operated under the Sierra Sacramento Valley Medical Society and exists as a vehicle to involve physicians in the community. SPIRIT recruits and places physician volunteers in local clinics to provide free specialty medical care to the uninsured and coordinates and case manages surgical procedures donated at local hospitals and ambulatory surgery centers. This collaboration is between the Sierra Sacramento Valley Medical Society, Dignity Health hospitals within the Sacramento Market, Sacramento County, and other health systems in the region.
Community Benefit Category	A2 - Community Based Clinical Services - Ancillary/other clinical services
FY 2021 Report	
Program Goal / Anticipated Impact	To meet the healthcare needs of the underserved/uninsured community by recruiting and placing physician volunteers to provide free medical services to our region's uninsured.
Measurable Objective(s) with Indicator(s)	Increased number of volunteer physicians to provide free care to the uninsured. Number of patients served and number of surgeries performed.
Intervention Actions for Achieving Goal	Continue to work with all partners to improve the number of volunteer physicians well as available facilities to serve and perform donated surgeries.
Collaboration	This collaboration is between the Sierra Sacramento Valley Medical Society, Dignity Health hospitals within the Sacramento Market, Sacramento County, and other health systems in the region.
Performance / Impact	22 patients were served and 22 donated surgeries were performed by Dignity Health physician volunteers.
Hospital's Contribution / Program Expense	$35,000, a shared expense by Dignity Health Hospitals in Sacramento County. The value of surgical and specialty care donations provided by Dignity Health physician volunteers is $132,887.
FY 2022 Plan	
Program Goal / Anticipated Impact	Continue to meet the healthcare needs of the underserved/uninsured community by recruiting and placing physician volunteers to provide free medical services to our region's uninsured.
Measurable Objective(s) with Indicator(s)	Increased number of volunteer physicians to provide free care to the uninsured. Number of patients served and number of surgeries performed.

Intervention Actions for Achieving Goal	Continue to work with all partners to improve the number of volunteer physicians well as available facilities to serve and perform donated surgeries.
Planned Collaboration	This collaboration is between the Sierra Sacramento Valley Medical Society, Dignity Health hospitals within the Sacramento Market, Sacramento County, and other health systems in the region.

Substance Use Navigation

Significant Health Needs Addressed	❑ Access to Quality Primary Care Health Services ✓ Access to Mental, Behavioral and Substance Use Services ✓ Access to Basic Needs ❑ System Navigation ✓ Injury and Disease Prevention and Management ✓ Safe and Violence-Free Environment ❑ Access to Active Living and Healthy Eating ❑ Cultural Competency ✓ Access to Specialty and Extended Care
Program Description	The Public Health Institute, through the CA Bridge Program, and the CA Department of Health Care Services through the Behavioral Health Pilot Program are working to ensure that people with substance use disorders receive 24/7 high-quality care in every California healthy system by 2025. By supporting Medication Assisted Treatment (MAT) training for emergency department physicians, and a Substance Use Navigator, the programs seeks to fully integrate addiction treatment into standard medical practice-increasing access to treatment to save more lives. A Substance Use Navigator is able to build a trusting relationship with the patient and motivate 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.
Community Benefit Category	A3-Health Care Support Services
FY 2021 Report	
Program Goal / Anticipated Impact	By providing a 'No Wrong Door' approach to linking treatment for substance use disorder from the emergency department to local MAT clinics.
Measurable Objective(s) with Indicator(s)	Continue to build relationships between community MAT clinics and hospital providers by providing education opportunities, training, and dialogue.
Intervention Actions for Achieving Goal	Meetings with ED physicians, medical staff, nursing staff, social workers, and community MAT providers. Follow up phone calls to patients and providers to ensure warm handoff.

Collaboration	This program is in collaboration with local MAT agencies in Sacramento including WellSpace Health.
Performance / Impact	Connected with 537 patients admitted through the ED and provided services to connect care at local MAT agencies.
Hospital's Contribution / Program Expense	This program is funded through a California Department of Health Care Services Behavioral Health Pilot Project grant. Leadership from Emergency Department, Care Coordination and Community Health and Outreach help manage program.
FY 2022 Plan	
Program Goal / Anticipated Impact	Continue work 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
Measurable Objective(s) with Indicator(s)	Increase the number of ED providers and hospitalist providers with X-Waiver designation to allow for extended prescription of suboxone (or alternative) upon discharge from the hospital until a patient can be seen in a community MAT program. Engage in conversations and provide education to local OB providers to discuss initiation of Suboxone (or alternate) in the outpatient offices as appropriate.
Intervention Actions for Achieving Goal	Provide education to OB providers on Suboxone initiation in the outpatient setting. Continue two-way communication with ED physicians, medical staff, nursing staff, social workers, and community MAT providers. Follow up phone calls to patients and providers to ensure warm handoff.
Planned Collaboration	Continue work with local MAT agencies in Sacramento.

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.

- Community Vision (formerly Northern California Community Loan Fund) - Dignity Health has partnered with Community Vision since 1992, and was one of Dignity Health's first community investment. This CDFI has invested more than $254 million in projects throughout Northern and Central California, promoting economic justice and alleviating poverty by increasing the financial resilience and sustainability of community-based nonprofits and enterprises. In 2016 and 2017 Dignity Health approved two 7-year $1,000,000 loans respectively—the first as lending capital for NCCLF's many projects, and the second as lending capital in a "FreshWorks" Fund supporting the bringing of grocery stores and other innovative forms of healthy food retail to underserved communities ("food deserts").

- Rural Community Assistance Corporation (RCAC) - In June 2017 Dignity Health approved a 7-year $500,000 loan to RCAC for projects in rural California, Nevada and Arizona. RCAC assists rural communities in building social capital, environmental infrastructure, and affordable housing. It also provides nonprofit organizations with access to financing. RCAC financing creates employment opportunities, affordable housing, safe and reliable environmental infrastructure, and much-needed community facilities and services. RCAC operates in rural California, Nevada and Arizona, and several other states west of the Rockies. In March 2021, CommonSpirit approved another $1,000,000 to RCAC to continue to support the organization's mission in rural areas.

- California FarmLink - In June 2020, CommonSpirit approved a $500,000 loan to California FarmLink used to support the organization's loan program, which in turn provides affordable financing for small-scale farmers, beginning farmers, and farmers of color. California FarmLink is a nonprofit public benefit corporation formed in 1999 with a mission to invest in the prosperity of farmers and ranchers through lending, education, and access to land throughout farming communities in Central Coast, Sacramento, San Joaquin, and North Coast, California.

- Health Care Without Harm - Health Care Without Harm (HCWH) is a 501(c)(3) nonprofit international coalition of hospitals and health care systems, medical professionals, community groups, health-affected constituencies, labor unions, environmental and environmental health organizations, and religious groups working to "transform health care worldwide so that it reduces its environmental footprint and becomes a community anchor for sustainability and a leader in the global movement for environmental health and justice." In November, 2017, Dignity Health approved a 4-year $1,000,000 loan to HCWH for working capital needs, primarily for Practice Greenhealth (PGH), a controlled 501(c)(3) nonprofit affiliate of HCWH. The network allows HCWH to scale sustainability solutions across a significant number of hospitals and health systems across the country.

- Sacramento County Health Authority Commission – The hospital has appointed representation on the Commission which was established by the Board of Supervisors of the County of Sacramento, State of California. The Sacramento County Health Authority Commission shall serve the public interest of Medi-Cal beneficiaries in the county, and strive to improve health care quality, to better integrate the services of Medi-Cal managed care plans and behavioral health and oral health services, to promote prevention and wellness, to ensure the provision of cost-effective health and mental health care services, and to reduce health disparities. The responsibilities of this Commission are mandated in Title 2 of the Sacramento County Code, Chapter 2.136. All of the rights, duties, privileges, and immunities vested in Sacramento County pursuant to Article 2.7 of Chapter 7 of Part 3 of Division 9 of the California Welfare and Institutions Code are vested in the Health Authority.

- Health Professions Education - The hospital regularly sponsors seminars and training for medical students, physicians, nurses, and other students in the health care field. Hundreds of hours each year are committed to providing internships for nurses, paramedics, therapists, and clinical laboratory technicians.

Additionally, members of the hospital's leadership and management teams volunteer significant time and expertise as board members of nonprofit health care organizations and civic and service agencies, such as

the American Heart Association, Citrus Heights Chamber of Commerce, Sacramento Covered, Hospital Council of Northern and Central California, the CARES Foundation and Boys and Girls Club. Annual sponsorships also support multiple programs, services and fund-raising events of organizations; among them, Cristo Rey High School, Joshua's House, City of Refuge, Los Rios College, Sacramento Regional Family Justice Center, Salvation Army, American Heart Association National, and others.

Economic Value of Community Benefit

	Persons	Expense	Revenue	Net Benefit	% of Expense
Benefits for Poor					
Financial Assistance	**10,375**	**13,896,909**	**0**	**13,896,909**	**1.9%**
Medicaid	**41,078**	**269,092,992**	**225,428,671**	**43,664,321**	**5.9%**
Means-Tested Programs	**1**	**139,562**	**21,491**	**118,071**	**0.0%**
Community Services					
A - Community Health Improvement Services	10,319	9,292,164	465,477	8,826,687	1.2%
C - Subsidized Health Services	226	1,754,525	0	1,754,525	0.2%
E - Cash and In-Kind Contributions	38	1,810,461	969,132	841,329	0.1%
Totals for Community Services	434	110,931	0	110,931	0.0%
G - Community Benefit Operations	2	199,828	0	199,828	0.0%
Totals for Community Services	**11,019**	**13,167,909**	**1,434,609**	**11,733,300**	**1.6%**
Totals for Poor	**62,473**	**296,297,372**	**226,884,771**	**69,412,601**	**9.4%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	1,202	46,720	0	46,720	0.0%
B - Health Professions Education	575	3,406,467	52,417	3,354,050	0.5%
F - Community Building Activities	1	20,000	0	20,000	0.0%
Totals for Community Services	**1,778**	**3,473,187**	**52,417**	**3,420,770**	**0.5%**
Totals for Broader Community	**1,778**	**3,473,187**	**52,417**	**3,420,770**	**0.5%**
Totals - Community Benefit	**64,251**	**299,770,559**	**226,937,188**	**72,833,371**	**9.8%**
Medicare	**27,634**	**251,395,218**	**186,746,069**	**64,649,149**	**8.7%**
Totals with Medicare	**91,885**	**551,165,777**	**413,683,257**	**137,482,520**	**18.6%**

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 Sacramento Service Area Community Board

Linda Ubaldi, Chair Retired, Dignity Health Quality	Sister Eileen Enright, RSM, Vice Chair Retired, Director of Cristo Rey High School
Brian King, Secretary Chancellor, Los Rios Community College District	Marian Bell Holmes Retired, Dignity Health Human Resources
Darrell Teat CEO, Darrell Teat & Associates	Martin Camsey CFO, The Niello Company
Sister Patricia Simpson, O.P. Retired, Administrator of Our Lady of Lourdes Convent, Dominican Sisters of San Rafael	Pat Fong Kushida Executive Director, Asian Chamber of Commerce
Brian Wagner, MD Chief of Staff Mercy General Hospital	Jeffrey Cragun, MD Chief of Staff Mercy Folsom
Jennifer Osborn, MD Chief of Staff Mercy San Juan Hospital	Thomas Valdez, MD Chief of Staff Methodist Hospital
Todd Strumwasser, MD Chief Executive Officer Dignity Health Northern California Division	