2025 Community Health Implementation Strategy and Plan

Adopted September 2025

Mercy Medical Center

Merced, California

Dignity Health.
A member of CommonSpirit

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At-a-Glance Summary

Community Served 	Dignity Health Mercy Medical Center is located in Merced, California. The service area is in Merced County in the Northern San Joaquin Valley and includes the cities of Atwater, Chowchilla, Merced and Winton. The population of the service area is 186,200. Merced County is a productive agricultural area that spans from the coastal ranges to the foothills of Yosemite National Park.
Significant Community Health Needs Being Addressed 	The significant community health needs the hospital is helping to address were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs the hospitals intends to address with strategies and programs are: • Access to health care • Birth indicators • Chronic diseases • Overweight/obesity/healthy eating/physical activity • Preventive care
Strategies and Programs to Address Needs 	The hospital intends to take several actions and to dedicate resources to these needs, including: • Access to health care – financial assistance program, primary care clinics, and Connected Community Network. • Birth indicators – education, Baby Café, prenatal yoga. • Chronic diseases – education and outreach programs for asthma, cancer, diabetes and stroke, plus tobacco cessation clinics. • Overweight/obesity/healthy eating/physical activity – Classes in yoga, Walk with Ease, and Zumba. • Preventive care – health education and community outreach, screening, support groups.

Planned resources and collaborators to help address these needs, as well as anticipated impacts of the strategies and programs, are described in the "Strategies and Program Activities by Health Need" section of the document.

This document is publicly available online at the hospital's website. Written comments on this strategy and plan can be submitted to the Mercy Medical Center, Mission Integration Department, 333 Mercy Ave. Merced, CA 95340 or by e-mail to: **mmcm-communityhealth@commonspirit.org**

Our Hospital and the Community Served

About the Hospital

Mercy Medical Center is a part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 2,200 care sites in 24 states coast to coast, serving patients in big cities and small towns across America.

- Located at 333 Mercy Ave., Merced, CA 95340, Mercy Medical Center is a 186-bed acute care hospital under the sponsoring congregation of the Dominican Sisters of Kenosha, Wisconsin.
- Includes outpatient facilities: Mercy Cancer Center, Mercy Outpatient Center, Mercy Medical Pavilion and Rural Health Clinics.
- Provides cardiac services, emergency services, family birth center, orthopedic services, home health, rehabilitation services, women's health, surgical services, and others.

Our Mission

The hospital's dedication to assessing significant community health needs and helping to address them in conjunction with the community is in keeping with its 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.

Financial Assistance for Medically Necessary Care

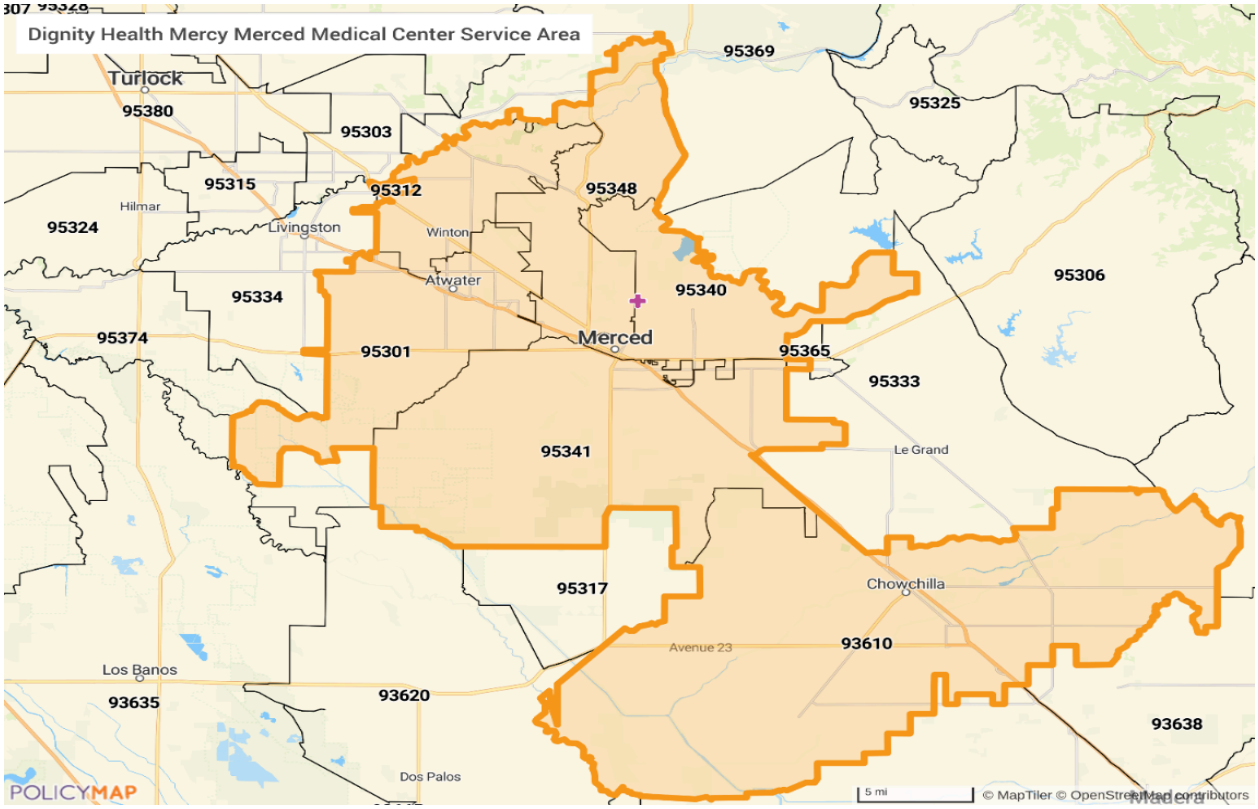
It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay.

This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

Description of the Community Served

The hospital service area includes the following cities, ZIP Codes and Counties.

Place	ZIP Code	County
Atwater	95301	Merced
Chowchilla	93610	Madera
Merced	95340, 95341, 95348	Merced
Winton	95388	Merced



A summary description of the community is below, and additional details can be found in the CHNA report online.

The population of the service area is 186,200. Children and youth, ages 0-17, make up 27.6% of the population, 61.2% are adults, ages 18-64, and 11.2% of the population are seniors, ages 65 and older. The largest portion of the population in the service area are Hispanic or Latino residents (55.6%), 28.3% are White or Caucasian residents, 8.5% are Asian residents, and 4% are Black or African American residents. 2.6% of the population are non-Latino multiracial (two-or-more races) residents, 0.4% are American Indian or Alaskan Native residents, and 0.3% are Native Hawaiian or Pacific Islander residents. Those who identify with a race and ethnicity not listed represent 0.3% of the population.

In the hospital service area, 25.3% of adults ages 25 and older lack a high school diploma, which is higher than the state rate (15.6%). 16.2% of area adults have a bachelor's or higher degree.

The U.S. Health Services Administration (HRSA) designates medically underserved areas/populations (MUA) as areas or populations having too few primary care providers, high infant mortality, high poverty, or a high elderly population. Madera County, including the Chowchilla area, and part of Merced County east of Merced, known as the 'Planada Le Grande Service Area' are designated as Medically Underserved Areas (MUAs) for primary care.

There are three categories of Health Professions Shortage Area (HPSA) designations based on the health discipline that is experiencing a shortage: 1) primary medical, 2) dental, and 3) mental health. The primary factor used to determine a HPSA designation is the number of health professionals relative to the population with consideration of high need. For primary care, the Atwater and Chowchilla areas are designated as HPSAs, as is the Merced/Merced Southwest area for low-income residents, and the Le Grand/Planada area for the Medicaid eligible population. The Chowchilla area is designated as an HPSA for Medicaid eligible residents for dental health, and all of Merced and Madera Counties are designated as HPSAs for mental health.

Community Assessment and Significant Needs

The health issues that form the basis of the hospital's community health implementation strategy and plan were identified in the most recent CHNA report, which was adopted in March 2025. The CHNA report includes:

- description of the community assessed consistent with the hospital's service area;
- description of the assessment process and methods;
- data, information and findings, including significant community health needs;
- community resources potentially available to help address identified needs; and
- impacts of actions taken by the hospital since the preceding CHNA.

Additional details about the needs assessment can be found in the CHNA report, which is publicly available on the hospital's website or upon request from the hospital, using the contact information in the At-a-Glance Summary.

Significant Health Needs

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

Significant Health Need	Description	Intend to Address?
Access to Care	Access to health care refers to the availability of primary care, specialty care, vision care and dental care services. Health insurance coverage is considered a key component to ensure access to health care. Barriers to care can include lack of transportation, language and cultural issues.	●
Birth Indicators	Poor pregnancy and birth outcomes include low birthweight, preterm births and infant mortality. These are associated with late or no prenatal care, unplanned pregnancy, cigarette smoking, alcohol and other drug use, being HIV positive, obesity, maternal age, and poor nutrition.	●
Chronic Diseases	A chronic disease or condition usually lasts for three months or longer and may get worse over time. Chronic diseases can usually be controlled but not always cured. The most common types of chronic diseases are cancer, heart disease, stroke, diabetes, and arthritis.	●
Economic Insecurity	Economic insecurity is correlated with poor health outcomes. People with low incomes are more likely to have difficulty accessing health care, have poor-quality health care, and seek health care less often.	
Food Insecurity	The USDA defines food insecurity as limited or uncertain availability of nutritionally adequate foods or an uncertain ability to acquire foods in socially acceptable ways.	
Housing and Homelessness	Homelessness is known as a state of being unhoused or unsheltered and is the condition of lacking stable, safe, and adequate housing.	
Mental Health	Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act.	
Overweight and Obesity Healthy Eating and Physical Activity	Overweight and obesity are common conditions that are defined as the increase in size and amount of fat cells in the body. Obesity is a chronic health condition that raises the risk for chronic diseases. Overweight and obesity are linked to a lack of physical activity and unhealthy eating habits.	●
Preventive Care	Preventive practices refer to health maintenance activities that help to prevent disease. For example, preventive care includes vaccines, routine health screenings (mammogram,	●

Significant Health Need	Description	Intend to Address?
	colonoscopy, Pap smear) and injury prevention strategies.	
Substance Use	Substance use is the use of tobacco products, illegal drugs, prescription drugs, over-the-counter drugs or alcohol. Excessive use of these substances or use for purposes other than those for which they are meant to be used, can lead to physical, social or emotional harm.	
Violence and Injury Prevention	Violent crimes include homicide, rape, robbery and assault. Property crimes include burglary, larceny and motor vehicle theft. Injuries are caused by accidents, falls, hits, and weapons, among other causes.	

Significant Needs the Hospital Does Not Intend to Address

Taking existing hospital and community resources into consideration, Mercy Medical Center will not directly address the remaining significant health needs identified in the CHNA, which include economic insecurity, food insecurity, housing and homelessness, mental health, substance use and violence and injury prevention.

Knowing there are not sufficient resources to address all the community health needs, Mercy Medical Center chose to concentrate on those health needs that can most effectively be addressed given the organization's areas of focus and expertise. The hospital has insufficient resources to effectively address all the identified needs and, in some cases, the needs are being addressed by others in the community.

2025 Implementation Strategy and Plan

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years, including resources for and anticipated impacts of these activities.

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

Creating the Implementation Strategy

The hospital is dedicated to improving community health and delivering community benefit with the engagement of its staff, clinicians and board, and in collaboration with community partners.

Mercy Medical Center engaged the hospital leadership and the Community Health team to create the Implementation Strategy. The CHNA served as the resource document for a review of the significant health needs as it provided information on the severity of issues and included community input on the significant health needs. Also, the community prioritization of the significant health needs was taken into consideration. The programs and initiatives described here were selected on the basis of:

- Existing Infrastructure: There are programs, systems, staff and support resources in place to address the issue.
- Established Relationships: There are established relationships with community partners to address the issue.
- Ongoing Investment: Existing resources are committed to the issue. Staff time and financial resources for this issue are counted as part of our community benefit effort.
- Focus Area: The hospital has acknowledged competencies and expertise to address the issue, and the issue fits with the organizational mission.

Community Health Core Strategies

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources. CommonSpirit Health has established three core strategies for community health improvement activities. These strategies help to ensure that program activities overall address strategic aims while meeting locally identified needs.

- Core Strategy 1: Extend the care continuum by aligning and integrating clinical and community-based interventions.
- Core Strategy 2: Implement and sustain evidence-informed health improvement strategies and programs.
- Core Strategy 3: Strengthen community capacity to achieve equitable health and well-being.

Vital Conditions and the Well-Being Portfolio

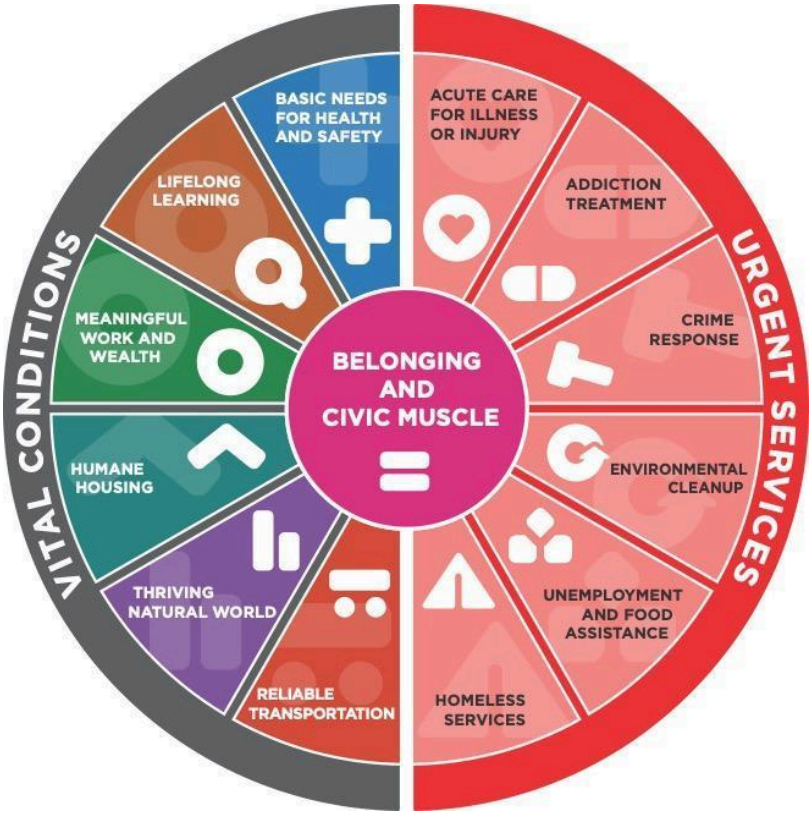
Community health initiatives at CommonSpirit Health use the Vital Conditions framework and the Well-Being Portfolio[1] to help plan and communicate about strategies and programs. Investments of time, resources, expertise and collaboration to improve health and well-being can take different approaches. And usually, no single approach can fully improve or resolve a given need on its own.

One way to think about any approach is that it may strengthen "vital conditions" or provide "urgent services," both of which are valuable to support thriving people and communities. A set of program activities may seek to do one or both. Taken together, vital conditions and urgent services compose a well-being portfolio.

What are Vital Conditions?
These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions of communities. They help create a community environment that supports health.

What are Urgent Services?
These are services that anyone under adversity may need temporarily to regain or restore health and well-being. Urgent services address the immediate needs of individuals and communities, say, during illness.

What is Belonging and Civic Muscle?
This is a sense of belonging and power to help shape the world. Belonging is feeling part of a community and valued for what you bring. Civic muscle is the power of people in a society to work across differences for a thriving future.



Well-Being Portfolio in this Strategy and Plan
The hospital's planned strategies and program activities that follow are each identified as aligning with one of the vital conditions or urgent services in this figure.

This helps to identify the range of approaches taken to address community needs and also acknowledges that the hospital is one community resource and stakeholder among many that are dedicated to and equipped for helping to address these needs and improve health.

[1] The Vital Conditions Framework and the Well-Being Portfolio were created by the Rippel Foundation and are being used with permission. Visit https://rippel.org/vital-conditions/ to learn more.

Strategies and Program Activities by Health Need

Health Need:	**Access to Health Care and Preventive Care**				
Population(s) of Focus:	Individuals who experience barriers to accessing health care and preventive care services. Uninsured and underinsured people.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Community Health Improvement Grants Program	Grant funds are awarded to nonprofit organizations to increase access to health care and preventive care.	●	●	●	Basic Needs for Health and Safety (VC) Acute care for illness or injury (UC)
Family Practice Clinic	This clinic is affiliated with the UC Davis Residency program and provides primary care and preventive services. It primarily serves Medi-Cal and underinsured patients. There also is a Mobile Health Clinic for outreach to underserved populations.	●	●		Basic Needs for Health and Safety (VC), Acute care for illness or injury (UC)
Financial Assistance Program	Financial assistance is provided to uninsured and underinsured patients.	●	●		Acute care for illness or injury (UC)
General Medicine Clinic	This clinic provides rotating specialty physicians who serve the underinsured, working poor, and patients with Medi-Cal coverage.	●	●		Basic Needs for Health and Safety (VC), Acute care for illness or injury (UC)

Health Need:	**Access to Health Care and Preventive Care**				
Kids Care Pediatric Clinic	This pediatric and obstetric clinic primarily serves managed Medi-Cal and underinsured patients.	●	●		Basic Needs for Health and Safety (VC), Acute care for illness or injury (UC)
Planned Resources:	The hospital will provide health care providers, patient financial staff, enrollment counselors, community health educators, case managers, philanthropic cash grants, outreach communications, and program management support.				
Planned Collaborators:	Merced Faculty Associates, UC Davis Residency Program, Livingston Community Health Clinic, Central CA Alliance for Health, Merced County Continuum of Care, The Salvation Army, Collaborative Planning and Implementation Merced (CalAIM), Merced County Department of Public Health				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increase access to health care for the medically underserved and reduce barriers to care.	Reduce to 5.9% the proportion of people who can't get medical care when they need it.	Healthy People 2030
Increase the number of adults who get recommended preventive health care.	11.5% of adults receive recommended preventive care services.	Healthy People 2030

Health Need:	**Birth Indicators**				
Population(s) of Focus:	Pregnant women and their families, breastfeeding women, women contemplating becoming pregnant.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Baby Café	Childbirth Educators and Lactation Consultants from Mercy Medical Center and Merced County WIC facilitate this support group. New and experienced moms help each other with challenges they encounter with breastfeeding and postpartum depression.		●	●	Lifelong learning (VC)
California Lactation Coalition and the Merced County Breastfeeding Network	Hospital staff participate in collaborative efforts to increase breastfeeding.		●	●	Lifelong learning (VC)
Community Grants Program	Grant funds are awarded to nonprofit organizations to improve birth outcomes.	●	●		Lifelong learning (VC)
Kids Care Pediatric Clinic	This pediatric and obstetric clinic primarily serves managed Medi-Cal and underinsured patients.	●	●		Basic Needs for Health and Safety (VC), Acute care for illness or injury (UC)
Maternal and Infant Care Education	Pregnant women and their families are provided with educational opportunities and resources to improve birth outcomes. Childbirth education classes and postpartum education included.		●		Lifelong learning (VC)

Health Need:	**Birth Indicators**				
Prenatal Yoga	Incorporates stretching, mental centering and focused breathing to reduce stress, improve sleep and improve flexibility and strength.		•		Lifelong learning (VC)
Planned Resources:	The hospital will provide registered nurses, IBCLC/CLC, community health educators, philanthropic cash grants, outreach communications, and program management support.				
Planned Collaborators:	Family Practice clinics, Merced County WIC, California Lactation Coalition, Merced County Breastfeeding Network, Lactation Action Group, California Breastfeeding Committee, Merced County Department of Public Health, First 5 of Merced County, All Dads Matter, All Moms Matter, Merced Maternal Wellness Coalition				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Improve maternal and infant health outcomes.	80.5% of pregnant women receive early and adequate prenatal care.	Healthy People 2030
Increase breastfeeding among infants.	42.4% of infants are breastfed exclusively through age 6 months.	Healthy People 2030

Health Need:	**Chronic Diseases**				
Population(s) of Focus:	Individuals with chronic diseases and their families, people at risk of developing chronic diseases.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Accessible Yoga	Provides a modified yoga program tailored to cancer patients' physical abilities.		●		Lifelong learning (VC)
American Cancer Society Collaborative	The Collaborative Action Plan is a partnership with ACS and the Cancer Center. Provides educational materials and the Reach to Recovery program.			●	Lifelong learning (VC)
Asthma Awareness and Education Outreach	Partners with community groups to raise asthma awareness. Provides education via health presentations, health screening events, and health fairs.			●	Lifelong learning (VC)
Asthma Awareness and Education	Provides education via individual and group sessions, health presentations, and health fair outreach.		●	●	Lifelong learning (VC)
Cancer Support Group	This support group is open to any person affected by cancer; patient or family member, regardless of where they received treatment.		●		Lifelong learning (VC)
Community Health Improvement Grants Program	Grant funds are awarded to nonprofit organizations to address management and treatment of chronic diseases.	●	●	●	Lifelong learning (VC)
Connected Community	Hospital care coordination and community	●	●		Basic Needs for

Health Need:	**Chronic Diseases**				
Network (CCN)	partner agencies work together to identify the health and health-related social needs of vulnerable patients and electronically link health care providers to organizations that provide direct services.				Health and Safety (VC), Acute care for illness or injury (UC)
Diabetes Self Management Program (DSMP)	Designed by Stanford University, an evidenced-based self-management program that helps participants manage their diabetes and adjust to a healthier lifestyle.	●	●	●	Lifelong learning (VC)
Diabetes Support Group and Educational Program	Weekly diabetes education sessions are provided via Zoom, phone, and in-person in English and Spanish. Sessions provide education and an opportunity for participants to offer each other support.		●		Lifelong learning (VC)
Kindness Box Program	Food box program provides quarterly noncontact food delivery front door or drive thru service for cancer patients and their families.			●	Unemployment and food assistance (UC)
Mercy Cancer Center	Provides oncology care to the community. Partners with the American Cancer Society for outreach programs and support services. Collaborates in the community to provide cancer screening events. Provides cancer patients with access to synthetic wigs and head coverings at no cost.	●	●	●	Lifelong learning, (VC), Basic needs for health and safety (VC)
Chronic Disease Self Management Program (CDSMP)	Designed by Stanford University, an evidenced-based self-management program that helps participants take control of their chronic conditions and adopt a healthier lifestyle.	●	●	●	Lifelong learning (VC)

Health Need:	**Chronic Diseases**				
Stroke Support and Resource Class	Monthly meetings provide individuals with information on preventing strokes, coping with disabilities and changes after a stroke, and support for caregivers.	●	●	●	Lifelong learning (VC)
Tobacco Cessation Clinics	Through the American Lung Association's Freedom from Smoking Clinics, provides clinic sessions to prepare community members to quit tobacco use	●	●	●	Lifelong learning (VC)
Transportation Program	A comprehensive assistance program supports cancer patients with navigating benefits, resources and other programs to secure transportation for treatment.			●	Reliable transportation (VC)
Planned Resources:	The hospital will provide nurses, community health educators, philanthropic cash grants, outreach communications, and program management support.				
Planned Collaborators:	Community collaboratives, American Heart Association, American Cancer Society, Tobacco Coalition, Asthma Coalition, American Lung Association, Centers for Disease Control, walking groups, senior groups, Merced County Department of Public Health, Mercy Medical Center Foundation				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increased compliance with chronic disease management recommendations.	55.2% of people with diabetes get formal diabetes education. 80.3% of females get screened for breast cancer.	Healthy People 2030

Health Need:	**Overweight and Obesity, Healthy Eating and Active Living**				
Population(s) of Focus:	People who are overweight or obese or at risk of becoming overweight. Individuals and families who want to improve healthy eating and increase physical activity.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Community Health Improvement Grants Program	Grant funds are awarded to nonprofit organizations to increase physical activity and provide access to nutritious food.		●	●	Basic needs for health and safety. (UC)
Community Exercise Programs	Community exercise classes are offered for adults of all fitness levels to increase balance, strengthen muscles, maintain flexibility and relieve stress. May include yoga, Zumba, walking classes, and Tai Chi.			●	Basic needs for health and safety. (UC)
Planned Resources:	The hospital will provide registered nurses, community health educators, philanthropic cash grants, outreach communications, and program management support.				
Planned Collaborators:	Food Policy Council of Merced County, Kids Discovery Station, Merced County Department of Public Health, City of Merced Parks and Recreation, Merced Senior Community Center				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Improved healthy eating and physical activity behaviors.	Reduce the proportion of adults with obesity to 36%.	Healthy People 2030

	Reduce the proportion of children and teens with obesity to 15.5%.	