# Mercy San Juan Medical Center

## Community Benefit 2020 Report and 2021 Plan

**Adopted October 2020**

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 2020 Report and 2021 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 2020 (FY20), Mercy San Juan provided $53,747,363 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $65,079,375 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2020 Report and 2021 Plan at its October 22, 2020 meeting.

Thank you for taking the time to review our report and plan.  If you have any questions, please contact us at (916) 851-2005.

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 2,500 employees, 370 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**

$53,747,363 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits

$65,079,375 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

**FY20 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.

- 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.
- 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 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.
- 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.

**FY21 Planned Programs and Services**

For FY21, the hospital plans to continue to build upon many of previous years' initiatives and explore new partnership opportunities with Sacramento County and the different cities, health plans and community organizations. Efforts to enhance patient navigation services in partnership with Sacramento Covered, Hope Cooperative and Turning Point will continue with specific focus on improving the linkages to community resources and the number of real-time referrals which will result in more face to face interactions between the navigators and the patients.

Mercy San Juan will play an active role in developing innovative strategies to address the growing number of individuals experiencing homelessness including the expansion of the Interim Care Program, active engagement with the City of Sacramento's Pathways to Health + Housing (Whole Person Care) 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 is a nationally recognized not-for-profit 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, 370 licensed acute care beds, and 31 emergency department beds. Mercy San Juan offers hospital-based hyperbaric oxygen (HBO) treatment. Providing HBO services in a hospital setting gives patients added safety and comfort, knowing they are surrounded by a team of highly trained nurses, physicians and HBO therapists. The Neonatal Intensive Care Units (NICU) has long been a leader in caring for the smallest of newborns. Mercy San Juan's NICU includes 26 licensed beds and is equipped to provide specialized care including invasive monitoring, conventional ventilation, surgery, transport service, inhaled nitric oxide and high frequency oscillator ventilation

## 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 delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services.

A plain language summary of the policy is at the end of this report. The financial assistance policy and plain language summary 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. The hospital is part of the region historically known for its lack of safety net providers to serve low-income and vulnerable residents. The hospital's primary service area is comprised of 28 zip codes and home to over one million residents; nearly 30 percent of these 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. A summary description of the community is below. Additional details can be found in the CHNA report online.

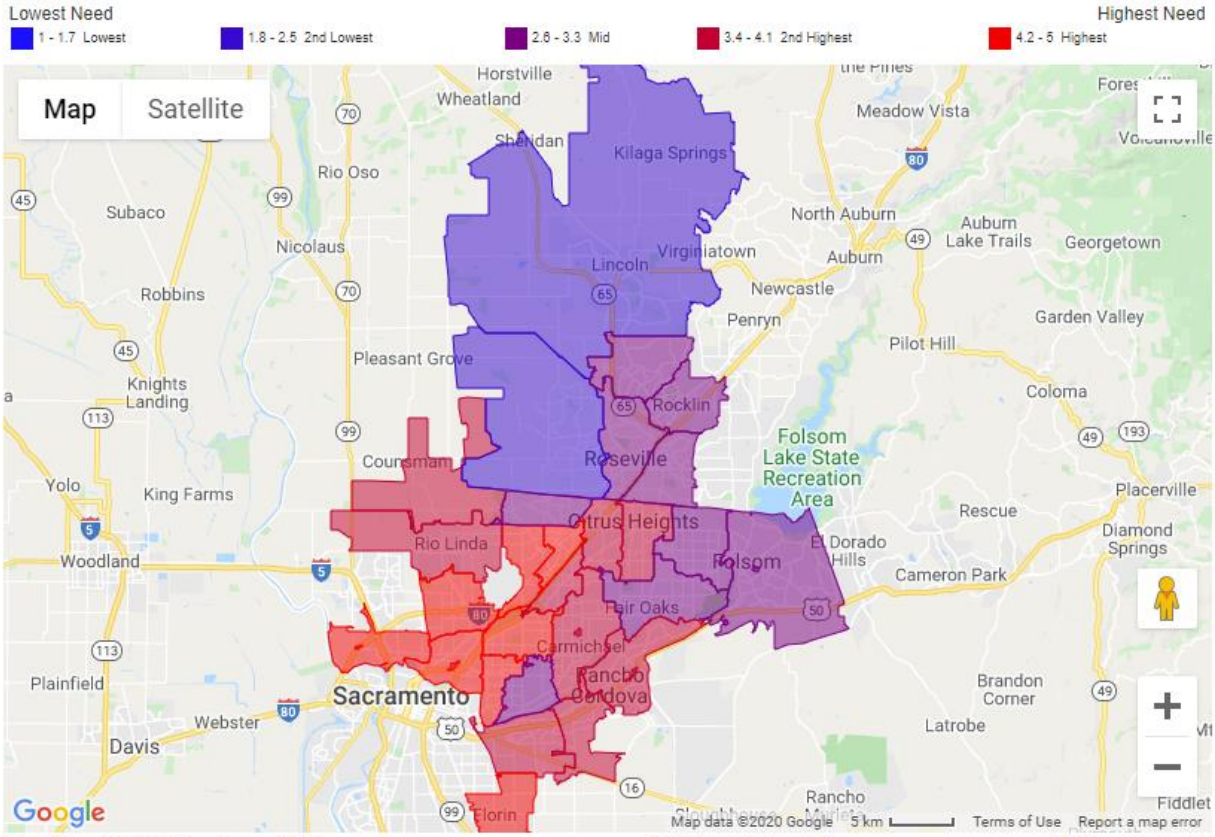
Demographics within the Mercy San Juan hospital service area are as follows, derived from 2020 estimates provided by Strategy's SG2 Analytics Platform (*Source: Claritas Pop-Facts® 2020)*:

- Total Population: 1,114,188
- Race/Ethnicity: Hispanic or Latino: 21.1%; White: 56.0%, Black/African American: 6.4% Asian/Pacific Islander: 11.2%, All Other: 5.4%.
- % Below Poverty: 10.0%
- Unemployment: 6.3%
- No High School Diploma: 10.3%
- Medicaid (household): 8.9%
- Uninsured (household): 4.7%

## 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): 3.6 / Mean(person): 3.5 CNI Score Median: 3.6 CNI Score Mode: 3.6

# 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.

# 2020 Report and 2021 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 FY20 and planned activities for FY21, 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

A general approach is taken when planning and developing initiatives to address priority health issues. At the onset, 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 also sparked fears of an impending economic crisis and recession. Social distancing, self-isolation and travel restrictions have led to a reduced workforce across all economic sectors and caused many jobs to be lost. Schools have closed down, and the need for commodities and manufactured products has decreased. The food sector is also facing increased demand due to panic-buying and stockpiling of food products.

Moreover, the COVID-19 pandemic has caused an unprecedented challenge for our Greater Sacramento Division 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 Division 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 Division 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 FY20, 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 FY20 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.

- Together with Kaiser, Sutter Health, UC Davis, The California Endowment, Union Pacific and Sacramento Covered, Dignity Health supported Sacramento Covered and Solomon's Deli in their COVID-19 Community Kitchen project which served 400 meals a day for homeless individuals in the community.
- Collaborated with Sutter, UC Davis and Kaiser Permanente on a coordinated communication campaign – 'Here For You' – intended to increase understanding within the community that it is safe to receive care at all local hospitals and clinics.
- 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.
- Mobilized 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's Chief Medical Officer (CMO) coordinated weekly COVID-19 calls for other CMOs in the community to collaborate on providing the most up to date education and strategizing for how to best provide care for the community.
- Implemented pre-procedure testing at all Division hospitals.

In addition to continuing many of the actions identified above, Mercy San Juan plans to take the following actions in FY21 to continue helping alleviate pandemic-induced needs:

- Adapted our FY21 Community Grants to allow for COVID-19 specific funding.
- Collaborating together 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 Kaiser, Sutter Health, UC Davis and Sacramento County to support a community driven Latinx Public Health Campaign to stop the spread of COVID-19, targeting Sacramento's Latinx communities.
- 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.
- 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.
- Launching new pilot programs focusing on food insecurity, which was identified as a significant need in light of COVID-19, for vulnerable populations, including children and older adults.
- Mercy San Juan is strongly encouraging community members to get their flu shot and educating patients regarding the importance especially in light of COVID-19.
- 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 FY20 | Planned FY21 |
|---|---|---|---|
| School Nurse Program | Nearly 750 students and their family members received health services annually within the Catholic Diocese of Sacramento through the hospital's School Nurse program. 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 | Mercy San Juan and the other Dignity Health hospitals in Sacramento County partnered with Sacramento County, other health system and the Sierra Sacramento Valley Medical Society to develop an initiative that launched in FY16 to provide primary and specialty care, including surgery, to the region's undocumented immigrants who currently have no insurance or access to care. In FY18, the hospital helped advocate for expanded enrollment and increasing the age range to ensure more individuals could access primary care and limited specialty care services. | ☒ | ☒ |

**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 FY20 | Planned FY21 |
|---|---|---|---|
| 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. The program also assists with navigation and transportation through a partnership with Heart of Gold Medical Transport. | ☒ | ☒ |
| Navigation to Wellness | Through our Community Grants, this initiative engages nonprofit mental health provider, Turning Point, to improve the quality of care for patients in mental health crisis. Clinical social workers from Turning Point work side by side hospital social workers to ensure patients are linked to appropriate public and community behavioral health services needed for wellness when they are discharged. The program provides ongoing support for up to 60 days post-discharge. | ☒ | ☒ |
| 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. | ☒ | ☒ |
| Hope Cooperative Triage Navigator | In partnership with Sacramento County and Hope Cooperative, 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 are placed in hospital emergency departments as well as the county jail and Loaves & Fishes to assist patients in accessing outpatient mental health services and other resources. In FY19, program services will be expanding to serve the inpatient population. | ☒ | ☒ |
| Education Response & Access (ERA) 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. | ☒ | ☒ |

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|---|---|---|---|
| Sacramento Covered Behavioral Health Recuperative Care | Under the Community Grants community grants, this collaboration between Sacramento Covered, Sacramento Native Health Center and Legal Services of Northern California propose to build and test a program to provide 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. | ☒ | ☒ |

**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 FY20 | Planned FY21 |
|---|---|---|---|
| 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. All partners are currently working together to identify expansion opportunities to respond to the growing need. | ☒ | ☒ |
| Housing with Dignity | In partnership with Lutheran Social Services, Mercy San Juan 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. Ongoing health care for these participants is provided by a variety of Dignity Health and community resources with the goal of transitioning participants into permanent housing. | ☒ | ☒ |

**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 FY20 | Planned FY21 |
|---|---|---|---|
| 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. | ☒ | ☒ |

**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 FY20 | Planned FY21 |
|---|---|---|---|
| Healthier Living | 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. | ☒ | ☒ |

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|---|---|---|---|
| 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. In FY18, the program received a Mercy Foundation grant for the purchase of scales, blood pressure cuffs and oximeter to better evaluate patients during phone consultations. | ☒ | ☒ |
| 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. | ☒ | ☒ |

**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 FY20 | Planned FY21 |
|---|---|---|---|
| Community Based Violence Prevention | The Community Based Violence Prevention Program initiative focuses on:<br>• Educating staff to identify and respond to victims of violence and human trafficking within the hospital;<br>• Provide victim-centered, trauma-informed care;<br>• Collaborate with community agencies to improve quality of care;<br>• Access critical resources for victims; and<br>• Provide and support innovative programs for recovery and reintegration.<br>• Public policy initiatives | ☒ | ☒ |

| | | | |
|---|---|---|---|
| | • Community-based programs<br>• Research on best practices<br>• Resources for education and awareness<br>• Partnerships with national, state and local organizations<br>• Socially responsible investing and shareholder advocacy | | |
| Healthy Women and Families | Through our community grants and in partnership with Community Against Sexual Harm (CASH) Bishop Gallegos Maternity Home, and Freedom Through Education, the program provides an easily accessible, strong safety net to victims of commercial sexual exploitation and at-risk young women. The program helps stabilize and ensure that the most vulnerable receive a coordinated system of support capable of addressing the individual and family needs that often lead to a pattern of continued abuse, exploitation, and poor health outcomes. | ☒ | ☒ |
| Initiative to Reduce African American Child Deaths | Mercy San Juan and 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. | ☒ | ☒ |

**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: Access to Active Living and Healthy Eating

| Strategy or Program Name | Summary Description | Active FY20 | Planned FY21 |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Food Exploration and School Transformation (FEAST) | Under the Community Grants, Mercy San Juan supports this organization's efforts to teach food literacy and nutrition through cooking classes at underserved elementary schools. The program offers strategies to create behavior change and prevent childhood obesity through two core programs, which together provide a complete, scalable and replicable solution to the problem: 1) teaching food literacy to low-income pre-K through 6th graders, and 2) training community members as food literacy instructors. Through collaboration with Health Education Council, FEAST expanded their reach to parents and families. The hospital will partner with Middletown Elementary School, the Middletown Health Advocate Network, and a local federal-qualified health center to deliver this access to care strategy. In addition, the public health department will provide in-kind services. | ☒ | ☒ |
| **Impact:** The anticipated result is to increase access to healthy foods and safe activity and improve the community's knowledge about the importance of living a healthy and active lifestyle. 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 FY20 | Planned FY21 |
|---|---|---|---|
| Healthier Living | 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. | ☒ | ☒ |
| Dementia Care and Support Navigation | The collaboration between Alzheimer's Association of Northern California, Del Oro Caregiver Resource Center, Rebuilding Together and Mercy Medical Group focuses on connecting patients with Alzheimer's or other cognitive impairments and their caregivers to community services. Integrating education, emotional support, economic assistance | ☒ | ☐ |

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| | and safety services will improve the lives of persons with Alzheimer's and caregivers. | | |
| Salud con Dignidad (Health with Dignity) | Under the Community Grants community grants, Latino Coalition for a Healthy California focuses on providing underserved, undocumented individuals and families access to an array of culturally and linguistically competent health and wellness services. This collaborative will deliver the "Know your Health Care Rights" curriculum via promotores and provide access to both primary care and behavioral health services, including dance therapy, to the Undocumented population. | ☒ | ☒ |

**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 FY20 | Planned FY21 |
|---|---|---|---|
| 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. | ☒ | ☒ |
| 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 San Juan, sister Dignity Health hospitals, Sacramento County, and other health systems in the region. | ☒ | ☒ |
| Care for the Undocumented | Mercy San Juan and the other Dignity Health hospitals in Sacramento County partnered with Sacramento | ☒ | ☒ |

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| | County, other health system and the Sierra Sacramento Valley Medical Society to develop an initiative that launched in FY16 to provide primary and specialty care, including surgery, to the region's undocumented immigrants who currently have no insurance or access to care. In FY18, the hospital helped 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) | Under the Community Grants community grants, Latino Coalition for a Healthy California focuses on providing underserved, undocumented individuals and families access to an array of culturally and linguistically competent health and wellness services. This collaborative will deliver the "Know your Health Care Rights" curriculum via promotores and provide access to both primary care and behavioral health services, including dance therapy, to the Undocumented population. Additional partners include Vision y Compromiso, La Familia Counseling Center and Sacramento Native American Health Center. | ☒ | ☒ |

**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.

## Financial Assistance for Medically Necessary Care

Mercy San Juan delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services. A plain language summary of the hospital's Financial Assistance Policy is on the last page of this report. The amount of financial assistance provided in FY20 is listed in the Economic Value of Community Benefit section of this report.

The hospital notifies and informs patients and members of the community about the Financial Assistance Policy in ways reasonably calculated to reach people who are most likely to require patient financial assistance. These include:

- providing a paper copy of the plain language summary of the Policy to patients as part of the intake or discharge process;
- providing patients a conspicuous written notice about the Policy at the time of billing;
- posting notices and providing brochures about the financial assistance program in hospital locations visible to the public, including the emergency department and urgent care areas, admissions office and patient financial services office;
- making the Financial Assistance Policy, Financial Assistance Application, and plain language summary of the Policy widely available on the hospital's web site;

- making paper copies of these documents available upon request and without charge, both by mail and in public locations of the hospital; and
- providing these written and online materials in appropriate languages.

Mercy San Juan also includes the Financial Assistance Policy in the reports made publicly available, including the annual Community Benefit reports and triennial Implementation Strategies.

## 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 FY20, Dignity Health's Sacramento county hospitals awarded grants totaling $776,195. Programs below have ties to Mercy San Juan. Some projects also may be described elsewhere in this report.

| Grant Recipient | Project Name | Amount |
|---|---|---|
| Sacramento Life Center | Continuum of Care for Arden Area's Low Income Pregnant Women and Teens | $75,000 |
| Sacramento Covered | Behavioral Health Recuperative Care: Supporting client needs and building community capacity through collaboration | $100,000 |
| La Familia Counseling Center | Salud Con Dignidad (Health with Dignity) | $56,195 |
| Harm Reduction Services | Education, Response, and Access | $80,000 |
| Alzheimer's Association | Dementia Care and Support Navigation | $75,000 |
| Mutual Assistance Network | Passport to Adulthood | $80,000 |
| 3 Strands Global Foundation | The Employ + Empower Reintegration Program | $80,000 |
| Community Against Sexual Harm | Healthy Women and Families | $75,000 |

## 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.

| Patient Navigator | |
|---|---|
| Significant Health Needs Addressed | ✓ Access to Quality Primary Care Health Services<br>☐ Access to Mental, Behavioral and Substance Abuse Services<br>☐ Access to Basic Needs<br>✓ System Navigation<br>✓ Injury and Disease Prevention and Management<br>☐ Safe and Violence-Free Environment<br>☐ Access to Active Living and Healthy Eating<br>☐ Access to Meeting Functional Needs<br>☐ Cultural Competency<br>☐ Access to Specialty and Extended Care |
| Program Description | Assists patients who rely on emergency departments for non-urgent needs. The navigators help patients by connecting them to a primary care medical home and assisting them with scheduling a follow up appointment along with any other barriers that may create obstacles with accessing care. |
| Community Benefit Category | A3 - Health Care Support Services – Information & Referral. |
| **FY 2020 Report** | |
| Program Goal / Anticipated Impact | Assist underserved patients admitting to the emergency department (ED) for primary care in finding primary care medical homes or reconnecting them with their assigned provider and other social support services to reduce their reliance on the ED, improve their health and lower costs. |
| Measurable Objective(s) with Indicator(s) | Nearly 50% of all emergency department visits are for primary care and could be avoided if care were received in a physician's office or clinic. Program will be measured by improved access for patients; reduced emergency department primary care visits; and reduced costs. |
| Intervention Actions for Achieving Goal | Work with emergency department staff, patient registration and Sacramento Covered to strengthen a comprehensive program that responds to the growing Medi-Cal population and engage health plans, IPA, and community clinics to address the need for improved access to primary care. Provide education regarding Urgent Care access, mental health, transportation and dental services. |
| Collaboration | The program is a collaborative initiative between the hospital, Health Net, Sacramento Covered and community health centers. Health Net has increased their engagement in FY18 which resulted in a greater unified effort between Health Net and Dignity to ensure program success. |
| Performance / Impact | 12,458 patients were assisted and 33% of the patients assisted had a follow up appointment scheduled with a primary care or other type of provider. All patients received education or referrals to resources. |

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| Hospital's Contribution / Program Expense | $89,965 which is a shared expense by Dignity Health hospitals in Sacramento County. |
| **FY 2021 Plan** | |
| Program Goal / Anticipated Impact | Continue to assist underserved patients admitting to the emergency department (ED) for primary care in finding primary care medical homes or reconnecting them with their assigned provider and other social support services to reduce their reliance on the ED, improve their health and lower costs. |
| Measurable Objective(s) with Indicator(s) | The program will at least serve 70% of weekday high-utilizers defined as those with three (3) or more ER visits at a participating Dignity Health facility within a 90 day period below and 60% of total volume of the weekday non-urgent/non-emergent. |
| Intervention Actions for Achieving Goal | Continue to work with emergency department staff, patient registration, and Sacramento Covered to build a comprehensive program that responds to the growing Medi-Cal population and engage other plans, IPA, and community clinics to work collectively in addressing the need for improved access to primary care. To meet the new metrics, emphasis will be on increasing referrals and strengthening collaboration with Health Net to ensure patients have the most current information and resources. |
| Planned Collaboration | The program is a collaborative initiative between the hospital, Sacramento Covered and community health centers. |

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| **Interim Care Program (ICP)** | |
| Significant Health Needs Addressed | ✓ Access to Quality Primary Care Health Services<br>✓ Access to Mental, Behavioral and Substance Abuse Services<br>✓ Access to Basic Needs<br>❑ System Navigation<br>✓ Injury and Disease Prevention and Management<br>✓ Safe and Violence-Free Environment<br>✓ Access to Active Living and Healthy Eating<br>❑ Access to Meeting Functional Needs<br>❑ Cultural Competency<br>❑ 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 abuse treatment, and social services support to transition to a healthier lifestyle. |
| Community Benefit Category | A2 - Community Based Clinical Services - Ancillary/other clinical services |
| **FY 2020 Report** | |

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| 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 number of successful ICP referrals, improve housing outcomes, and provide additional supportive services while patients are in the program such as substance abuse. |
| Intervention Actions for Achieving Goal | Work with all partners to improve 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 San Juan, sister Dignity Health Hospitals, other health systems, Sacramento County, and WellSpace Health which is a Federally Qualified Health Center (FQHC). |
| Performance / Impact | 64 persons served with an average length of stay of 23 days, which otherwise would have been days spent in hospital. |
| Hospital's Contribution / Program Expense | $700,000 which is a shared expense by Dignity Health Hospitals in Sacramento County. Includes funding provided for expansion of the program in FY20. |
| **FY 2021 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 number of successful ICP referrals, improve housing outcomes, and provide additional supportive services while patients are in the program such as mental health substance abuse 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 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 San Juan, sister Dignity Health Hospitals, other health systems, Sacramento County, and WellSpace Health which is a Federally Qualified Health Center (FQHC). |

| Safe Kids Car Seat and Health/Safety Education | |
|---|---|
| Significant Health Needs Addressed | ☐ Access to Quality Primary Care Health Services<br>☐ Access to Mental, Behavioral and Substance Abuse Services<br>☐ Access to Basic Needs<br>☐ System Navigation<br>☐ Injury and Disease Prevention and Management<br>✓ Safe and Violence-Free Environment<br>☐ Access to Active Living and Healthy Eating<br>☐ Access to Meeting Functional Needs<br>☐ Cultural Competency<br>☐ Access to Specialty and Extended Care |
| Program Description | Infant and child car seat and health/safety education classes are provided at no cost to families with children living in poverty and to families with children in immigrant communities, where the need is greatest. Safe Kids health and safety fairs are part of the overall program. These offer a venue to provide safety education to parents, care-givers and children in the community. The hospital is the only provider offering car seat education to the largest non-English speaking populations in the region – Hispanic, Russian and Hmong. |
| Community Benefit Category | A1 - Community Health Education - Lectures/Workshops |
| **FY 2020 Report** | |
| Program Goal / Anticipated Impact | Improve the public awareness of child safety and provide education workshops for families living in poverty and immigrant communities. |
| Measurable Objective(s) with Indicator(s) | Lead a coalition of over 30 local agencies devoted to preventing childhood injury and death with ongoing engagement of additional agencies that share the same mission. Continue to offer classes/educational opportunities and car seat checks in areas of need. |
| Intervention Actions for Achieving Goal | Conduct regular coalition meeting and provide outreach, education and resources to targeted communities. |
| Collaboration | The Safe Kids program leads a coalition of over 30 local agencies, including hospitals, fire, police, state and county agencies devoted to preventing childhood injury and death. |
| Performance / Impact | 3,550 community members served which includes 226 car seat checks and distribution of 101 car seats at various events. |
| Hospital's Contribution / Program Expense | $361,387 from Mercy San Juan. |
| **FY 2021 Plan** | |
| Program Goal / Anticipated Impact | Improve the public awareness of child safety and provide education workshops for families living in poverty and immigrant communities. |

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| Measurable Objective(s) with Indicator(s) | Continue leading a coalition of over 30 local agencies devoted to preventing childhood injury and death with ongoing engagement of additional agencies that share the same mission. Continue to offer classes/educational opportunities and car seat checks in areas of need. |
| Intervention Actions for Achieving Goal | Continue conducting regular coalition meeting and provide outreach, education and resources to targeted communities. Build relationships with other community organizations that can assist in the outreach efforts. |
| Planned Collaboration | The Safe Kids program leads a coalition of over 30 local agencies, including hospitals, fire, police, state and county agencies devoted to preventing childhood injury and death. |

## Healthier Living

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| Significant Health Needs Addressed | ☐ Access to Quality Primary Care Health Services<br>☐ Access to Mental, Behavioral and Substance Abuse Services<br>☐ Access to Basic Needs<br>☐ System Navigation<br>✓ Injury and Disease Prevention and Management<br>☐ Safe and Violence-Free Environment<br>✓ Access to Active Living and Healthy Eating<br>☐ Access to Meeting Functional Needs<br>✓ Cultural Competency<br>☐ Access to Specialty and Extended Care |
| Program Description | Healthier Living provides residents with chronic diseases knowledge, tools and motivation needed to become proactive with their health. Healthier Living workshops are open to anyone with any ongoing health condition, as well as those who care for persons with chronic health conditions. 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 |
| Community Benefit Category | A1 - Community Health Education – Lectures/Workshops. |

### FY 2020 Report

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| 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. |

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| 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. In FY18, A Matter of Balance workshop was added that focuses on fall prevention. |
| 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 143 community members and 107 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 | $84,881 which is a shared expense by Dignity Health hospitals in Sacramento County. |
| **FY 2021 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) | Continue to 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. 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 and Russian speaking lay leaders. |
| Planned Collaboration | Workshops are conducted in collaboration with a variety of community organizations and 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. |

## Housing with Dignity

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| Significant Health Needs Addressed | ✓ Access to Quality Primary Care Health Services<br>✓ Access to Mental, Behavioral and Substance Abuse Services<br>✓ Access to Basic Needs<br>❑ System Navigation<br>✓ Injury and Disease Prevention and Management |

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|---|---|
| | ✓ Safe and Violence-Free Environment<br>✓ Access to Active Living and Healthy Eating<br>❑ Access to Meeting Functional Needs<br>❑ Cultural Competency<br>❑ 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 2020 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, Lutheran Social Services and Health Net that assisted in expanding the program. |
| Performance / Impact | 18 patients were referred from Dignity Health hospitals and received program services. 2 patients moved out of the program during this time and were either reunified with family, placed in supportive housing/referred to other housing programs or found their own place to live. 16 patients received other referrals to resources and/or aid through the program. |
| Hospital's Contribution / Program Expense | $150,000 which is a shared expense by Dignity Health Hospitals in Sacramento County. |
| **FY 2021 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. |

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| 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 | Lutheran Social Services (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, Lutheran Social Services and Health Net. |

## Navigation to Wellness

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| Significant Health Needs Addressed | ✓ Access to Quality Primary Care Health Services<br>✓ Access to Mental, Behavioral and Substance Abuse Services<br>✓ Access to Basic Needs<br>❑ System Navigation<br>❑ Injury and Disease Prevention and Management<br>✓ Safe and Violence-Free Environment<br>❑ Access to Active Living and Healthy Eating<br>❑ Access to Meeting Functional Needs<br>❑ Cultural Competency<br>❑ Access to Specialty and Extended Care |
| Program Description | The Navigation to Wellness program utilizes a team comprised of Clinicians and a Peer Support Specialist that work closely with Dignity Health staff in identifying individuals with a self-reported behavioral health problem, who repeatedly access hospital services, and who could be more effectively served if linked to non-emergency room resources. Once a patient is referred by the hospital, the Navigation Team assesses patients to determine what outpatient behavioral health services they are eligible for or may need and links them to appropriate public and general behavioral health services. |
| Community Benefit Category | A2 - Community Based Clinical Services - Ancillary/other clinical services |
| **FY 2020 Report** | |
| Program Goal / Anticipated Impact | Decrease the overutilization of hospital services by individuals with behavioral health problems through the use of a team that supports the individual on discharge planning in such a way that facilitates the |

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| | process and provides linkages to public and general mental health services. |
| Measurable Objective(s) with Indicator(s) | Individuals who were not linked previously or who were unaware of additional services available to them will be linked, decreasing any future uses of ED or inpatient services during a mental health crisis. |
| Intervention Actions for Achieving Goal | Build the program in collaboration with the hospital and Turning Point to link identified patients to community resources and have a peer navigator assist patients in the community setting. |
| Collaboration | The Navigation to Wellness program is a partnership between Turning Point, Strategies for Change, Consumers Self Help Center, and NAMI through the Dignity Health Community Grants |
| Performance / Impact | 129 patients were linked to community resources upon emergency department and inpatient discharge and followed up with for 30 days to ensure they were connected to the resources. |
| Hospital's Contribution / Program Expense | $145,000 which is a shared expense by Dignity Health Hospitals in Sacramento County. |
| **FY 2021 Plan** | |
| Program Goal / Anticipated Impact | Continue to decrease the overutilization of hospital services by individuals with behavioral health problems through the use of a team that supports the individual on discharge planning in such a way that facilitates the process and provides linkages to public and general mental health services. |
| Measurable Objective(s) with Indicator(s) | Focus on linking individuals to additional outpatient resources and reconnecting individuals who were previously linked but have not received services. Decrease any future uses of hospital services during a mental health crisis and successful connect to community resources. |
| Intervention Actions for Achieving Goal | Continue to build the program in collaboration with the hospital and Turning Point to link identified patients in the emergency department to community resources and have a peer navigator assist patients in the community setting. Focus will be place on ensuring hospital staff continues to utilize the program and increase the number of opportunities where the Navigation to Wellness navigator can collaborate with navigators from other programs to increase the continuum of care. |
| Planned Collaboration | The Navigation to Wellness program is a partnership between Turning Point, Strategies for Change, Consumers Self Help Center, and NAMI. |

## Co-occurring Substance Use Disorder Treatment

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| Significant Health Needs Addressed | ✓ Access to Quality Primary Care Health Services<br>✓ Access to Mental, Behavioral and Substance Abuse Services<br>✓ Access to Basic Needs |

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| | ❑ System Navigation<br>✓ Injury and Disease Prevention and Management<br>❑ Safe and Violence-Free Environment<br>❑ Access to Active Living and Healthy Eating<br>❑ Access to Meeting Functional Needs<br>❑ Cultural Competency<br>❑ Access to Specialty and Extended Care |
| Program Description | Through community grants, this pilot program allows for a seamless continuum of care for individuals experiencing homelessness or at-risk struggling with co-occurring substance abuse disorder and in need of mental health services. By partnering with Harm Reductions Services, Gender Health Clinic, and Lighthouse of Hopeful Hearts, 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 2020 Report** | |
| Program Goal / Anticipated Impact | Decrease the overutilization of hospital services by individuals with co-occurring substance abuse 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 abuse disorder. Improved access to outpatient mental health and substance abuse services and resources. |
| Intervention Actions for Achieving Goal | Build the program in collaboration with Hope Cooperative 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 abuse disorder program is a partnership between Harm Reduction Services, Gender Health Clinic, and Lighthouse of Hopeful Hearts through the Dignity Health Community Grants. |
| Performance / Impact | 24 of the 34 ERA participants received expedited access to a MAT program, 10 of these participants have since been assisted in moving to another program of their choice after their bridge period ended. 5 ERA participants were assisted with entering other drug treatment programs such as in-patient or a detox program. 5 other ERA participants are still in case management. LOHH held 10 group counseling sessions that were attended by 11 of the 34 ERA program participants. |

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| Hospital's Contribution / Program Expense | $80,000 from Dignity Health Sacramento hospitals. |
| **FY 2021 Plan** | |
| Program Goal / Anticipated Impact | Decrease the overutilization of hospital services by individuals with co-occurring substance abuse 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 abuse disorder. Improved access to outpatient mental health and substance abuse 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 abuse disorder program is a partnership between Harm Reduction Services, Gender Health Clinic, and Lighthouse of Hopeful Hearts through the Dignity Health Community Grants. |

## 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").

- 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.

- Transitional Housing and Lodging - When there are no available alternatives, Mercy San Juan Hospital subsidizes payments for room and board in the community for patients unable to pay when they are discharged from the hospital.

- Sacramento County Medi-Cal Managed Advisory Committee -The hospital has appointed representation on this Committee which was established by Senator Steinberg's legislation in 2010. The purpose of the Committee is to improve services and health outcomes for beneficiaries of the region's Geographic Managed Medi-Cal system. The Committee grapples with issues that include access, quality and care coordination, and reviews and provides input on quality indicators, policies and processes.

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 | Net Benefit | % of Expenses |
|---|---|---|---|
| **Benefits for Poor** | | | |
| **Financial Assistance** | **4,889** | **11,661,664** | **1.7%** |
| **Medicaid** | **45,342** | **31,346,566** | **4.5%** |
| **Means-Tested Programs** | **1** | **166,259** | **0.0%** |
| **Community Services** | | | |
| A - Community Health Improvement Services | 15,494 | 7,103,249 | 1.0% |
| C - Subsidized Health Services | 226 | 1,635,320 | 0.2% |
| E - Cash and In-Kind Contributions* | 67 | 0 | 0.0% |
| F - Community Building Activities | 571 | 94,325 | 0.0% |
| G - Community Benefit Operations | 0 | 151,222 | 0.0% |
| **Totals for Community Services** | **16,358** | **8,984,116** | **1.3%** |
| **Totals for Poor** | **66,590** | **52,158,605** | **7.4%** |
| **Benefits for Broader Community** | | | |
| **Community Services** | | | |
| A - Community Health Improvement Services | 2,556 | 52,736 | 0.0% |
| B - Health Professions Education | 551 | 1,519,429 | 0.2% |
| D - Research | 0 | 14,217 | 0.0% |
| E - Cash and In-Kind Contributions | 2 | 804 | 0.0% |
| F - Community Building Activities | 3 | 1,572 | 0.0% |
| **Totals for Community Services** | **3,112** | **1,588,758** | **0.2%** |
| **Totals for Broader Community** | **3,112** | **1,588,758** | **0.2%** |
| **Totals - Community Benefit** | **69,702** | **53,747,363** | **7.7%** |
| **Medicare** | **29,700** | **65,079,375** | **9.3%** |
| **Totals with Medicare** | **99,402** | **118,826,738** | **17.0%** |

**Cash and in-kind contributions reported at $0 net benefit due to return of a large donation in the fiscal year.*

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<br>Retired, Dignity Health Quality | Sister Eileen Enright, RSM, Vice Chair<br>Retired, Director of Cristo Rey High School |
| Brian King, Secretary<br>Chancellor, Los Rios Community College District | Marian Bell Holmes<br>Retired, Dignity Health Human Resources |
| Darrell Teat<br>CEO, Darrell Teat & Associates | Martin Camsey<br>CFO, The Niello Company |
| Sister Patricia Simpson, O.P. | Pat Fong Kushida<br>Executive Director, Asian Chamber of Commerce |
| Brian Wagner, MD<br>Chief of Staff<br>Mercy General Hospital | Jeffrey Cragun, MD<br>Chief of Staff<br>Mercy Folsom |
| Jennifer Osborn, MD<br>Chief of Staff<br>Mercy San Juan Hospital | Thomas Valdez, MD<br>Chief of Staff<br>Methodist Hospital |
| Dr. Glennah Trochet<br>Community Physician | Laurie Harting<br>Chief Executive Officer<br>Dignity Health Greater Sacramento Division |

# Financial Assistance Policy Summary

Dignity Health's Financial Assistance Policy describes the financial assistance programs available to uninsured or underinsured patients who meet certain income requirements to help pay for medically necessary hospital services provided by Dignity Health. An uninsured patient is someone who does not have health coverage, whether through private insurance or a government program, and who does not have the right to be reimbursed by anyone else for their hospital bills. An underinsured patient is someone who has health coverage, but who has large hospital bills that are not fully covered by their insurance.

### Free Care

- If you are uninsured or underinsured with a family income of up to 250% of the Federal Poverty Level you may be eligible to receive hospital services at no cost to you.

### Discounted Care

- If you are uninsured or underinsured with an annual family income between 250-350% of the Federal Poverty level, you may be eligible to have your bills for hospital services reduced to the highest amount reasonably expected to be paid by a government payer, which is usually the amount that Medicare would pay for the same services.
- If you are uninsured or underinsured with an annual family income between 350-500% of the Federal Poverty level you may be eligible to have your bills for hospital services reduced to the Amount Generally Billed, which is an amount set under federal law that reflects the amount that would have been paid to the hospital by private health insurers and Medicare (including co-pays and deductibles) for the medically necessary services.

If you are eligible for financial assistance under our Financial Assistance Policy you will not be required to pay more than the Amount Generally Billed described above. If you qualify, you may also request an interest-free extended payment plan.

You will never be required to make advance payment or other payment arrangements in order to receive emergency services.

Free copies of the hospital's Financial Assistance Policy and financial assistance application forms are available online at your hospital's website listed below or at the hospital Admitting areas located near the main entrance. (Follow the signs to "Admitting" or "Registration"). Copies of these documents can also be mailed to you upon request if you call Patient Financial Services at the telephone number listed below for your hospital.

**Traducción disponible:** You may also obtain Spanish and other language translations of these documents at your hospital's website, in your hospital's Admitting area, or by calling your hospital's telephone number.

Dignity Health Financial Counselors are available to answer questions, provide information about our Financial Assistance Policy and help guide you through the financial assistance application process. Our staff is located in the hospital's Admitting area and can be reached at the telephone number listed below for your hospital.

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**Mercy General Hospital** 4001 J St, Sacramento, CA 95819 | **Financial Counseling** 916-389-8626
**Patient Financial Services** 888-488-7667 | www.dignityhealth.org/sacramento/paymenthelp

**Mercy Hospital of Folsom** 1650 Creekside Dr, Folsom, CA 95630 | **Financial Counseling** 916-983-7512
**Patient Financial Services** 888-488-7667 | www.dignityhealth.org/sacramento/paymenthelp

**Mercy San Juan Medical Center** 6501 Coyle Ave, Carmichael, CA 95608 | **Financial Counseling** 916-536-3053
**Patient Financial Services** 888-488-7667 | www.dignityhealth.org/sacramento/paymenthelp

**Methodist Hospital of Sacramento** 7500 Hospital Dr, Sacramento, CA 95823 | **Financial Counseling** 916-423-6199
**Patient Financial Services** 888-488-7667 | www.dignityhealth.org/sacramento/paymenthelp

**Sierra Nevada Memorial Hospital** 155 Glasson Way, Grass Valley, CA 95945 | **Financial Counseling** 530-274-6758
**Patient Financial Services** 888-488-7667 | www.dignityhealth.org/sacramento/paymenthelp

**Woodland Healthcare** 1325 Cottonwood St, Woodland, CA 95695 | **Financial Counseling** 530-662-3961 ext. 4559
**Patient Financial Services** 888-488-7667 | www.dignityhealth.org/woodland/paymenthelp