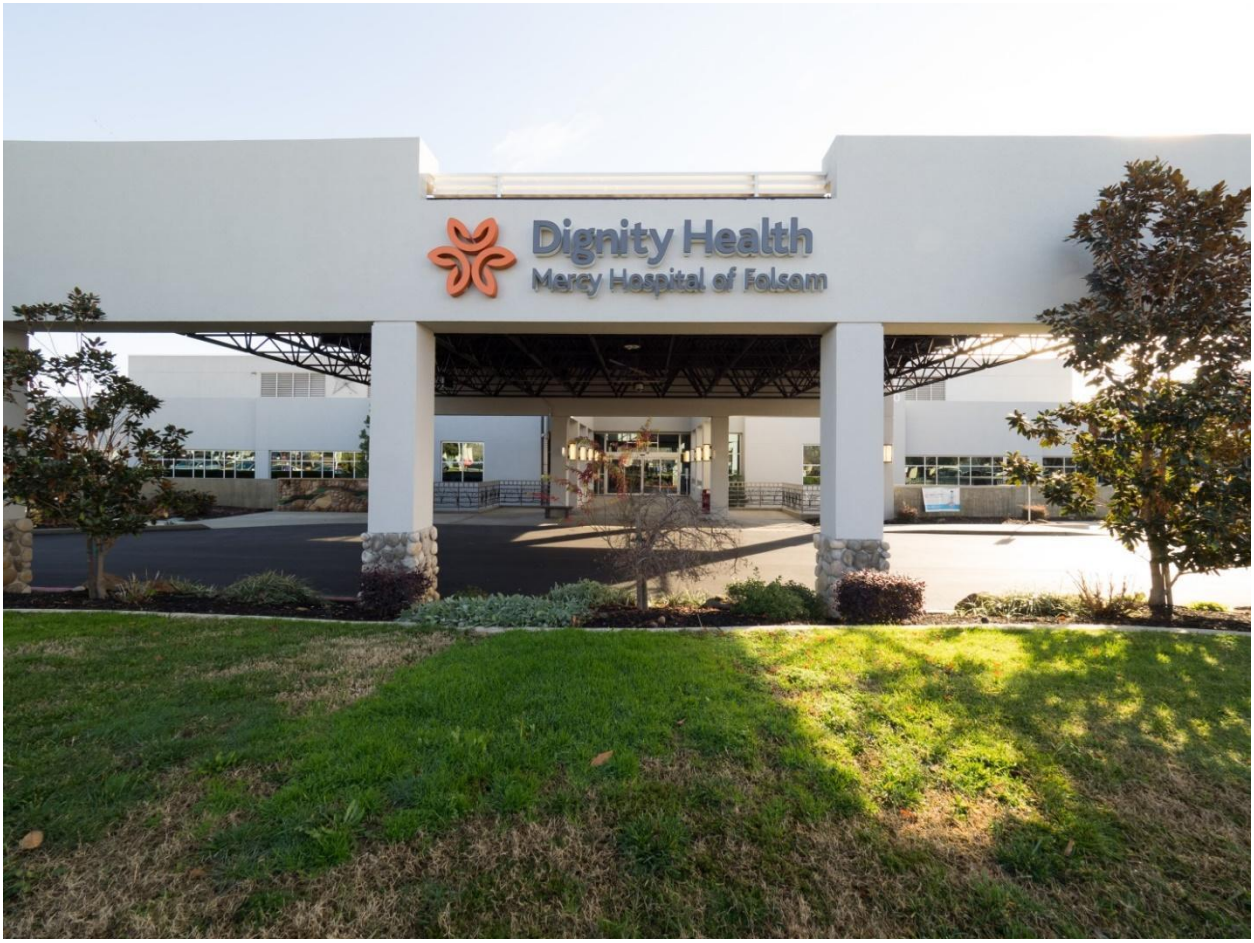
Mercy Hospital of Folsom

Community Benefit 2022 Report and 2023 Plan

Adopted October 2022



Dignity Health™
Mercy Hospital of Folsom

A message from

Lisa Hausmann, RN, President and CEO of Mercy Hospital of Folsom, and Marian Bell-Holmes, 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 Hospital of Folsom (Mercy Folsom) 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 2022 Report and 2023 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 voluntarily 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 2022 (FY22), Mercy Folsom provided $25,252,496 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $15,704,977 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2022 Report and 2023 Plan at its October 27, 2021 meeting.

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

Sincerely,

Lisa Hausmann, RN
President/CEO

Marian Bell-Holmes
Chairperson, Board of Directors

Table of Contents

At-a-Glance Summary

Community Served

Mercy Folsom is located in Folsom and has 850 employees, 120 active medical staff, 106 licensed acute care beds, and 25 emergency department beds. Mercy Folsom is a community hospital serving the Sierra foothills communities of Folsom, El Dorado Hills, Granite Bay, Cameron Park, Shingle Springs and Rescue.

Economic Value of Community Benefit

$25,252,496 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits

$15,704,977 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 Mental/Behavioral Health and Substance-Use Services
2. Access to Basic Needs Such as Housing, Jobs, and Food
3. Access to Quality Primary Care Health Services
4. System Navigation
5. Injury and Disease Prevention and Management
6. Health Equity: Equal Access to Opportunities to be Healthy
7. Active Living and Healthy Eating
8. Safe and Violence-Free Environment
9. Increased Community Connections
10. Access to Specialty and Extended Care

FY22 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.
- Gregory Bunker Care Transitions Center of Excellence: This collaborative engages other Dignity Health hospitals and health systems in the region, the Salvation Army, Sacramento County and Federally Qualified Health Center, WellSpace Health, and provides a respite care shelter for homeless patients with available physical and mental health, and substance abuse treatment.
- ReferNet Intensive Outpatient Mental Health Partnership: The hospitals works in collaboration with community-based nonprofit mental health provider, El Hogar, to provide a seamless process for patients admitting to

	the emergency department with mental illness to receive immediate and ongoing treatment and other social services they need for a continuum of care when they leave the hospital. ● SPIRIT Project: The Sacramento Physicians' Initiative to Reach Out, Innovate and Teach (SPIRIT) operated under the Sierra Sacramento Valley Medical Society exists as a vehicle to involve physicians in the community. SPIRIT recruits physician volunteers to provide free specialty medical care to the uninsured and coordinates and case manages surgical procedures donated at local hospitals and ambulatory surgery centers. ● Patient Navigator Program: Patient navigators in the hospital's emergency department connect patients seen and treated at the hospital to medical homes at community health centers and provider offices throughout the region. The Patient Navigator Program represents a unique collaboration between Dignity Health, Sacramento Covered, a community-based nonprofit organization, and community clinics in the region. ● 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.
FY23 Planned Programs and Services	Mercy Folsom plans to continue to build upon many of previous years' initiatives and explore new partnership opportunities with Sacramento County, the different cities, health plans and community organizations. Efforts to enhance navigation services in partnership with Sacramento Covered, Bay Area Community Services and El Hogar will continue with specific focus on improving the linkages to primary care, mental health services, social services and community resources. Mercy Folsom will continue to play an active role in developing innovative strategies to address the growing number of individuals experiencing homelessness including: the Gregory Bunker Care Transitions Center of Excellence; Housing with Dignity; and active engagement with CalAIM Enhanced Care Management and Community Supports; Homelessness and Healthcare Pilot Project; and working in partnership with both the city and county to improve our relationship with the shelters.

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

Written comments on this report can be submitted to the Mercy Folsom 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 Hospital of Folsom

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

Mercy Folsom opened in 1989, located at 1650 Creekside Drive in Folsom, CA, and today has 850 employees, 120 active medical staff, 106 licensed acute care beds, and 25 emergency department beds. Services range from outpatient surgery to inpatient care delivered in Medical Telemetry, Surgical Acute and Intensive Care units. The hospital provides surgical services including minimally-invasive general, urological and gynecological surgeries. Mercy Folsom is certified as a Baby Friendly Hospital by the WHO and UNICEF and has a wonderful Family Birth Center unit with 8 labor/post-partum rooms, offering a free Doula service, labor tubs and an outpatient lactation clinic located directly next to the Hospital. This hospital has a comprehensive and award-winning orthopedic services, which include surgery, inpatient and outpatient rehabilitation and specialty orthopedic care. As a certified Joint Commission Stroke Center, the hospital provides exceptional care to patients in Medical, Surgical and Intensive Care units, as well as the Emergency Department.

Our Mission

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

Our Vision

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

Financial Assistance for Medically Necessary Care

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

Description of the Community Served

Mercy Folsom is a growing acute care community hospital situated in the northeastern section of Sacramento County. Mercy Folsom's community or hospital service area (HSA) is defined as the geographic area (by ZIP code) in which the hospital receives its top 75% of discharges. The hospital's primary service area comprises 11 zip codes (95630, 95670, 95762, 95682, 95662, 95628, 95827, 95610, 95667, 95742, and 95608). A summary description of the community is below. Additional details can be found in the CHNA report online.

The hospital serves a variety of suburban cities including Folsom, Rancho Cordova, and El Dorado Hills, as well as the more rural communities of Shingle Springs, Placerville, Rescue, and others identified in the Communities Needs Index map. While poverty rates are lower here than other sections of the region, the expanded 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 Folsom has made it a priority to provide patient navigation services to this population which helps to educate patients on how to access care in the appropriate healthcare setting. The hospital must balance its responsibility for caring for the acutely ill with an increasing role as a safety net provider for the vulnerable.

Demographics within Mercy Folsom's hospital service area are as follows, derived from 2022 estimates provided by SG2's Analytics Platform (*Source: Claritas Pop-Facts® 2022; SG2 Market Demographic Module)*:

- Total Population: 486,988
- Race/Ethnicity: Hispanic or Latino: 16.2%; White: 60.6%, Black/African American: 3.9% Asian/Pacific Islander: 11.1%, All Other: 8.2%.
- % Below Poverty: 5.4%
- Unemployment: 4.7%
- No High School Diploma: 7.0%
- Medicaid: 28.9%
- Uninsured: 5.2%

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 May 2022.

This document also reports on programs delivered during fiscal year 2022 that were responsive to needs prioritized in the hospital's previous CHNA report.

The CHNA contains several key elements, including:

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

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at https://www.dignityhealth.org/sacramento/about-us/community-health-and-outreach/health-needs-assessment or upon request at the hospital's Community Health office.

Significant Health Needs

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

Significant Health Need	Description	Intend to Address?
1. Access to Mental/Behavioral Health and Substance-Use Services	Individual health and well-being are inseparable from individual mental and emotional outlook. Coping with daily life stressors is challenging for many people, especially when other social, familial, and economic challenges occur. Access to mental, behavioral, and substance-use services is an essential ingredient for a healthy community where residents can obtain additional support when needed.	✓
2. Access to Basic Needs Such as Housing, Jobs, and Food	Access to affordable and clean housing, stable employment, quality education, and adequate food for good health are vital for survival. Maslow's Hierarchy of Needs suggests that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health. Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, influence individual health as much as health behaviors and access to clinical care.	✓
3. Access to Quality Primary Care Health Services	Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners and physician assistants, pharmacists, telephone advice nurses, and other similar resources. Primary care	✓

Significant Health Need	Description	Intend to Address?
	services are typically the first point of contact when an individual seeks healthcare. These services are the front line in the prevention and treatment of common diseases and injuries in a community.	
4. System Navigation	System navigation refers to an individual's ability to traverse fragmented social services and healthcare systems in order to receive the necessary benefits and supports to improve health outcomes. Research has demonstrated that navigating the complex U.S. healthcare system is a barrier for many that results in health disparities. Furthermore, accessing social services provided by government agencies can be an obstacle for those with limited resources such as transportation access and English proficiency.	✓
5. Injury and Disease Prevention and Management	Knowledge is important for individual health and well-being, and efforts aimed at injury and disease prevention are powerful vehicles to improve community health. When community residents lack adequate information on how to prevent, manage, and control their health conditions, those conditions tend to worsen. Prevention efforts focus on reducing cases of injury and infectious disease control (e.g., sexually transmitted infection (STI) prevention and influenza shots), and intensive strategies in the management of chronic diseases (e.g., diabetes, hypertension, obesity, and heart disease) are important for community health improvement.	✓
6. Health Equity: Equal Access to Opportunities to be Healthy	Health equity is defined as everyone having the same opportunity to be as healthy as possible.8 Health is largely determined by social factors. Some communities have resources needed to be healthy readily available to them, while others do not. Many people experience barriers as the result of policies, practices, systems, and structures that discriminate against certain groups. Individual and community health can be improved by removing or mitigating practices that result in health inequity. While health equity is described as a specific health need in this assessment, it is recognized that equity plays a role in each health need in a community.	✓
7. Active Living and Healthy Eating	Physical activity and eating a healthy diet are important for one's overall health and well-being. Frequent physical activity is vital for prevention of disease and maintenance of a strong and healthy heart and mind. When access to healthy foods is challenging for community residents, many turn to unhealthy foods that are convenient, affordable, and readily available. Communities experiencing social vulnerability and poor health outcomes are often overloaded with fast food and other establishments where unhealthy food is sold. They are often challenged with food insecurity, lacking the means to	✓

Significant Health Need	Description	Intend to Address?
	consistently secure food for themselves or their families. When families rely on food pantries and school meals alone, these may not always provide sufficient nutrition for maintaining health.	
8. Safe and Violence-Free Environment	Feeling safe in one's home and community is fundamental to overall health. Next to having basic needs met (e.g., food, shelter, and clothing) physical safety is essential. Feeling unsafe affects the way people act and react to everyday life occurrences. Furthermore, research has demonstrated that individuals exposed to violence in their homes, the community, and schools are more likely to experience depression and anxiety and demonstrate more aggressive, violent behavior.	✓
9. Increased Community Connections	As humans are social beings, community connection is a crucial part of living a healthy life. People have a need to feel connected with a larger support network and the comfort of knowing they are accepted and loved. Research suggests "individuals who feel a sense of security, belonging, and trust in their community have better health. People who don't feel connected are less inclined to act in healthy ways or work with others to promote well-being for all." Assuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a healthy community. Furthermore, healthcare and community support services are more effective when they are delivered in a coordinated fashion, where individual organizations collaborate with others to build a network of care.	✓
10. Access to Specialty and Extended Care	Extended care services, which include specialty care, are services provided in a particular branch of medicine and focused on the treatment of a particular disease. Primary and specialty care go hand in hand, and without access to specialists such as endocrinologists, cardiologists, and gastroenterologists, community residents are often left to manage the progression of chronic diseases, including diabetes and high blood pressure, on their own. In addition to specialty care, extended care refers to care extending beyond primary care services to support overall physical health and wellness, such as skilled-nursing facilities, hospice care, and in-home healthcare.	✓
11. Access to Functional Needs	Functional needs include indicators related to transportation and disability. Having access to transportation services to support individual mobility is a necessity of daily life. Without transportation, individuals struggle to meet their basic needs, including those needs that promote and support a healthy life. The number of people with a disability is also	

Significant Health Need	Description	Intend to Address?
	an important indicator for community health and must be examined to ensure that all community members have access to necessities for a high quality of life.	
12. Access to Dental Care and Preventive Services	Oral health is important for overall quality of life. When individuals have dental pain, it is difficult to eat, concentrate, and fully engage in life. Oral health disease, including gum disease and tooth decay are preventable chronic diseases that contribute to increased risk for other chronic diseases, as well as play a large role in chronic school absenteeism in children. Poor oral health status impacts the health of the entire body, especially the heart and the digestive and endocrine systems.	
13. Healthy Physical Environment	Living in a pollution-free environment is essential for health. Individual health is determined by a number of factors, and some models show that one's living environment, including the physical (natural and built) and sociocultural environment, has more impact on individual health than other factors such as one's lifestyle, heredity, or access to medical services.	

Significant Needs the Hospital Does Not Intend to Address

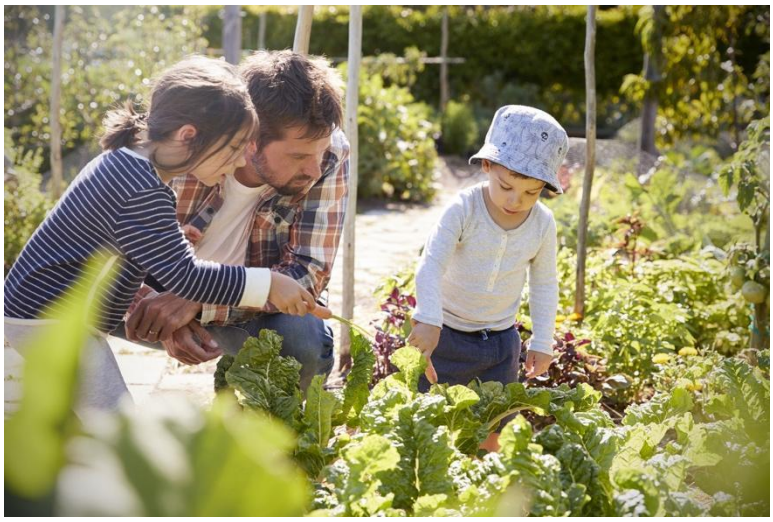
Mercy Folsom does not have the capacity or resources to address all priority health issues identified in Sacramento County, although the hospitals continue to seek opportunities that respond to the needs that have not been selected as priorities. The hospital is not addressing access to functional needs, access to dental care and preventive services, and healthy physical environment as these priorities are beyond the capacity and service expertise of Mercy Folsom. However, the hospital will look for opportunities to coordinate and collaborate with other entities that offer programs that address these needs.

2022 Report and 2023 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 FY22 and planned activities for FY23, with statements on impacts and community collaboration. Program Highlights provide additional detail on select programs.

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

Creating the Community Benefit Plan



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

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

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

The following outlines the approach taken when planning and developing initiatives to address priority health issues. At the outset, Community Health and Outreach staff engages a core internal team that may include clinical staff, care coordinators and social workers, members of the hospital 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.

Community Health Strategic Objectives

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

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

Advance Community Health Alignment and Integration

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

Expand Clinical - Community Partnerships and Linkages

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

Build Capacity for More Equitable Communities

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

Inspire, Innovate and Scale High Impact Initiatives

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

Report and Plan by Health Need

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

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

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

Strategy or Program	Summary Description	Active FY22	Planned FY23
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 admitted to the emergency department with mental illness to receive immediate and ongoing treatment and other social services they need for a continuum of care when they leave the hospital.	☑	☑
Sacramento County Crisis Navigation Program	In partnership with Sacramento County Behavioral Health and Bay Area Community Services, the Crisis Navigation 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. Navigators respond to hospital emergency departments as well as the county jail and Loaves & Fishes to assist patients in accessing outpatient mental health services and other resources.	☑	☑
Substance Use Navigation	CA Bridge is a program of the Public Health Institute working to ensure that people with substance use disorder receive 24/7 high-quality care in every California health system by 2025. The CA Bridge program seeks to fully integrate addiction treatment into standard medical practice—increasing access to treatment to save more lives. Utilizing a Substance Use Navigator to build a trusting relationship with the patient and motivating them to engage in treatment. The hospital works to reduce the language that stigmatizes people who use drugs, treating substance use disorder like any other disease. Program is currently funded through a Behavioral Health Pilot Program grant.	☑	☑
Navigation to Wellness	This program engages nonprofit mental health provider, Turning Point, to improve the quality of care for patients in mental health crisis. A Peer Support Specialist works 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 hospitals provide Mental Health Evaluations as well as Psychiatric Consultations to all patients who are in need of those crisis services throughout their hospital stay. The hospitals also provide conservatorship services to patients who lack capacity and have no one to represent their wishes and needs.	☑	☑

Tele-Psychiatry	Psychiatrists are available via remote technology to provide early evaluation and psychiatric intervention for patients, improving access to timely quality care. Access is available to both the ED and inpatient setting.	☑	☑
Connect to Health - Supporting Healthy Newcomer Community	Supported through the Community Health Improvement Grants Program, a partnership between International Rescue Committee, Inc. River City Food Bank, One Community Health, Creekside Adult Center, San Juan Adult Education, and Turning Point Community Programs- Mental Health Urgent Care Clinic, Connect to Health provides culturally and linguistically congruent health/mental health navigation services and supports to refugees and immigrants as an underserved community in Sacramento. This project aims to address health disparities, promote independent health access, and connect refugees and immigrants to basic needs resources.	☑	☑
#RAGE Healing	Supported through the Community Health Improvement Grants Program, a partnership between The Race and Gender Equity Project, RocSolid Logistics LLC, Sacramento Unified School District Foster Youth Services, and Monroe Howard Transformational Coaching, #RAGE Healing serves to increase the capacity of a youth-driven community wellness hub to provide individual support and increase youth-led healing practices (peer-to-peer support) both virtually and in-person. Project components include: Direct healing services, development of a RAGE Healing Youth Collaborative (including building capacity among youth social entrepreneurs) and Training & Trauma Stewardship for those serving Black youth.	☑	☑
ARC Supportive Housing and Reentry Initiative	Supported through the Community Health Improvement Grants Program, a partnership between The Anti-Recidivism Coalition (ARC), Exodus Project and Freedom, this program seeks to bridge this gap with these strategic partnerships to provide transitional housing sites in Sacramento County. The program seeks to integrate existing ARC wraparound member services and workforce development programs into a larger model that also includes housing support within facilities that are operated by the partner organizations for formerly incarcerated individuals.	☑	☑
Bigs with Badges Sacramento Mentoring Program	Supported through the Community Health Improvement Grants Program, a partnership between Big Brothers Big Sisters of the Greater Sacramento Area, California Department of Corrections and Rehabilitation and Sacramento County Sheriff's Department, Bigs with	☑	☑

	Badges is a one-to-one mentoring program that connects youth with law enforcement officers and first responders to build lasting relationships. Bigs with Badges is an extension of a proven, research-based program backed by years of strong results as it pertains to higher aspirations, avoidance of risky behaviors and educational success among participants.		

Goal and 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.

Collaborators: The hospital will partner with El Hogar, Sacramento County Behavioral Health, Bay Area Community Services, International Rescue Committee, Inc. River City Food Bank, One Community Health, Creekside Adult Center, San Juan Adult Education, Turning Point Community Programs- Mental Health Urgent Care Clinic, The Race and Gender Equity Project, RocSolid Logistics LLC, Sacramento Unified School District Foster Youth Services, Monroe Howard Transformational Coaching, ARC, Exodus Project and Freedom Through Education, Big Brothers Big Sisters of the Greater Sacramento Area, California Department of Corrections and Rehabilitation and Sacramento County Sheriff's Department and local community based organizations to deliver this access to mental/ behavioral health and substance-use services strategy.

	**Health Need: Access to Basic Needs Such as Housing, Jobs, and Food**		
Strategy or Program	**Summary Description**	**Active FY22**	**Planned FY23**
Gregory Bunker Care Transitions Center of Excellence (The Bunker	The hospital is an active partner in the Gregory Bunker Care Transitions Center of Excellence (The Bunker), formerly known as the Interim Care Program (ICP). This collaborative engages other Dignity Health hospitals and health systems in the region, Sacramento County and Federally Qualified Health Center, WellSpace Health, and provides a respite care shelter for homeless patients with available physical and mental health, and substance abuse treatment. The program provides case management services to assist participants in connecting with outpatient services and community resources.	☑	☑
Housing with Dignity	In partnership with Lutheran Social Services and Centene, the hospital aims to assist homeless individuals with severe chronic health and mental health issues obtain and retain housing, care and services designed to achieve stability in their lives. Hospital case managers work directly with Lutheran Social Services staff to identify participants who will be housed in supportive	☑	☑

	stabilization apartments and receive intensive case management and supportive services.		
Resources for Low-Income Patients	The hospital partially or fully subsidizes cost of transportation, prescription medication, medical supplies and equipment, and short term room and board in the community for patients unable to pay for or access these resources after being discharged from the hospital.	☑	☑
Resources for Homeless Patients	The hospital provides clothing, meals, prescription medication, transportation, room and board, information and referrals to available community resources to homeless patients being discharged from the hospital, with the intent to help prepare them for return to the community.	☑	☑
Healthcare and Homelessness Pilot Program	Supported through the Homeless Health Initiative, and led by Community Solutions and Institute for Healthcare Improvement (IHI), the healthcare and homeless pilot seeks to understand the most meaningful, measurable and transformative contribution health care can make to ending chronic homelessness. Over the course of the 2 year initiative, the Health Systems alongside the homeless Continuum of Care partners in Sacramento, will have made measurable progress toward ending chronic homelessness, with a focus on building racially equitable systems.	☑	☑
Connect to Health - Supporting Healthy Newcomer Community	Supported through the Community Health Improvement Grants Program, a partnership between International Rescue Committee, Inc. River City Food Bank, One Community Health, Creekside Adult Center, San Juan Adult Education, and Turning Point Community Programs- Mental Health Urgent Care Clinic, Connect to Health provides culturally and linguistically congruent health/mental health navigation services and supports to refugees and immigrants as an underserved community in Sacramento. This project aims to address health disparities, promote independent health access, and connect refugees and immigrants to basic needs resources.	☑	☑
#RAGE Healing	Supported through the Community Health Improvement Grants Program, a partnership between The Race and Gender Equity Project, RocSolid Logistics LLC, Sacramento Unified School District Foster Youth Services, and Monroe Howard Transformational Coaching, #RAGE Healing serves to increase the capacity of a youth-driven community wellness hub to provide individual support and increase youth-led healing practices (peer-to-peer support) both virtually and in-person. Project components include: Direct	☑	☑

	healing services, development of a RAGE Healing Youth Collaborative (including building capacity among youth social entrepreneurs) and Training & Trauma Stewardship for those serving Black youth.		
ARC Supportive Housing and Reentry Initiative	Supported through the Community Health Improvement Grants Program, a partnership between The Anti-Recidivism Coalition (ARC), Exodus Project and Freedom, this program seeks to bridge this gap with these strategic partnerships to provide transitional housing sites in Sacramento County. The program seeks to integrate existing ARC wraparound member services and workforce development programs into a larger model that also includes housing support within facilities that are operated by the partner organizations for formerly incarcerated individuals.	☑	☑
Increase of Client Capacity and Collaborative Service	Supported through the Community Health Improvement Grants Program, a partnership between EveryONE Matters Ministries, Women's Empowerment and Operation Hope, the Increase of Client Capacity and Collaborative Services increase homeless services with housing, case management including assistance with financial literacy and to double the current client capacity by increasing the RV fleet with larger model RVs.	☑	☑
Access to Food for Low-Income Families through Sacramento School Districts	Supported through the Community Health Improvement Grants Program, a partnership between Sacramento Food Bank & Family Services, California Association of Food Banks and Raley's Food for Families, this project provides staple grocery items to families to support their child's health through the school food pantry project. This project serves the hard-to-reach food insecure families as well as meet the increased immediate need for food access resulting from the pandemic, and remove barriers to accessing food since it will be available on the school site. Food resources are also offered to assist schools with developing positive, trusting relationships with families in need.	☑	☑
YMCA Kids Health and Wellness Workshop 2022	Supported through the Community Health Improvement Grants Program, a partnership between YMCA of Superior California, St. John's Program for Real Change, First Step Communities, and Bridge Network Co., the YMCA Kids Health and Wellness Workshop 2022 program will seek to provide a healthy and safe space for homeless children (K-12) where, alongside other developmental curriculum, they can learn about the value of positive healthy lifestyle choices, reducing their risk of lifestyle related chronic illness.	☑	☑

Goal and 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. Brief overall statement for these strategies and programs.

Collaborators: The hospital will partner with other healthcare systems in the region, Sacramento County, FQHCs, WellSpace Health, Lutheran Social Services, IRC, River City Food Bank, One Community Health, Creekside Adult Center, San Juan Adult Education, Turning Point Community Programs- Mental Health Urgent Care Clinic, The Race and Gender Equity Project, RocSolid Logistics LLC, Sacramento Unified School District Foster Youth Services, Monroe Howard Transformational Coaching, ARC, Exodus Project, Freedom Through Education, EveryONE Matters Ministries, Women's Empowerment, Operation Hope, Sacramento Food Bank & Family Services, California Association of Food Banks, Raley's Food for Families, YMCA of Superior California, St. John's Program for Real Change, First Step Communities, Bridge Network Co., and local community based organizations to deliver this access to basic needs such as housing, jobs, and food.

	**Health Need: Access to Quality Primary Care Health Services**		
Strategy or Program	**Summary Description**	**Active FY22**	**Planned FY23**
Care for the Undocumented	Dignity Health hospitals in Sacramento County partner with Sacramento County, other health system and the Sierra Sacramento Valley Medical Society on an initiative to provide primary and specialty care, including surgery, to the region's undocumented immigrants who currently have no insurance or access to care. The hospital continues to advocate for expanded enrollment and increasing the age range to ensure more individuals could access primary care and limited specialty care services.	☑	☑
Health Professions Education - Other	Provides a clinical setting for trainings and internships for students in the greater Sacramento region pursuing health professions other than physicians and nurses. This includes, but is not limited to: EMT, Paramedics, Pharmacy, Respiratory Therapy, Physical Therapy, Radiology Technologist and Surgical Technologist.	☑	☑
Health Professions Education - Nursing	Provides clinical setting for nursing students enrolled in education with an outside local college or university for additional training and education. This includes, but is not limited to: Undergraduate Nursing, Undergraduate Nursing-Preceptorship, Nursing BSN and Nursing ADN.	☑	☑
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.		
Connect to Health - Supporting Healthy Newcomer Community	Supported through the Community Health Improvement Grants Program, a partnership between International Rescue Committee, Inc. River City Food Bank, One Community Health, Creekside Adult Center, San Juan Adult Education, and Turning Point Community Programs- Mental Health Urgent Care Clinic, Connect to Health provides culturally and linguistically congruent health/mental health navigation services and supports to refugees and immigrants as an underserved community in Sacramento. This project aims to address health disparities, promote independent health access, and connect refugees and immigrants to basic needs resources.	☑	☑
Health Equity Collaborative	Supported through the Community Health Improvement Grants Program, a partnership between Hmong Youth Parents United, Iu-Mien Community Services and Hmong Nurses Association, the Health Equity Collaborative will educate and provide the Hmong and Iu-Mien communities a variety of free health related services and topics to improve the concerning health status and disparity in both communities. The project will also engage and educate youth and seniors in these communities on reporting crimes for a violence free community through local partnerships and collaborations.	☑	☑
Salud en la Comunidad (SelC)	Supported through the Community Health Improvement Grants Program, a partnership between Latino Coalition for Healthy California, Youth Forward and La Familia Counseling Center, Inc., Salud en la Comunidad connects and navigates low-income, under-insured/uninsured, predominantly Latino, Sacramento youth and residents with health education and social service resources. SelC will utilize a holistic, coordinated-care approach to well-being by providing behavioral health, COVID-19 education and prevention, health education and access to primary, vision, and oral health services. In addition, SelC recruits, trains and builds leadership capacity among underrepresented youth leaders to advocate for upstream public health policy solutions and systems	☑	☑

changes that may increase access to healthcare, mental health and substance abuse services, positively reform the youth criminal justice system, and address the basic needs of youth.

Goal and 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 healthcare system; increased primary care "medical homes" among those reached by navigators; reduce barriers to care; and improve collaborative efforts between all health care providers.

Collaborators: The hospital will partner with Sacramento County, other healthcare systems in the region, Sierra Sacramento Valley Medical Society, Sacramento Covered, IRC, River City Food Bank, One Community Health, Creekside Adult Center, San Juan Adult Education, Turning Point Community Programs- Mental Health Urgent Care Clinic, Hmong Youth Parents United, Iu-Mien Community Services, Hmong Nurses Association, Latino Coalition for Healthy California, Youth Forward and La Familia Counseling Center, Inc., and local community clinics, school districts and local community based organizations to deliver this access to quality primary care health services.

	Health Need: System Navigation		
Strategy or Program	**Summary Description**	**Active FY22**	**Planned FY23**
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.	☑	☑
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 admitted to the emergency department with mental illness to receive immediate and ongoing treatment and other social services they need for a continuum of care when they leave the hospital.	☑	☑

Sacramento County Crisis Navigation Program	In partnership with Sacramento County Behavioral Health and Bay Area Community Services, the Crisis Navigation 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. Navigators respond to hospital emergency departments as well as the county jail and Loaves & Fishes to assist patients in accessing outpatient mental health services and other resources.	☑	☑
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 their diagnosis and treatment options. The Navigation program also provides referrals for nutritional and psycho-social support as well hosting multiple cancer support groups across the region.	☑	☑
Substance Use Navigation	CA Bridge is a program of the Public Health Institute working to ensure that people with substance use disorder receive 24/7 high-quality care in every California health system by 2025. The CA Bridge program seeks to fully integrate addiction treatment into standard medical practice—increasing access to treatment to save more lives. Utilizing a Substance Use Navigator to build a trusting relationship with the patient and motivating them to engage in treatment. The hospital works to reduce the language that stigmatizes people who use drugs, treating substance use disorder like any other disease. Program is currently funded through a Behavioral Health Pilot Program grant.	☑	☑
Salud en la Comunidad (SelC)	Supported through the Community Health Improvement Grants Program, a partnership between Latino Coalition for Healthy California, Youth Forward and La Familia Counseling Center, Inc., Salud en la Comunidad connects and navigates low-income, under-insured/uninsured, predominantly Latino, Sacramento youth and residents with health education and social service resources. SelC will utilize a holistic, coordinated-care approach to well-being by providing behavioral health, COVID-19 education and prevention, health education and access to primary, vision, and oral health services. In addition, SelC recruits, trains and builds leadership capacity among underrepresented youth leaders to advocate for upstream public health policy solutions and systems changes that may increase access to healthcare, mental health and substance abuse services,	☑	☑

	positively reform the youth criminal justice system, and address the basic needs of youth.		

Goal and Impact: The hospital's initiatives to address system navigation is to continue to assist underserved patients admitted 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.

Collaborators: The hospital will partner with Sacramento Covered, El Hogar, Sacramento County Behavioral Health, Bay Area Community Services, Latino Coalition for Healthy California, Youth Forward, La Familia Counseling Center, and local community based organizations to deliver an increase of system navigation in healthcare.

	**Health Need: Injury and Disease Prevention and Management**		
Strategy or Program	**Summary Description**	**Active FY22**	**Planned FY23**
Healthier Living Program	The Healthier Living program allows participants to learn about and practice a wide variety of tools to help them become better self-managers of their ongoing health conditions. Workshops are open to anyone with a chronic health condition, as well as those who care for persons with chronic health conditions. They are offered at the community level in partnership with medical clinics, food banks, affordable housing developments and others to ensure the underserved have access to these peer led health education classes. Provided in both English and Spanish.	☑	☑
Falls Prevention Program	Matter of Balance (MOB) is specifically designed to reduce the fear of falling and improve activity levels among community-dwelling older adults. The program enables participants to reduce the fear of falling by learning to view falls as controllable, setting goals for increasing activity levels, making small changes to reduce fall risks at home, and exercise to increase strength and balance.	☑	☑
Congestive Heart Active Management Program (CHAMP®	CHAMP® establishes a relationship with patients who have heart failure after discharge from the hospital through regular phone interactions to support, educate and assist primary care physicians/cardiologists to manage this disease and monitoring of symptoms or complications.	☑	☐
Mercy Faith and Health Partnership	This interfaith community outreach program supports the development of health ministry programs including healthcare professionals, clergy and other interested members who have a desire to focus on health promotion and disease prevention programs within their congregations. Providing education, advocacy and referrals	☑	☑

	for available resources within the congregation, health ministry teams do not duplicate available services, such as nursing or medical care, but seek to creatively bridge gaps in healthcare.		
Disease-Specific Support Groups	Education and support are offered monthly to those affected by specific diseases in the community. Current groups include: cancer; and stroke. Program transitioned to phone based support due to COVID concerns.	☑	☑
Health Equity Collaborative	Supported through the Community Health Improvement Grants Program, a partnership between Hmong Youth Parents United, Iu-Mien Community Services and Hmong Nurses Association, the Health Equity Collaborative will educate and provide the Hmong and Iu-Mien communities a variety of free health related services and topics to improve the concerning health status and disparity in both communities. The project will also engage and educate youth and seniors in these communities on reporting crimes for a violence free community through local partnerships and collaborations.	☑	☑
Catholic School Student Health and Wellness	Support provided to three low-income Catholic Schools in Sacramento (St Philomene, St Robert and St Patrick Academy) for student health and wellness. This includes, but is not limited to, activities that support physical and mental health, as well as social determinants of health. The specific activities are at the discretion of School leadership and are based on areas of highest need.	☑	☑

Goal and 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.

Collaborators: The hospital will partner with other medical clinics, food banks, affordable housing development, senior centers, health ministry, congregations, Hmong Youth Parents United, Iu-Mien Community Services, Hmong Nurses Association, and local community based organizations to increase injury and disease prevention and management.

	Health Need: Health Equity: Equal Access to Opportunities to be Healthy		
Strategy or Program	**Summary Description**	**Active FY22**	**Planned FY23**
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.		
Healthcare and Homelessness Pilot Program	Supported through the Homeless Health Initiative, and led by Community Solutions and Institute for Healthcare Improvement (IHI), the healthcare and homeless pilot seeks to understand the most meaningful, measurable and transformative contribution health care can make to ending chronic homelessness. Over the course of the 2 year initiative, the Health Systems alongside the homeless Continuum of Care partners in Sacramento, will have made measurable progress toward ending chronic homelessness, with a focus on building racially equitable systems.	☑	☑
Care for the Undocumented	Dignity Health hospitals in Sacramento County partner with Sacramento County, other health system and the Sierra Sacramento Valley Medical Society on an initiative to provide primary and specialty care, including surgery, to the region's undocumented immigrants who currently have no insurance or access to care. The hospital continues to advocate for expanded enrollment and increasing the age range to ensure more individuals could access primary care and limited specialty care services.	☑	☑
Community Based Violence Prevention	The Community Based Violence Prevention Program initiative focuses on: • Educating staff to identify and respond to victims of violence and human trafficking within the hospital; • Provide victim-centered, trauma-informed care; • Collaborate with community agencies to improve quality of care; • Access critical resources for victims; and • Provide and support innovative programs for recovery and reintegration. • Public policy initiatives • Community-based programs • Research on best practices • Resources for education and awareness • Partnerships with national, state and local organizations • Socially responsible investing and shareholder advocacy	☑	☑
#RAGE Healing	Supported through the Community Health Improvement Grants Program, a partnership between The Race and Gender Equity Project, RocSolid Logistics LLC, Sacramento Unified School District Foster Youth Services, and Monroe Howard Transformational Coaching, #RAGE	☑	☑

	Healing serves to increase the capacity of a youth-driven community wellness hub to provide individual support and increase youth-led healing practices (peer-to-peer support) both virtually and in-person. Project components include: Direct healing services, development of a RAGE Healing Youth Collaborative (including building capacity among youth social entrepreneurs) and Training & Trauma Stewardship for those serving Black youth.		
Health Equity Collaborative	Supported through the Community Health Improvement Grants Program, a partnership between Hmong Youth Parents United, Iu-Mien Community Services and Hmong Nurses Association, the Health Equity Collaborative will educate and provide the Hmong and Iu-Mien communities a variety of free health related services and topics to improve the concerning health status and disparity in both communities. The project will also engage and educate youth and seniors in these communities on reporting crimes for a violence free community through local partnerships and collaborations.	☑	☑
Salud en la Comunidad (SelC)	Supported through the Community Health Improvement Grants Program, a partnership between Latino Coalition for Healthy California, Youth Forward and La Familia Counseling Center, Inc., Salud en la Comunidad connects and navigates low-income, under-insured/uninsured, predominantly Latino, Sacramento youth and residents with health education and social service resources. SelC will utilize a holistic, coordinated-care approach to well-being by providing behavioral health, COVID-19 education and prevention, health education and access to primary, vision, and oral health services. In addition, SelC recruits, trains and builds leadership capacity among underrepresented youth leaders to advocate for upstream public health policy solutions and systems changes that may increase access to healthcare, mental health and substance abuse services, positively reform the youth criminal justice system, and address the basic needs of youth.	☑	☑

Goal and Impact: The initiative to address health equity by the hospital is anticipated to result in: ensuring that everyone has equal access to the same opportunities to be as healthy as possible. Individual and community health will be improved through elimination of barriers as the result of policies, practices, systems, and structures that discriminate against certain groups.

Collaborators: The hospital will partner with Sacramento Covered, other healthcare systems in the region, community clinics, Community Solutions, Institute for Healthcare Improvement, The Race and Gender Equity Project, RocSolid Logistics LLC, Sacramento Unified School District Foster Youth Services, Monroe Howard Transformational Coaching, Hmong Youth Parents United, Iu-Mien Community Services, Hmong Nurses Association, Latino Coalition for Healthy California, Youth

Forward and La Familia Counseling Center, Inc. and local community based organizations to deliver an increase for health equity in the community.

	**Health Need: Active Living and Healthy Eating**		
Strategy or Program	**Summary Description**	**Active FY22**	**Planned FY23**
Healthier Living Program	The Healthier Living program allows participants to learn about and practice a wide variety of tools to help them become better self-managers of their ongoing health conditions. Workshops are open to anyone with a chronic health condition, as well as those who care for persons with chronic health conditions. They are offered at the community level in partnership with medical clinics, food banks, affordable housing developments and others to ensure the underserved have access to these peer led health education classes. Provided in both English and Spanish.	☑	☑
Access to Food for Low-Income Families through Sacramento School Districts	Supported through the Community Health Improvement Grants Program, a partnership between Sacramento Food Bank & Family Services, California Association of Food Banks and Raley's Food for Families, this project provides staple grocery items to families to support their child's health through the school food pantry project. This project serves the hard-to-reach food insecure families as well as meet the increased immediate need for food access resulting from the pandemic, and remove barriers to accessing food since it will be available on the school site. Food resources are also offered to assist schools with developing positive, trusting relationships with families in need.	☑	☑
Recreate for Health	Supported through the Community Health Improvement Grants Program, a partnership between Bike Lab, Always Knocking, and Hooked on Fishing not Violence, Recreate for Health is an outdoor endeavor that believes in the power of being rejuvenated in nature. The week-long summer program seeks to encourage youth to learn new skills, be active, and mentally and physically engage with nature. The program consists of outdoor outings that range from fishing trips to healing circles and bike rides to trips to the ocean.	☑	☑
YMCA Kids Health and Wellness Workshop 2022	Supported through the Community Health Improvement Grants Program, a partnership between YMCA of Superior California, St. John's Program for Real Change,	☑	☑

	First Step Communities, and Bridge Network Co., the YMCA Kids Health and Wellness Workshop 2022 program will seek to provide a healthy and safe space for homeless children (K-12) where, alongside other developmental curriculum, they can learn about the value of positive healthy lifestyle choices, reducing their risk of lifestyle related chronic illness.		

Goal and 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

Collaborators: The hospital will partner with Elk Grove Food Bank, medical clinics, food banks, affordable housing developments, senior centers, Sacramento Food Bank & Family Services, California Association of Food Banks, Raley's Food for Families, Bike Lab, Always Knocking, Hooked on Fishing not Violence, YMCA of Superior California, St. John's Program for Real Change, First Step Communities, Bridge Network Co., and local community based organizations to deliver an increase for active living and healthy living in the community.

	**Health Need: Safe and Violence-Free Environment**		
Strategy or Program	**Summary Description**	**Active FY22**	**Planned FY23**
Community Based Violence Prevention	The Community Based Violence Prevention Program initiative focuses on: • Educating staff to identify and respond to victims of violence and human trafficking within the hospital; • Provide victim-centered, trauma-informed care; • Collaborate with community agencies to improve quality of care; • Access critical resources for victims; and • Provide and support innovative programs for recovery and reintegration. • Public policy initiatives • Community-based programs • Research on best practices • Resources for education and awareness • Partnerships with national, state and local organizations • Socially responsible investing and shareholder advocacy	☑	☑
Health Equity Collaborative	Supported through the Community Health Improvement Grants Program, a partnership between Hmong Youth Parents United, Iu-Mien Community Services and Hmong Nurses	☑	☑

	Association, the Health Equity Collaborative will educate and provide the Hmong and Iu-Mien communities a variety of free health related services and topics to improve the concerning health status and disparity in both communities. The project will also engage and educate youth and seniors in these communities on reporting crimes for a violence free community through local partnerships and collaborations.		
Salud en la Comunidad (SelC)	Supported through the Community Health Improvement Grants Program, a partnership between Latino Coalition for Healthy California, Youth Forward and La Familia Counseling Center, Inc., Salud en la Comunidad connects and navigates low-income, under-insured/uninsured, predominantly Latino, Sacramento youth and residents with health education and social service resources. SelC will utilize a holistic, coordinated-care approach to well-being by providing behavioral health, COVID-19 education and prevention, health education and access to primary, vision, and oral health services. In addition, SelC recruits, trains and builds leadership capacity among underrepresented youth leaders to advocate for upstream public health policy solutions and systems changes that may increase access to healthcare, mental health and substance abuse services, positively reform the youth criminal justice system, and address the basic needs of youth.	☑	☑
Bigs with Badges Sacramento Mentoring Program	Supported through the Community Health Improvement Grants Program, a partnership between Big Brothers Big Sisters of the Greater Sacramento Area, California Department of Corrections and Rehabilitation and Sacramento County Sheriff's Department, Bigs with Badges is a one-to-one mentoring program that connects youth with law enforcement officers and first responders to build lasting relationships. Bigs with Badges is an extension of a proven, research-based program backed by years of strong results as it pertains to higher aspirations, avoidance of risky behaviors and educational success among participants.	☑	☑
Truth Sets You Free Part 2: Living Informed Free of Trauma, Intergenerationally (LIFTING	Supported through the Community Health Improvement Grants Program, a partnership between Neighborhood Wellness Foundation, Jubilare Evangelistic Ministries, Del Paso Union Baptist Church and Sacramento Regional Family	☑	☑

	Justice Center, this program strategically aligned with three partners to begin to formalize a structural framework for mental wellness that is culturally engaging, relevant and sustainable by addressing Adverse Childhood Experiences (ACES). By leveraging the generational roots of more than 4 decades in 95838 and 95815 zip codes, this program will teach families the impact of ACEs on health outcomes through healing circles with mental/physical learning tools and reference guides. The impact is improvement in disease management, violence suppression and literacy.		
Recreate for Health	Supported through the Community Health Improvement Grants Program, a partnership between Bike Lab, Always Knocking, and Hooked on Fishing not Violence, Recreate for Health is an outdoor endeavor that believes in the power of being rejuvenated in nature. The week-long summer program seeks to encourage youth to learn new skills, be active, and mentally and physically engage with nature. The program consists of outdoor outings that range from fishing trips to healing circles and bike rides to trips to the ocean.	☑	☑
ARC Supportive Housing and Reentry Initiative	Supported through the Community Health Improvement Grants Program, a partnership between The Anti-Recidivism Coalition (ARC), Exodus Project and Freedom Through Education, this program seeks to bridge this gap with these strategic partnerships to provide transitional housing sites in Sacramento County. The program seeks to integrate existing ARC wraparound member services and workforce development programs into a larger model that also includes housing support within facilities that are operated by the partner organizations for formerly incarcerated individuals.	☑	☑
Goal and 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.			

Collaborators: The hospital will partner with health clinics, affordable housing developments, senior centers, Hmong Youth Parents United, Iu-Mien Community Services, Hmong Nurses Association, Latino Coalition for Healthy California, Youth Forward and La Familia Counseling Center, Inc, Big Brothers Big Sisters of the Greater Sacramento Area, California Department of Corrections and Rehabilitation, Sacramento County Sheriff's Department, Neighborhood Wellness Foundation, Jubilare Evangelistic Ministries, Del Paso Union Baptist Church, Sacramento Regional Family Justice

Center, Bike Lab, Always Knocking, Hooked on Fishing not Violence, ARC, Exodus Project and Freedom Through Education, and local community based organizations to deliver an increased safe and violence-free environment for the community.

	**Health Need: Increased Community Connections**		
Strategy or Program	**Summary Description**	**Active FY22**	**Planned FY23**
Disease-Specific Support Groups	Education and support are offered monthly to those affected by specific diseases in the community. Current groups include: cancer; and stroke. Program transitioned to phone based support due to COVID concerns.	☑	☑
Healthier Living Program	The Healthier Living program allows participants to learn about and practice a wide variety of tools to help them become better self-managers of their ongoing health conditions. Workshops are open to anyone with a chronic health condition, as well as those who care for persons with chronic health conditions. They are offered at the community level in partnership with medical clinics, food banks, affordable housing developments and others to ensure the underserved have access to these peer led health education classes. Provided in both English and Spanish.	☑	☑
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.	☑	☑
Connect to Health -Supporting Healthy Newcomer Community	Supported through the Community Health Improvement Grants Program, a partnership between International Rescue Committee, Inc. River City Food Bank, One Community Health, Creekside Adult Center, San Juan Adult Education, and Turning Point Community Programs- Mental Health Urgent Care Clinic, Connect to Health provides culturally and linguistically congruent health/mental health navigation services and supports to refugees and immigrants as an underserved community in Sacramento. This project aims to address health disparities, promote independent health access, and connect refugees and immigrants to basic needs resources.	☑	☑

Health Equity Collaborative	Supported through the Community Health Improvement Grants Program, a partnership between Hmong Youth Parents United, Iu-Mien Community Services and Hmong Nurses Association, the Health Equity Collaborative will educate and provide the Hmong and Iu-Mien communities a variety of free health related services and topics to improve the concerning health status and disparity in both communities. The project will also engage and educate youth and seniors in these communities on reporting crimes for a violence free community through local partnerships and collaborations.	☑	☑
Salud en la Comunidad (SelC)	Supported through the Community Health Improvement Grants Program, a partnership between Latino Coalition for Healthy California, Youth Forward and La Familia Counseling Center, Inc., Salud en la Comunidad connects and navigates low-income, under-insured/uninsured, predominantly Latino, Sacramento youth and residents with health education and social service resources. SelC will utilize a holistic, coordinated-care approach to well-being by providing behavioral health, COVID-19 education and prevention, health education and access to primary, vision, and oral health services. In addition, SelC recruits, trains and builds leadership capacity among underrepresented youth leaders to advocate for upstream public health policy solutions and systems changes that may increase access to healthcare, mental health and substance abuse services, positively reform the youth criminal justice system, and address the basic needs of youth.	☑	☑

Goal and Impact: The initiative to address increased community connections by the hospital is anticipated to result in: individuals with a sense of security, belonging, and trust in their community have better health. Community members will have opportunities to connect with each other through programs, and services resulting in fostering a healthier community. Healthcare and community support services will be more effective when they are delivered in a coordinated fashion and in collaboration to build a network of care.

Collaborators: The hospital will partner with Sacramento County, WEAVE, other medical clinics, health ministry, congregations, IRC, River City Food Bank, One Community Health, Creekside Adult Center, San Juan Adult Education, and Turning Point Community Programs- Mental Health Urgent Care Clinic, Hmong Youth Parents United, Iu-Mien Community Services, Hmong Nurses Association, Latino Coalition for Healthy California, Youth Forward and La Familia Counseling Center, Inc., and local community based organizations to deliver an increased safe and violence-free environment for the community.

	Health Need: Access to Specialty and Extended Care		
Strategy or Program	**Summary Description**	**Active FY22**	**Planned FY23**
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 around their diagnosis and treatment options. The Navigation program also provides referrals for nutritional and psycho-social support as well hosting multiple cancer support groups across the region.	☑	☑
Health Professions Education - Other	Provides a clinical setting for trainings and internships for students in the greater Sacramento region pursuing health professions other than physicians and nurses. This includes, but is not limited to: EMT, Paramedics, Pharmacy, Respiratory Therapy, Physical Therapy, Radiology Technologist and Surgical Technologist.	☑	☑
Health Professions Education - Nursing	Provides clinical setting for nursing students enrolled in education with an outside local college or university for additional training and education. This includes, but is not limited to: Undergraduate Nursing, Undergraduate Nursing-Preceptorship, Nursing BSN and Nursing ADN.	☑	☑
Goal and 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 healthcare system for specialty and extended care, specifically to those that are uninsured or underinsured.			

Collaborators: The hospital will partner with local medical health organizations and local community based organizations to deliver this access to specialty and extended care.

Community Health Improvement Grants Program

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

In FY22, Dignity Health's Sacramento County hospitals awarded grants totaling $813,423. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
International Rescue Committee, Inc.	Connect to Health -Supporting Healthy Newcomer Community	$100,000
The Race and Gender Equity Project	#RAGE Healing	$100,000
Anti-Recidivism Coalition	ARC Supportive Housing and Reentry Initiative	$100,000
EveryONE Matters Ministries	Increase of Client Capacity and Collaborative Services	$70,000
Sacramento Food Bank & Family Services	Access to Food for Low-Income Families through Sacramento School Districts	$75,000
Bike Lab	Recreate for Health	$20,000
YMCA of Superior California	YMCA Kids Health and Wellness Workshop 2022	$40,000
Neighborhood Wellness Foundation	Truth Sets You Free Part 2: Living Informed Free of Trauma, Intergenerationally (LIFTING)	$75,000
Hmong Youth and Parents United	Health Equity Collaborative	$75,000
Big Brothers Big Sisters of the Greater Sacramento Area	Bigs with Badges Sacramento Mentoring Program	$83,423
Latino Coalition for Healthy California	Salud en la Comunidad (SelC)	$75,000

Program Highlights

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

Housing with Dignity

Significant Health Needs Addressed

- ✓ Access to Mental/Behavioral Health and Substance-Use Services
- ✓ Access to Basic Needs Such as Housing, Jobs, and Food
- ✓ Access to Quality Primary Care Health Services
- ✓ System Navigation
- ✓ Injury and Disease Prevention and Management
- ☐ Health Equity: Equal Access to Opportunities to be Healthy
- ☐ Active Living and Healthy Eating
- ✓ Safe and Violence-Free Environment
- ☐ Increased Community Connections

	☐ 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 transition into to permanent/permanent supportive housing.
Population Served	The primary beneficiaries are individuals and families in Sacramento County that are chronically homeless with chronic health and/or mental issues.
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.
FY 2022 Report	
Activities Summary	Hospital case managers/social workers work directly with Lutheran Social Services case managers to identify participants who are housed in 24 supportive stable apartments and receive intensive case management and supportive social services.
Performance / Impact	45 patients were referred from Dignity Health hospitals and received program services.
Hospital's Contribution / Program Expense	$350,000
FY 2023 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.
Planned Activities	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.

Healthier Living Program	
Significant Health Needs Addressed	☐ Access to Mental/Behavioral Health and Substance-Use Services ☐ Access to Basic Needs Such as Housing, Jobs, and Food ☐ Access to Quality Primary Care Health Services

	□ System Navigation ✓ Injury and Disease Prevention and Management □ Health Equity: Equal Access to Opportunities to be Healthy ✓ Active Living and Healthy Eating □ Safe and Violence-Free Environment ✓ Increased Community Connections □ Access to Specialty and Extended Care
Program Description	The Healthier Living program allows participants to learn about and practice a wide variety of tools to help them become better self-managers of their ongoing health conditions. Workshops are open to anyone with a chronic health condition, as well as those who care for persons with chronic health conditions. They are offered at the community level in partnership with medical clinics, food banks, affordable housing developments and others to ensure the underserved have access to these peer led health education classes.
Population Served	The primary beneficiaries of this program are underserved individuals with chronic health conditions and their caretakers.
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 a maximum target metric goal or better – 70% of all participants avoid admission post program intervention.
FY 2022 Report	
Activities Summary	Healthier Living workshops for the community members, Diabetes Empowerment Education Program training for leaders, and Chronic Disease Self-Management Program training for leaders.
Performance / Impact	All of the workshops were held virtually due to COVID-19. There were 5 Healthier Living workshops conducted, including a reach of 46 community members and 23 participants completing the program. There are now 7 active leaders who could facilitate, Diabetes Empowerment Education Program, and/or Chronic Disease Self-Management Program.
Hospital's Contribution / Program Expense	$35,874 which is a shared expense by Dignity Health hospitals in Sacramento, Yolo and Nevada Counties.
FY 2023 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 a maximum target metric goal or better – 70% of all participants avoid admission post program intervention.
Planned Activities	Outreach to the community clinics and other nonprofits. Continue to build community partnerships to expand workshops. Continue to identify community

	lay leaders and partnerships for growth including strategies to recruit and train Hmong, Russian, and Spanish speaking lay leaders.

	Connect to Health -Supporting Healthy Newcomer Community
Significant Health Needs Addressed	✓ Access to Mental/Behavioral Health and Substance-Use Services ✓ Access to Basic Needs Such as Housing, Jobs, and Food ✓ Access to Quality Primary Care Health Services ✓ System Navigation ☐ Injury and Disease Prevention and Management ✓ Health Equity: Equal Access to Opportunities to be Healthy ☐ Active Living and Healthy Eating ☐ Safe and Violence-Free Environment ✓ Increased Community Connections ☐ Access to Specialty and Extended Care
Program Description	This program supported through Community Grants provides culturally and linguistically congruent health and mental health navigation services and supports to refugees and immigrants as an underserved community in Sacramento. This project aims to address health disparities, promote independent health access, and connect refugees and immigrants to basic needs resources.
Population Served	The primary beneficiaries of this program are refugees and immigrants in Sacramento County, especially focused on refugees from Afghanistan.
Program Goal / Anticipated Impact	Ensure that new refugees and immigrants residing in Sacramento will have: access to quality primary healthcare services, the knowledge, skills, and attitudes to effectively use services and supports, increase visits for preventative and primary care, decrease number of emergency room visits, access to behavioral health services and supports, ability to utilize skills and strategies to promote their mental health, know how to advocate for their and their family's healthcare needs and have access to basic needs, particularly to nutrition and food security.
	FY 2022 Report
Activities Summary	• Health navigation services and coaching to individuals and families. • Provide culturally responsive and linguistically mental health support. • Weekly wellness workshops on health and mental health topics. • Provide access to food and basic needs and education on how to access community resources.
Performance / Impact	Between the months of January and June 2022, the project has served 44 individuals with information on food security, and basic need resources. In addition, 10 psychoeducation classes have been provided which have reached 147 individuals. Lastly, 8 refugees and immigrants have received linguistically appropriate and culturally congruent mental health support.

Hospital's Contribution / Program Expense	$100,000
FY 2023 Plan	
Program Goal / Anticipated Impact	Ensure that new refugees and immigrants residing in Sacramento will have: access to quality primary healthcare services, the knowledge, skills, and attitudes to effectively use services and supports, increase visits for preventative and primary care, decrease number of emergency room visits, access to behavioral health services and supports, ability to utilize skills and strategies to promote their mental health, know how to advocate for their and their family's healthcare needs and have access to basic needs, particularly to nutrition and food security.
Planned Activities	Collaborate with partnering organizations to provide health navigation services, basic needs and health and social services resources in the community for the new refugee and immigrant population.

	**ReferNet**
Significant Health Needs Addressed	✓ Access to Mental/Behavioral Health and Substance-Use Services ✓ Access to Basic Needs Such as Housing, Jobs, and Food ✓ Access to Quality Primary Care Health Services □ System Navigation ✓ Injury and Disease Prevention and Management □ Health Equity: Equal Access to Opportunities to be Healthy □ Active Living and Healthy Eating ✓ Safe and Violence-Free Environment □ Increased Community Connections □ Access to Specialty and Extended Care
Program Description	The program provides a seamless way for individuals admitted to the emergency department with mental illness to receive immediate and ongoing intensive outpatient treatment and other social services they need to ensure continuity of care when they leave the hospital.
Population Served	The primary beneficiaries of this program are individuals not connected to mental services that reside in Sacramento County in need of mental/behavioral health services.
Program Goal / Anticipated Impact	Provide immediate access to intensive outpatient mental health care for those who suffer from this illness and connect them to other available resources that may be appropriate as well as county behavioral health services if eligible.
FY 2022 Report	

Activities Summary	Hospital case managers/social workers work directly to schedule with El Hogar case managers to provide immediate and ongoing mental/behavioral health services and linkages.
Performance / Impact	132 patients successfully received intensive outpatient treatment through the program. All patients were referred through hospital social workers and El Hogar referred to other social service resources as needed.
Hospital's Contribution / Program Expense	$117,596
FY 2023 Plan	
Program Goal / Anticipated Impact	Provide immediate access to intensive outpatient mental health care for those who suffer from this illness and connect them to other available resources that may be appropriate as well as county behavioral health services if eligible
Planned Activities	Efforts will continue around building hospital referrals and capacity. Continue to work on navigation and transportation as needed to ensure patients are able to attend their appointment. Ongoing evaluation of partner options to add substance use treatment. Develop a mechanism to help increase awareness of the program by emergency department staff.

	Substance Use Navigation
Significant Health Needs Addressed	✓ Access to Mental/Behavioral Health and Substance-Use Services ☐ Access to Basic Needs Such as Housing, Jobs, and Food ☐ Access to Quality Primary Care Health Services ☐ System Navigation ✓ Injury and Disease Prevention and Management ☐ Health Equity: Equal Access to Opportunities to be Healthy ☐ Active Living and Healthy Eating ✓ Safe and Violence-Free Environment ✓ Increased Community Connections ☐ Access to Specialty and Extended Care
Program Description	The Public Health Institute, through the CA Bridge Program, and the CA Department of Health Care Services through the Behavioral Health Pilot Program are working to ensure that people with substance use disorders receive 24/7 high-quality care in every California healthy system by 2025. By supporting Medication Assisted Treatment training for emergency department physicians, and a Substance Use Navigator, the program seeks to fully integrate addiction treatment into standard medical practice-increasing access to treatment to save more lives. A Substance Use Navigator is able to build a trusting relationship with the patient and motivate them to engage in treatment. The hospital works to reduce the language that stigmatizes people who use drugs, treating substance use disorder like any other disease.

Population Served	The primary beneficiaries of this program are individuals not currently engaging in substance use treatment and services.
Program Goal / Anticipated Impact	By providing a 'No Wrong Door' approach to linking treatment for substance use disorder from the emergency department to local MAT clinics.
FY 2022 Report	
Activities Summary	• Patient assessment using the SBIRT screening tool. • Make referrals to various support groups and treatments dependent on the patient's level of need. • Patient navigation to MAT programs and provides free Narcan (Naloxone) as needed. • Outreach and established relationships with HART Orangevale & Fair Oaks and HART Folsom to better assist with homeless individuals. • Spreading awareness of substance use disorder with hospital staff and the community.
Performance / Impact	Connected with 777 patients and provided services to connect to care at local MAT agencies.
Hospital's Contribution / Program Expense	This program is funded through a California Department of Health Care Services Behavioral Health Pilot Project grant. Leadership from the Emergency Department, Care Coordination and Community Health and Outreach help manage the program.
FY 2023 Plan	
Program Goal / Anticipated Impact	Continue work to fully integrate addiction treatment into standard medical practice—increasing access to treatment to save more lives. Utilizing a Substance Use Navigator to build a trusting relationship with the patient and motivating them to engage in treatment. The hospital works to reduce the language that stigmatizes people who use drugs, treating substance use disorder like any other disease.
Planned Activities	Provide education to OB providers on Suboxone initiation in the outpatient setting. Continue two-way communication with ED physicians, medical staff, nursing staff, social workers, and community MAT providers. Follow up phone calls to patients and providers to ensure warm handoff.

	**Patient Navigator**
Significant Health Needs Addressed	□ Access to Mental/Behavioral Health and Substance-Use Services ✓ Access to Basic Needs Such as Housing, Jobs, and Food ✓ Access to Quality Primary Care Health Services □ System Navigation ✓ Injury and Disease Prevention and Management □ Health Equity: Equal Access to Opportunities to be Healthy

	□ Active Living and Healthy Eating □ Safe and Violence-Free Environment □ Increased Community Connections □ 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.
Population Served	The primary beneficiaries of this program are individuals on Medi-Cal or uninsured not connected to primary care services or need immediate assistance to schedule with their primary care.
Program Goal / Anticipated Impact	Assist underserved patients admitted 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.
FY 2022 Report	
Activities Summary	Patient Navigators scheduled follow-up primary care appointments for individuals in the emergency department (ED). Also, they provided assistance with social services resources, health insurance eligibility and linkages to other community health care services.
Performance / Impact	7,024 patients were assisted and 59% 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.
Hospital's Contribution / Program Expense	$918,852
FY 2023 Plan	
Program Goal / Anticipated Impact	Continue to assist underserved patients admitted 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.
Planned Activities	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.

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.

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

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

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

- WellSpace Health - In September 2020, CommonSpirit approved a 7-year, $2,000,000 line of credit with WellSpace Health used for working capital to fund operations as WellSpace Health waits for reimbursement payments from the State of California. WellSpace Health is a nonprofit public-benefit corporation and Federally Qualified Health Center (FQHC) providing comprehensive health care including medical care, dental care, mental health and behavioral health services.

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

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

Additionally, members of the hospital's leadership and management teams volunteer significant time and expertise as board members of nonprofit health care organizations and civic and service agencies, such as the Folsom Chamber of Commerce, El Dorado Hills Chamber of Commerce, Folsom Lake College Foundation, Folsom Economic Development Corporation, Folsom Police Advocacy Board, CARES Foundation and Boys and Girls Club. Annual sponsorships also support multiple programs, services and fund-raising events of organizations; among them, Cristo Rey High School, Joshua's House, City of Refuge, Los Rios College, Sacramento Regional Family Justice Center, Salvation Army, American Heart Association National, and others.

Economic Value of Community Benefit

	Persons	Expense	Offsetting Revenue	Net Benefit	% of Expenses
Benefits For Poor					
Financial Assistance	**6,383**	**3,267,257**	**0**	**3,267,257**	**1.4%**
Medicaid	**18,486**	**54,876,490**	**36,553,096**	**18,323,394**	**8.1%**
Community Services					
A - Community Health Improvement Services	3,495	1,567,149	0	1,567,149	0.7%
C - Subsidized Health Services	774	740,428	0	740,428	0.3%
E - Cash and In-Kind Contributions	30	134,134	0	134,134	0.1%
F - Community Building Activities	6	45,582	0	45,582	0.0%
G - Community Benefit Operations	1	63,056	0	63,056	0.0%
Totals for Community Services	**4,306**	**2,550,349**	**0**	**2,550,349**	**1.1%**
Totals for Poor	**29,175**	**60,694,096**	**36,553,096**	**24,141,000**	**10.6%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	598	16,413	0	16,413	0.0%
B - Health Professions Education	245	1,095,083	0	1,095,083	0.5%
Totals for Community Services	**843**	**1,111,496**	**0**	**1,111,496**	**0.5%**
Totals for Broader Community	**843**	**1,111,496**	**0**	**1,111,496**	**0.5%**
Totals - Community Benefit	**30,018**	**61,805,592**	**36,553,096**	**25,252,496**	**11.1%**
Medicare	**9,314**	**58,164,436**	**42,459,459**	**15,704,977**	**6.9%**
Totals with Medicare	**39,332**	**119,970,028**	**79,012,555**	**40,957,473**	**18.0%**

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

Marian Bell Holmes, Chair Retired, Dignity Health Human Resources	Martin Camsey, Vice Chair CFO, The Niello Company
Brian King, Secretary Chancellor, Los Rios Community College District	Sister Eileen Enright, RSM Retired, Director of Cristo Rey High School
Darrell Teat CEO, Darrell Teat & Associates	Sister Nora Mary Curtin, RN, BSN, MSN Sisters of Mercy
Sister Patricia Simpson, O.P. Retired, Administrator of Our Lady of Lourdes Convent, Dominican Sisters of San Rafael	Pat Fong Kushida Executive Director, Asian Chamber of Commerce
Larry Garcia Founder/President, Garcia Consulting Group, Inc. Retired Lawyer	Michael Korpiel President, Dignity Health Greater Sacramento Market & President/CEO, Dignity Health Mercy San Juan Hospital
Todd Strumwasser, MD Chief Executive Officer Dignity Health Northern California Division	Ron Chambers, MD Chief of Staff Methodist Hospital
Sam Hu, MD Chief of Staff Mercy General Hospital	Parminder Deol, MD Chief of Staff Mercy Folsom
Joelle Jakobsen, MD Chief of Staff Mercy San Juan Hospital	