Mercy Medical Center Redding

Community Benefit 2022 Report and 2023 Plan

Adopted November 2022

Dignity Health™
Mercy Medical Center
Redding

A message from

Dear Community Members, Community Partners and Colleagues,

On behalf of Mercy Medical Center Redding, we'd like to thank you for your interest in the health of our community as we seek to improve the overall health in Shasta County. Our Mission is to 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. We are excited to share our Community Benefit 2022 Report and 2023 Plan.

It's no secret that our world is more complicated than ever. The COVID-19 global pandemic has caused extraordinary challenges for us all. Yet, in some ways this disruption has been a positive force of change and new beginnings. The ongoing pandemic taught us that improving the health of our community requires all of us to come together and bring our expertise, engagement and investment, only by working together in partnership, can we become a healthier, stronger community.

Dignity Health's approach to community health improvement aims to address significant health needs identified in the 2022 Community Health Needs Assessments (CHNA) 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.

In fiscal year 2022 (FY22), Mercy Medical Center Redding provided $46,071,820 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $46,006,587 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 November 10, 2022, meeting. We welcome any questions or ideas for collaborating that you may have, by reaching out to Laura Acosta, Community Health Director at 530-225-6114 or by email at laura.acosta900@commonspirit.org.

We look forward to partnering across our sectors to build a stronger, more equitable future for all.

Sincerely,

Todd Smith
President

Riico Dotson
Chairperson, Board of Directors

Table of Contents

At-a-Glance Summary **Page 4**

Our Hospital and the Community Served **Page 5**

About the Hospital Page 5
Our Mission Page 5
Financial Assistance for Medically Necessary Care Page 5
Description of the Community Served Page 6

Community Assessment and Significant Needs **Page 7**

Community Health Needs Assessment Page 7
Significant Health Needs Page 7

2022 Report and 2023 Plan **Page 9**

Creating the Community Benefit Plan Page 10
Community Health Strategic Objectives Page 11
Report and Plan by Health Need Page 11
Community Health Improvement Grants Program Page 15
Program Highlights Page 16
Other Programs and Non-Quantifiable Benefits Page 21

Economic Value of Community Benefit **Page 22**

Hospital Board and Committee Rosters **Page 23**

At-a-Glance Summary

Community Served 	Mercy Medical Center Redding is located at the tip of the Sacramento River Valley in Redding, California and serves as a regional referral center for far Northern California. Situated along the north-south Interstate 5 corridor the county is lined with mountains on its north, east, and west sides. Beyond Redding, the county is rural. While the majority of individuals served reside in Shasta County there are community health services available to bordering communities in Tehama and Trinity Counties. Due to the rural nature of the county access to care is a consistent barrier for the many residents who are medically underserved and low-income and minority population.
Economic Value of Community Benefit 	$46,071,820 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $46,006,587 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). This document also reports on programs delivered during fiscal year 2022 that were responsive to needs prioritized in the hospital's previous 2019 CHNA report. In most cases, the needs in the two assessments were similar or related. Needs being addressed by strategies and programs are: • Access to Mental/Behavioral Health and Substance-Use Services • Access to Quality Primary Care Health Services • Safe and Violence-Free Environment • Diabetes (2019 CHNA priority only)
FY22 Programs and Services 	Mercy Medical Center Redding delivered several programs and services to help address identified significant community health need. These included: • Cancer Support Groups • • Community Grants • • Community Health Education • Health Professions Education • Housing Support for Transitional Age Youth • Human Trafficking • Medications for Uninsured and Indigent • Medical Respite/Scatter Site Housing Support • Transportation Services
FY23 Planned Programs and Services	For FY23, Mercy Medical Center plans to build upon many of the FY22 initiatives, explore new partnership opportunities with Shasta County community

organizations, and intends to take actions and to dedicate resources to address these needs.

This document is publicly available online at https://www.dignityhealth.org/north-state/locations/stelizabethhospital/about-us/community-benefit

Written comments on this report can be submitted Mercy Medical Center Redding via the Community Health Office at 2175 Rosaline Ave, Redding, CA 96001, Attn: Laura Acosta or by e-mail to laura.acosta900@commonspirit.org.

Our Hospital and the Community Served

About Mercy Medical Center Redding

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

Mercy Medical Center Redding is located at the tip of the Sacramento River Valley in Redding, California and serves as a regional referral center for far Northern California. Situated along the north-south Interstate 5 corridor the county is lined with mountains on its north, east, and west sides. Beyond Redding, the county is rural. While the majority of individuals served reside in Shasta County there are community health services available to bordering communities in Tehama and Trinity Counties. Due to the rural nature of the county access to care is a consistent barrier for the many residents who are medically underserved and low-income and minority population.

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.

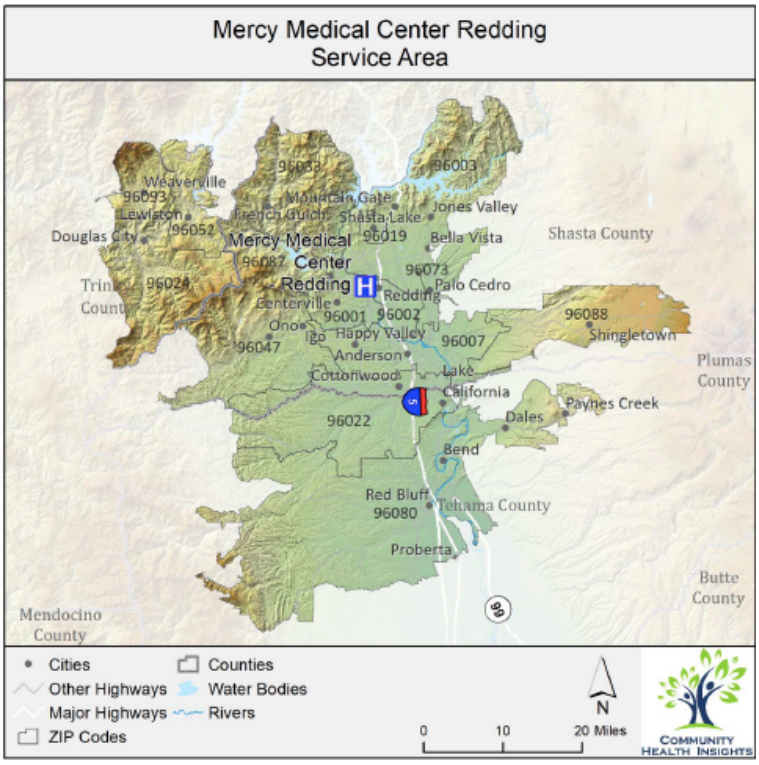
Financial Assistance for Medically Necessary Care

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 Medical Center Redding is located at the tip of the Sacramento River Valley in Redding, California and serves as a regional referral center for far Northern California. While the majority of individuals served reside in Shasta County there are community health services available to bordering communities in Tehama and Trinity Counties. Due to the rural nature of the county access to care is a consistent barrier for the many residents who are medically underserved and low-income and minority population.



Shasta County has a total area of 3,847 square miles and covers the Redding California Metropolitan Statistical Area. According to the US Census, the county's 2020 population was approximately 180,000 residents. The county seat is Redding, home to approximately one-half of Shasta County residents. Situated along the north-south Interstate 5 corridor the county is lined with mountains on its north, east, and west sides. Beyond Redding, the county is rural. Only a small portion of the MMCR service area dips into northern Tehama County. This area includes the city of Red Bluff, which is both the Tehama County Seat and the largest city in the county, with a population of just over 14 thousand residents. For the purposes of this assessment, the service area was further defined by 15 ZIP codes, 13 of which were located in Shasta and the remaining two in Tehama. The Shasta County ZIP codes included 96001, 96002, 96003, 96007, 96019, 96024, 96033, 96047, 96052, 96073, 96087, 96088, and 96093. The Tehama County ZIP codes included 96022 and 96080

Population Groups Experiencing Disparities

Key informants were asked to identify population groups that experienced health disparities in the MMCR service area. Interview participants were asked, "What specific groups of community members experience health issues the most?" Responses were analyzed by identifying all groups noted as one experiencing disparities. Groups identified by key informants are listed below. The groups are not mutually exclusive—one group could be a subset of another group. One of the purposes of identifying the sub-populations was to help guide additional qualitative data collection efforts to focus on the needs of these population groups. Additional details can be found in the CHNA report online.

- Low income
- Youth

- Native Americans
- Seniors
- Hispanic/Latino
- Men
- Homeless
- African American
- Asian
- People of Color
- Veterans
- Woman

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 April 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. In 2019, Aging Issues and Homelessness were identified as top needs in the community health needs assessment. Although not specifically identified in 2022, SECH recognizes these as vulnerable populations and will continue to take into account the their specific needs.

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/north-state/locations/stelizabethhospital/about-us/community-benefit or upon request at the hospital's Community Health office.

Significant Health Needs

Building a healthy community requires multiple stakeholders working together with a common purpose 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?
Access to Mental/Behavioral Health and Substance-Use Services	Access to mental, behavioral, and substance-use services is an essential ingredient for a healthy community where residents can obtain additional support when needed.	●
Access to Basic Needs Such as Housing, Jobs, and Food	Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, have a substantial impact on health behaviors and health outcomes. Addressing access to basic needs will improve health in the communities we serve.	
Access to Quality Primary Care Health Services	Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and other similar resources. Primary care 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.	●
Access to Specialty and Extended Care	Extended care services, which include specialty care, are care 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.	
Increased Community Connections	Community connection is a crucial part of living a healthy life. Research suggests individuals who feel a sense of security, belonging, and trust in their community have better health. 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 to build a coordinated ecosystem.	
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) is having physical safety. 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.	●
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	

Significant Health Need	Description	Intend to Address?
	complex U.S. healthcare system is a barrier for many that results in health disparities.	
Injury and Disease Prevention and Management	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.	
Access to Functional Needs	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.	
Diabetes (2019 CHNA priority only)	In 2019, Shasta County has a slightly lower rate (7.3%) than the State rate (9.6%) of individuals aged 20 and over who received a diabetes diagnosis. Even though Shasta County's rate of diagnosed diabetes is lower than the State, diabetes is listed in the leading causes of death in Shasta County indicating a sustained health need.	●

Significant Needs the Hospital Does Not Intend to Address

Mercy Medical Center Redding met with internal and community members to review and determine the top priorities the hospital would address. MMCR will continue to lean into the organizations who are addressing the needs and continue to build capacity by strengthening partnerships among local community-based organizations. Due to the magnitude of the need and the capacity of MMCR's ability to address the need the Implementation Strategy will not address the following health needs:

- Access to Basic-Needs Such as Housing, Jobs and Food
- Access to Specialty and Extended Care
- Increased Community Connections
- System Navigation
- Injury and Disease Prevention Management
- Access to Functional 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 Medical Center 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.

Mercy Medical Center Redding leaders met with internal and community members to review and determine the top priorities the hospital would address over the next three years.

To aid in determining the priority health needs, CHAC used the criteria below to consider when making a decision.

- Mission alignment
- Magnitude of the problem
- Severity of the problem
- Health disparities: The health need disproportionately impacts the health status of one or more vulnerable population groups.
- Need among vulnerable population
- Community's capacity and willingness to act on the issue
- Availability of hospital and community resources
- Ability to have measurable impact on the issue
- Existing Infrastructure: There are programs, systems, staff and support resources in place to address the issue.
- Established Relationships: There are established relationships with community partners to address the issue.
- Ongoing Investment: Existing resources are committed to the issue. Staff time and financial resources for this issue are counted as part of our community benefit effort.

Improving community health requires collaboration across community stakeholders and with community engagement. Each initiative involves research on best practice and is written to align with local resources, state or national health priorities and initiatives. The goals, objectives, and strategies contained in this document, where possible, intend to utilize upstream prevention models to address the social determinants of health. In addition, building and strengthening relationships with community-based providers that serve target populations for intended initiatives is critical to the success and sustainability to achieve 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.

This document also reports on programs delivered during fiscal year 2022 that were responsive to needs prioritized in the hospital's previous CHNA report. In 2019, Alcohol and Other Substance Abuse (including Tobacco Use), Child Abuse and Diabetes also were identified as top needs in the community health needs assessment. Although not specifically identified in 2022, MMCR recognizes the need and will continue to take into account and seek ways to address their specific needs.

Health Need: Diabetes (2019 CHNA priority only)

Strategy or Program	Summary Description	Active FY22	Planned FY23
Community Health Education	Collaboration with the Shasta Family YMCA to provide the Diabetes Prevention Program, an evidence-based diabetes education program for people with pre-diabetes.	☒	☐

Goal and Impact:

The anticipated result of offering these activities is to improve the health and quality of life for those who suffer from diabetes, 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:
Education sessions and workshops are conducted in collaboration with a variety of community organizations and are held in locations accessible to the residents, such as senior housing communities and organizations that serve a high percentage of residents that have or are caring for family members with chronic illnesses.

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

Strategy or Program	Summary Description	Active FY22	Planned FY23
Tele-Psychiatry	Psychiatrists are able to provide early evaluation and psychiatric intervention via remote consultations with patients, improving access to timely quality care. Access is available to both the ED and inpatient setting.	☒	☒
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 Navigator 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 Medication for Addiction Treatment (MAT) program.		
Continuum of Care	Collaboration with Empire Recovery Center for Detox Services.	☒	☒
Education and Awareness	Provide education and awareness and reduce stigma in the community. Hospital partnered with Pathways to Hope for Children to provide Hope Navigation training to the community.	☒	☒
Community Support 2019 CHNA need: Child Abuse	Support community programs, research, and monitoring systems that prevent child abuse and neglect while ensuring that children who are victims receive treatment and care.	☒	☐

Goal and Impact:

Goal

Improved system for patient linkages to outpatient behavioral health services; provide a seamless transition of care, reduce mental health stigma and increase in resources in the community.

Anticipated Impact

Ensure equitable access to quality, culturally responsive and linguistically appropriate services.

Collaborators:

MMCR will continue to seek out partnerships with local organizations that respond to the health needs of our community. Community-based collaborations continue to be a priority in for the hospital and will continue to drive community benefit efforts.

Health Need: Access to Quality Primary Care Health Services

Strategy or Program	Summary Description	Active FY22	Planned FY23
Provide services for vulnerable populations	Financial Assistance for uninsured/underinsured and low-income residents. Rural Health Clinics offering sliding fee scale for patients who do not qualify for insurance.	☒	☒
Increase Access to Care	Physician recruitment efforts. Rural Health Clinics eligible for federal and state student loan repayment programs for clinicians. Offer convenient appointments on the weekend acute care walk in or drive through	☒	☐

	clinic appointments. When appropriate, offer video and telephone visits to those who's health may limit their ability to drive to their appointment.		
Health Education Outreach	Participation at events as requested throughout the year.	☐	☒
Provide/facilitate funding and in-kind support for access to care to local community agencies	Funding directed towards access to health care programs.	☐	☒
CHW Navigator (Proposed)	SECH will conduct feasibly study to identify whether community health workers based in the emergency department is appropriate to assist patients with applying for immediate medical health insurance, make and keep follow up primary care appointments after visiting the ED, and navigating community health resources.	☐	☒
Workforce Development	Identify and partner with community organizations who are leading workforce development efforts to increase access to a diverse and inclusive health care workforce—both in clinical and nonclinical/corporate settings and improve health equity.	☐	☒
Transportation Assistance	Address transportation barriers to accessing healthcare services. Provide van service, taxi vouchers or bus tokens to patients who need assistance with access to our facilities.	☒	☒

Goal and Impact:
Leverage MMCR's investments as an anchor institution to address Social Determinants of Health (SDOH) needs in our communities to improve access to quality health care services for vulnerable populations by coordinating and improving resources and referrals to services to improve access.

Goal (Anticipated impact)

- Reduce the utilization of Emergency Departments for "avoidable", non-emergency visits
- Reduce the rates of uninsured people in the community

Collaborators: MMCR will continue to seek out partnerships with local organizations that respond to the health needs of our community. Community-based collaborations continue to be a priority in for the hospital and will continue to drive community benefit efforts.

Health Need: Safe and Violence-Free Environment

Strategy or Program	Summary Description	Active FY22	Planned FY23
Provide/facilitate funding and in-kind support for access to care to local community agencies	Funding directed towards access to health care programs.	☒	☒
Violence Prevention & Intervention	MMCR will increase internal capacity and community capacity to identify victims and respond though the Human Trafficking Task Force.	☐	☒

Goal and Impact:

Goals:

- Prevent future traumatization once violence has occurred
- Prevent violence

Anticipated Impact:

- Increase healthcare workforce capacity to provide trauma informed care for victims of violence
- Support community capacity to reduce violence

Collaborators: MMCR will continue to seek out partnerships with local organizations that respond to the health needs of our community. Community-based collaborations continue to be a priority in for the hospital and will continue to drive community benefit efforts.

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, the hospital awarded the grants below totaling $169,125. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Pathways to Hope for Children	Camp HOPE	$55,000
No. CA Center for Family Awareness	Kid's Turn Workshops	$25,000
FaithWorks	Housing and Supportive Services	$66,125

YMCA	Diabetes Prevention Program	$23,000

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.

Child Abuse (2019 CHNA Priority Only)	
Significant Health Needs Addressed	❑ Alcohol and Other Substance Abuse (including Tobacco) ✓ Child Abuse ❑ Diabetes ❑ Mental Health
Program Description	Support community programs, research, and monitoring systems that prevent child abuse and neglect while ensuring that children who are victims receive treatment and care.
Population Served	Low-income and vulnerable populations
Program Goal / Anticipated Impact	A reduction in opioid exposed infants at birth or in early childhood.
FY 2022 Report	
Activities Summary	● Collaborate with Children's Legacy Center to help establish an on-site forensic medical exam room at the new Children's Legacy Center's co-located facility, a volunteer advocacy program utilizing Child Life techniques, and best-practices for reducing trauma to child victims of abuse, neglect and trafficking. ● Partner with Pathways to Hope for Children to bring the Hope curriculum to Shasta County and assist with training Hope Ambassadors. ● Support the Camp Hope program which provides children who have been exposed to child abuse, domestic violence, or sexual assault with in-home case management, monthly mentoring opportunities and an opportunity to attend a week long camp to connect with others ● Continue to participate on the Public Health Institute's Northern California Adverse Childhood Experiences (ACE) and assist with the development of an ACEs Summit to be held in FY21.
Performance / Impact	Efforts in this area require collaboration with an internal multi-disciplinary team as well as collaboration with a variety of community-based non-profit organizations.

Community Health Worker (CHW)

Significant Health Needs Addressed	✓ Access to Mental/Behavioral Health and Substance-Use Services ✓ Access to Quality Primary Care Health Services ❑ Safe and Violent-Free Environment
Program Description	CHW Navigator (Proposed) MMCR will conduct feasibly study to identify whether community health workers based in the emergency department is appropriate to assist patients with applying for immediate medical health insurance, make and keep follow up primary care appointments after visiting the ED, and navigating community health resources.
Population Served	Low-income and vulnerable populations
Program Goal / Anticipated Impact	**Goal** To improve and increase access to health care and preventive services and for low-income and vulnerable populations that is culturally and linguistically appropriate by deploying programs to assist in the navigation of the health care system, provide education, and enrollment assistance. **Anticipated Impact** • Determine feasibility of proposed intervention • Identify baseline measurements • Reduce the utilization of Emergency Departments for "avoidable", non-emergency visits • Reduce the rates of uninsured people in the community • Increase access points for health-related and social needs
FY 2022 Report	
Activities Summary	The hospital's initiatives to address access to high quality health care and services are anticipated to result in: increased timely access and services; increased knowledge about how to access and navigate the health care system and reduce barriers to care.
Performance / Impact	Increased availability of services including chemotherapy infusion in the community, relieving the burden of individuals driving great distances to receive this type of care.
FY 2023 Plan	

Program Goal / Anticipated Impact	**Goal** To improve and increase access to health care and preventive services and for low-income and vulnerable populations that is culturally and linguistically appropriate by deploying programs to assist in the navigation of the health care system, provide education, and enrollment assistance. **Anticipated Impact** • Determine feasibility of proposed intervention • Identify baseline measurements • Reduce the utilization of Emergency Departments for "avoidable", non-emergency visits • Reduce the rates of uninsured people in the community • Increase access points for health-related and social needs

Substance Use Navigation

Significant Health Needs Addressed	✓ Access to Mental/Behavioral Health and Substance-Use Services ✓ Access to Quality Primary Care Health Services ❑ Safe and Violent-Free Environment
Program Description	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 Navigator 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 Medication for Addiction Treatment (MAT) program.
Population Served	Low-income and vulnerable populations
Program Goal / Anticipated Impact	**Goal** Identify, prevent and assist with the demands on a caregiver's body, mind and emotions leading to fatigue, hopelessness and ultimately burnout. **Impact (Anticipated)**

	Ensure equitable access to quality, culturally responsive and linguistically appropriate services. **Anticipated Impact** To strengthen and expand the infrastructure of collaborative partnerships in Tehama County by engaging public and private partners to work alongside us in the implementation of program services.
FY 2022 Report	
Activities Summary	The hospital's initiatives to address substance abuse and co-occurring mental/behavioral health have anticipated results in: increasing the community's knowledge of common mental health issues and how to deal with them.
Performance / Impact	Connection to community-based services for unmet health needs.
Hospital's Contribution / Program Expense	• Continue to collaborate with Hill Country Community Clinic for the dual diagnosis treatment program that will provide needed services to individuals who are suffering from the co-occurring conditions of mental illness and substance use disorder. • Continue to provide substance use navigator services for individuals with mental illness and substance use disorders that have an emergency department visit.
FY 2023 Plan	
Program Goal / Anticipated Impact	Improved system for patient linkages to outpatient behavioral health services; provide a seamless transition of care, reduce mental health stigma and increase in resources in the community.
Planned Activities	CHW Navigator (Proposed) MMCR will conduct feasibly study to identify whether community health workers based in the emergency department is appropriate to assist patients with applying for immediate medical health insurance, make and keep follow up primary care appointments after visiting the ED, and navigating community health 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. One of the most powerful ways is through partnerships. We recognize that no hospital facility can address all of the health needs present in its community, requires long-term focus and investment from all levels of community stakeholders.

Mobilizing for action through Planning and Partnership - Mercy Medical Center Redding was a contributing participant to the comprehensive community health improvement planning process that was initiated by Shasta County Health and Human Services Agency's Public Health Branch. The MAPP model was selected as the strategic planning framework to guide the development of the community health needs assessment because of its strong emphasis on community input.

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, and therapists.

Community Investment Program

Hill Country Community Clinic, Inc. (HCCC) - In June 2019 Dignity Health approved a $5,000,000 secured loan to Hills Country Community Clinic, Inc. for 7 years. HCCC is constructing the Center of Hope Redding health-care campus that will include medical, dental, mental health, substance abuse treatment, and recovery activities to support people with complex health and social needs projecting to serve 9,000 patients per year in Redding, California. In addition, a 5,000 square ft. supported housing development will be included for 16 transitional age youth students who are transitioning out of homelessness.

Shasta Community Health Center (SCHC) - In March 2017 Dignity Health approved a 7-year $2,500,000 participation loan with Primary Care Development Corporation to SCHC for the construction of a new and expanded health center in Anderson, California, replacing an older clinic building that is currently leased. SCHC has been providing comprehensive primary health and dental care to Shasta County residents, regardless of ability to pay, since 1988. SCHC is expanding its facility capacity to meet the existing and future demand for services.

Additionally, members of the hospital's leadership and management teams provide significant in-kind support and expertise to nonprofit health care organizations, civic, and service agencies such as Shasta College, Shasta Community Health Center, Empire Recovery Center, North State Cancer League, and Redding Chamber of Commerce. Annual sponsorships also support multiple programs, services and fund-raising events of organizations among them; Good News Rescue Mission, Leadership Redding, Northern Valley Catholic Social Services and One Safe Place.

Economic Value of Community Benefit

Mercy Medical Center Redding					
Complete Summary - Classified Including Non Community Benefit (Medicare)					
For period from 7/1/2021 through 6/30/2022					
	Persons	**Expense**	**Offsetting Revenue**	**Net Benefit**	**% of Expenses**
Benefits For Poor					
Financial Assistance	**16,595**	**8,807,035**	**0**	**8,807,035**	**1.6%**
Medicaid	**35,475**	**142,438,467**	**112,054,300**	**30,384,167**	**5.6%**
Community Services					
A - Community Health Improvement Services	2,186	185,652	0	185,652	0.0%
E - Cash and In-Kind Contributions	47	730,736	0	730,736	0.1%
G - Community Benefit Operations	0	69,544	0	69,544	0.0%
Totals for Community Services	**2,233**	**985,932**	**0**	**985,932**	**0.2%**
Totals for Poor	**54,303**	**152,231,434**	**112,054,300**	**40,177,134**	**7.4%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	217	7,985	0	7,985	0.0%
B - Health Professions Education	18	6,754,184	979,721	5,774,463	1.1%
D - Research	0	47,849	(150)	47,999	0.0%
E - Cash and In-Kind Contributions	52	64,239	0	64,239	0.0%
Totals for Community Services	**287**	**6,874,257**	**979,571**	**5,894,686**	**1.1%**
Totals for Broader Community	**287**	**6,874,257**	**979,571**	**5,894,686**	**1.1%**
Totals - Community Benefit	**54,590**	**159,105,691**	**113,033,871**	**46,071,820**	**8.5%**
Medicare	**42,356**	**197,107,878**	**151,101,291**	**46,006,587**	**8.5%**
Totals with Medicare	**96,946**	**356,213,569**	**264,135,162**	**92,078,407**	**17.0%**

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

Riico Dotson, M.D., Chairperson
Karolina DeAugustinis, M.D., Secretary
Todd Strumwasser, M.D., SVP Northern California Division
Alan Foley
Eva Jimenez
Irene DeLao
Keith Cool
Mary Rushka
Mike Davis
Nikita Gill, M.D.
Patrick Quintal, M.D.
Paul Johnson, M.D.
Robert Evans, M.D.
Russ Porterfield
Ryan Denham
Sister Bridget McCarthy
Sister Clare Marie Dalton

Any communications to Board Members should be made in writing and directed to:

Michelle Burke, Executive Assistant
Dignity Health North State
P.O. Box 496009
Redding, CA 96049-6009
(530) 225-6103
(530) 225-6118 fax