Mercy Hospital of Folsom

Community Benefit 2024 Report and 2025 Plan

Adopted October 2024

Dignity Health
Mercy Hospital of Folsom

A message from

Lisa Hausmann, RN, President and CEO of Mercy Hospital of Folsom, and Larry Garcia, 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 drivers of health.

Mercy Hospital of Folsom (Mercy Folsom) shares a commitment with others to improve the health of our community and promote health equity, and delivers programs and services to help achieve that goal. The Community Benefit 2024 Report and 2025 Plan describes much of this work. This report meets requirements in California (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. 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 2024 (FY24), Mercy Folsom provided $26,166,217 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $22,483,852 in unreimbursed costs of caring for patients covered by Medicare fee-for-service.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2024 Report and 2025 Plan at its October 24, 2024 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

Larry Garcia
Chairperson, Board of Directors

Table of Contents

At-a-Glance Summary

Hospital HCAI ID: 106344029

Report Period Start Date: July 1, 2023

Report Period End Date: June 30, 2024

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

Community Served	Mercy Folsom is located in Folsom and has 892 employees, 186 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	**$26,166,217** in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits **$22,483,852** in unreimbursed costs of caring for patients covered by Medicare fee-for-service. The hospital's net community benefit expenses for services to vulnerable populations and to the broader community are listed by category in the Economic Value of Community Benefit section of this report.
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
FY24 Programs and Services	The hospital delivered several programs and services to help address identified significant community health needs. These included: • 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. • Recuperative Care Program at the Gregory Bunker Care Transitions Center of Excellence: This collaborative engages other Dignity Health hospitals and health systems in the region, Medi-Cal Managed Care Plans, Sacramento County and WellSpace Health, and provides a respite care shelter for homeless patients with available physical and mental health, and substance abuse treatment. • Linked-Care Intensive Outpatient Mental Health Partnership: The hospitals works in collaboration with community-based nonprofit mental health provider, El Hogar Community Services Inc., 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. • 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 and Community HealthWorks, 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.
FY25 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 Community HealthWorks, 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 Recuperative Care Program at the Gregory Bunker Care Transitions Center of Excellence; Housing with Dignity; Sacramento Steps Forward, 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.

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 892 employees, 186 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. Mercy Folsom was recognized in the Human Rights Campaign Foundation's 2022 Healthcare Equality Index (HEI) for its equitable treatment and inclusion of LGBTQ+ patients, visitors and employees.

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 the geographic area (by ZIP code) outlined in the hospital's Community Health Needs Assessment (CHNA). This includes all of Sacramento County. 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 2023 estimates provided by SG2's Analytics Platform (Source: Claritas Pop-Facts® 2023; SG2 Market Demographic Module):

- Total Population: 1,654,035
- Race/Ethnicity: Hispanic or Latino: 24.3%; White: 39.8%, Black/African American: 8.7% Asian/Pacific Islander: 19.4%, All Other: 7.8%.
- % Below Poverty: 8.9%
- Unemployment: 5.6%
- No High School Diploma: 11.2%
- Medicaid: 28.8%
- Uninsured: 5.0%

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 20220.

The hospital makes the CHNA report widely available to the public online at https://www.dignityhealth.org/sacramento/about-us/community-health-and-outreach/health-needs-assessment and upon request from the hospital's Community Health office.

This document also reports on programs delivered during fiscal year 2024 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.

Community Groups that Attended or Engaged in the CHNA:

- Mercy General Hospital
- La Familia
- Methodist Hospital
- Mercy Hospital Folsom
- Sutter Medical Center Sacramento
- San Juan School Unified District
- UC Davis Medical Center
- Mercy San Juan Medical Center
- Sacramento Native American Health Center
- Sacramento Covered
- El Dorado Community Health Center
- People Reaching Out
- Slavic Assistance Center
- Elk Grove Food Bank (Pt. Pleasant Methodist Church)
- Asian Resource Center, Inc.
- Sacramento County Public Health
- Planned Parenthood
- WellSpace Health
- Sacramento Food Bank & Family Services
- Mutual Assistance Center
- CA Endowment Building Healthy Communities
- National Alliance on Mental Illness
- Sacramento Housing Alliance
- Valley Vision
- Latino Leadership Council
- Yolo County Children's Alliance
- Anti-Recidivism Coalition
- Sacramento Steps Forward
- World Relief Sacramento
- WEAVE
- Hope Cooperative
- My Sister's House
- Sac Breathe
- Sierra Health Foundation
- Sacramento LGBT Community Center
- Sacramento Area School District

- Lao Family Community Development Center
- Sacramento ACT
- Health Education Council
- Ethnic Chambers of Commerce
- Cal Voices
- Public Housing Agency
- Opening Doors
- Folsom Cordova Partnership
- WIND Youth Services
- Cancer Support Group
- Elk Grove Hart

Vulnerable Populations Represented by These Groups

- Racial and ethnic groups experiencing disparate health outcomes, including:
  - Black/African American
  - American Indian
  - Asian and Pacific Islanders including Asian Indian, Chinese, Filipino, Hmong, Laotian, Vietnamese, Guamanian, and Samoan,
  - Other non-white racial groups,
  - Individuals of Hispanic/Latino origin, including Mexicans, Mexican Americans, Chicanos, Salvadorans, and Guatemalans.
- Socially disadvantaged groups, including the following:
  - The unhoused
  - People with disabilities
  - People identifying as lesbian, gay, bisexual, transgender, or queer
  - Individuals with limited English proficiency

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	✓

Significant Health Need	Description	Intend to Address?
	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 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	✓

Significant Health Need	Description	Intend to Address?
	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 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	

Significant Health Need	Description	Intend to Address?
	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 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 Hospital of 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 Hospital of Folsom. However, the hospital will look for opportunities to coordinate and collaborate with other entities that offer programs that address these needs.

2024 Report and 2025 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 FY24 and planned activities for FY25, 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.

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 Core Strategies

Driven by a commitment to equity and social justice, we envision a future where health and well-being are attainable by all regardless of background or circumstance.

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 three core strategies for community health improvement activities. These strategies help to ensure that program activities overall address strategic aims while meeting locally-identified needs.

- Extend the care continuum by aligning and integrating clinical and community-based interventions.
- Strengthen community capacity to achieve equitable health and well-being.
- Implement and sustain evidence-based health improvement program initiatives.

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 FY24	Planned FY25
Linked-Care Outpatient Behavioral Health Partnership	In partnership with community-based nonprofit mental health provider, El Hogar Community Services Inc. The Linked-Care program links Medicare, uninsured, undocumented and out of county Medi-Cal patients with appropriate ongoing behavioral health service providers as well as provide services to bridge the gap between patient and provider.	☑	☑
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 grants.	☑	☑
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.	☑	☑
Future Focused: Fentanyl Education and Awareness Campaign	Supported through the Community Health Improvement Grants Program, a partnership between Arrive Alive California Inc., California Chaplain Corp, Sacramento County District Attorney's Office (SCDA), and Sacramento County Department of Health Services to bring education and awareness of drug prevention, counterfeit pills and Fentanyl poisoning deaths to students and teachers inside the classroom, to parents and guardians in Parent workshops, and to community members with Town Hall meetings, virtual trainings, train the trainer opportunities.	☑	☑
Building Health Equity and Wellness through Collaborative Care	Supported through the Community Health Improvement Grants Program, a partnership between Community Against Sexual Harm (CASH), STRIVE Community Health, and Emerge. The project organizes wellness fairs, workshops, groups, and mentoring programs tailored to meet the unique needs of individuals from marginalized communities. It seeks to empower adults and youth with knowledge and skills to access available resources with the goal to ensure that all participants have equal opportunities to thrive and succeed, regardless of their circumstances.	☑	☑
Cut to the Chase	Supported through the Community Health Improvement Grants Program, a partnership between Greater Sacramento Urban League, Capitol City Black Nurses Association, and Heart of the Matter Counseling. This project focuses on improving mental health for Black men and women in Del Paso Heights and Oak Park in Sacramento, California with	☑	☑

	ongoing advocacy for Black males and females to obtain required mental health services. To address the stigma around Black males and females seeking mental-emotional support, this program provides therapy in spaces that Black men and women already comfortably frequent such as local barbershops and beauty salons.		
Connect to Health -Supporting Healthy Newcomer Communities	Supported through the Community Health Improvement Grants Program, a partnership between International Rescue Committee, Inc., River City Food Bank, and One Community Health. This project aims to provide culturally and linguistically congruent health/mental health navigation services and psychosocial support to refugees and immigrants as an underserved community in Sacramento. This project directly addresses health disparities, promotes independent health access, enhances resilience and self-sufficiency, and connects refugees and immigrants to basic needs and resources.	☑	☑
Skate Nights Youth Development Program	Supported through the Community Health Improvement Grants Program, a partnership between Project Lifelong, San Juan Unified School District (SJUSD): Family & Community Engagement Department, and Sacramento Inspiring Connections Outdoors, and SJUSD: School Site Social Workers. This project brings pop-up skateboarding parks on middle school campuses through the Skate Nights program, which incorporates Social Emotional Learning (SEL) to foster life skills and a sense of belonging.	☑	☑
Basic Needs and Behavioral Health/SUD Services for Unhoused Women & Children	Supported through the Community Health Improvement Grants Program, a partnership between Saint John's Program for Real Change, Highlands Community Charter and Technical Schools, and California Mobility Center. This project addresses the basic needs of women and children in the Greater Sacramento area by providing housing, meals, childcare, employment training, job placement, psycho/social education, life skills training, transportation, and housing navigation services to improve social determinants of health.	☑	☑
The RAGE Healing Pipeline	Supported through the Community Health Improvement Grants Program, a partnership between The Race and Gender Equity Project, Flyte Studio, Sacramento City Unified School District (SCUSD), Foster Youth Services (FYS), and Monroe Howard Transformational Coaching.The RAGE Healing Pipeline will increase capacity of an intersectional youth-serving-youth cooperative to provide a network of healing, education, arts and leadership programs that work independently and collectively to increase Black youth wellbeing in the Sacramento region. This program will also develop and implement an infrastructure of support, resources and opportunities for Black youth to enter the behavioral health field through entrepreneurship and education/career pathways.	☑	☑
Opening Doors, Transforming Lives	Supported through the Community Health Improvement Grants Program, a partnership between Turning Point	☑	☑

	Community Programs, Consumer Self Help Center (CSH), Liberty Towers Church (LT), Sacramento Youth Center (SYC), and Uptown Studios. This initiative connects underserved Sacramento County community members with crucial behavioral health services by forming partnerships and offering culturally sensitive outreach to diminish the stigma surrounding mental health care. The goal is to enhance engagement, satisfaction, and participation in these services.		

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, mental health providers, MAT agencies, Community Against Sexual Harm (CASH), STRIVE Community Health, Emerge, Arrive Alive California Inc., California Chaplain Corp, Sacramento County District Attorney's Office (SCDA), Sacramento County Department of Public Health Services (SCPH),Greater Sacramento Urban League, Capitol City Black Nurses Association, Heart of the Matter The Race and Gender Equity Project, Flyte Studio, Sacramento City Unified School District (SCUSD), Foster Youth Services (FYS), Monroe Howard Transformational Coaching, Saint John's Program for Real Change, Highlands Community Charter and Technical Schools, and California Mobility Center, Turning Point Community Programs, Consumer Self Help Center (CSH), Liberty Towers Church (LT), Sacramento Youth Center (SYC), Uptown Studios, Project Lifelong, San Juan Unified School District (SJUSD): Family & Community Engagement Department, Sacramento Inspiring Connections Outdoors, 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 FY24	Planned FY25
Recuperative Care Program	The hospital is an active partner in the Recuperative Care Program, formerly known as the Gregory Bunker Care Transitions Center of Excellence's (The Bunker). This collaborative engages other Dignity Health hospitals and health systems in the region, Sacramento County and Federally Qualified Health Center, WellSpace Health, and provides respite care for homeless patients with available physical and mental health, and substance abuse treatment. This is a nurse-managed specialized unit that offers patients three meals a day, bed rest, nurse care and self-care. 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.	☑	☑
Medical Legal Partnership	Supported through the Homeless Health Initiative, and in partnership with Legal Services of Northern California, the Medical Legal Partnership (MLP) will address the legal needs of patients at the hospitals and the Family Medicine Residency Program. MLP integrates and embeds lawyers into the healthcare setting to help clinicians, case managers and social workers address structural problems at the root of so many health inequities. This program will have a particular emphasis on addressing housing insecurities. This program sunsets in December 2024.	☑	☑
Bridging House for Women and Children Experiencing Homelessness	Supported through the Community Health Improvement Grants Program, a partnership between Bridging Initiatives International, Sacramento Steps Forward, Carmichael HART and Mercy Holistic Ministry. This program will increase comprehensive support to women and children experiencing homelessness, including food and shelter, case management, life skills training, support groups, and connecting them with other community services. The goal is to house individuals/families and transition them to a stable life, where they can thrive and build a better future.	☑	☑
Exodus Project Transitional Housing for Homeless Returning Citizens	Supported through the Community Health Improvement Grants Program, a partnership between Exodus Project, St. Vincent de Paul Sacramento, Sacramento Office of the Public Defender, and Boundless Freedom Project. This project enables low-income and homeless adults returning to society from jail in Sacramento County to regain their dignity and well-being. The project pilots the integration of case management, mindfulness training courses, and peer mentoring into the Exodus Project, St. Vincent de Paul Sacramento program's existing wrap-around support services	☑	☑

	of employment, emergency housing, counseling, and system navigation..		
Connect to Health -Supporting Healthy Newcomer Communities	Supported through the Community Health Improvement Grants Program, a partnership between International Rescue Committee, Inc., River City Food Bank, and One Community Health. This project aims to provide culturally and linguistically congruent health/mental health navigation services and psychosocial support to refugees and immigrants as an underserved community in Sacramento. This project directly addresses health disparities, promotes independent health access, enhances resilience and self-sufficiency, and connects refugees and immigrants to basic needs and resources.	☑	☑
Mercy Holistic Ministries Project	Supported through the Community Health Improvement Grants Program, a partnership between Mercy Holistic Ministries, City of Sacramento City Council District 4, Mount Calvary Baptist Church Del Paso, and Faith Presbyterian Church/Bethany Presbyterian Church. This grant project adds additional showers for the unhoused in Sacramento County. The outcome brings dignity to the unhoused by providing basic showers, hygiene kits, clean clothes, haircuts, meals/beverages, in addition to needed health screenings and social service counseling in partnership with the City and County of Sacramento. This partnership helps navigate homelessness and re-entry into the job market and subsequently affordable housing.	☑	☑
Basic Needs and Behavioral Health/SUD Services for Unhoused Women & Children	Supported through the Community Health Improvement Grants Program, a partnership between Saint John's Program for Real Change, Highlands Community Charter and Technical Schools, and California Mobility Center. This grant project addresses the basic needs of women and children in the Greater Sacramento area by providing housing, meals, childcare, employment training, job placement, psycho/social education, life skills training, transportation, and housing navigation services to improve social determinants of health.	☑	☑
Opening Doors, Transforming Lives	Supported through the Community Health Improvement Grants Program, a partnership between Turning Point Community Programs, Consumer Self Help Center (CSH), Liberty Towers Church (LT), Sacramento Youth Center (SYC), and Uptown Studios. This initiative connects underserved Sacramento County community members with crucial behavioral health services by forming partnerships and offering culturally sensitive outreach to diminish the stigma surrounding mental health care. The goal is to enhance engagement, satisfaction, and participation in these services.	☑	☑
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.			
Collaborators: The hospital will partner with other healthcare systems in the region, Sacramento County, FQHCs, WellSpace Health, Lutheran Social Services, Legal Services of Northern California, Homeless Health Initiative,			

Community Solutions and Institute for Healthcare Improvement (IHI), Exodus Project, St. Vincent de Paul Sacramento, Sacramento Office of the Public Defender, Boundless Freedom Project, Saint John's Program for Real Change, Highlands Community Charter and Technical Schools, California Mobility Center, Turning Point Community Programs, Consumer Self Help Center (CSH), Liberty Towers Church (LT), Sacramento Youth Center (SYC), Uptown Studios, Mercy Holistic Ministries, City of Sacramento City Council District 4, Mount Calvary Baptist Church Del Paso, Faith Presbyterian Church/Bethany Presbyterian Church, Race and Gender Equity Project, Flyte Studio, Sacramento City Unified School District (SCUSD), Foster Youth Services (FYS), Monroe Howard Transformational Coaching, 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 FY24	Planned FY25
Care for the Undocumented	Dignity Health hospitals in Sacramento County partner with Sacramento County, other health systems 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, Community HealthWorks, formerly known as Sacramento Covered, a community-based nonprofit organization, and community clinics in the region.	☑	☑
Bridging House for Women and Children Experiencing Homelessness	Supported through the Community Health Improvement Grants Program, a partnership between Bridging Initiatives International, Sacramento Steps Forward, Carmichael HART and Mercy Holistic Ministry. This program will increase	☑	☑

	comprehensive support to women and children experiencing homelessness, including food and shelter, case management, life skills training, support groups, and connecting them with other community services. The goal is to house individuals/families and transition them to a stable life, where they can thrive and build a better future.		
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, Community HealthWorks, and local community clinics, Bridging Initiatives International, Sacramento Steps Forward, Carmichael HART, Mercy Holistic Ministry 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 FY24	Planned FY25
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, Community HealthWorks, formerly known as Sacramento Covered, a community-based nonprofit organization, and community clinics in the region.	☑	☑
Linked-Care Outpatient Behavioral Health Partnership	In partnership with community-based nonprofit mental health provider, El Hogar Community Services Inc. The Linked-Care program (formerly known as ReferNet Program) links Medicare, uninsured, undocumented and out of county Medi-Cal patients with appropriate ongoing behavioral health service providers as well as provide services to bridge the gap between patient and provider.	☑	☑
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 grants.	☑	☑
Exodus Project Transitional Housing for Homeless Returning Citizen	Supported through the Community Health Improvement Grants Program, a partnership between Exodus Project, St. Vincent de Paul Sacramento, Sacramento Office of the Public Defender, and Boundless Freedom Project. This project enables low-income and homeless adults returning to society from jail in Sacramento County to regain their dignity and well-being. The project pilots the integration of case management, mindfulness training courses, and peer mentoring into the Exodus Project, St. Vincent de Paul Sacramento program's existing wrap-around support services of employment, emergency housing, counseling, and system navigation.	☑	☑
Building Health Equity and Wellness through Collaborative Care	Supported through the Community Health Improvement Grants Program, a partnership between Community Against Sexual Harm (CASH), STRIVE Community Health, and Emerge. The grant project organizes wellness fairs, workshops, groups, and mentoring programs tailored to meet the unique needs of individuals from marginalized communities. It seeks to empower adults and youth with knowledge and skills to access available resources with the goal to ensure that all participants have equal opportunities to thrive and succeed, regardless of their circumstances.	☑	☑
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 Community HealthWorks, El Hogar, Sacramento County Behavioral Health, Bay Area Community Services, MAT agencies, Exodus Project, St.			

Vincent de Paul Sacramento, Sacramento Office of the Public Defender, and Boundless Freedom Project, Community Against Sexual Harm (CASH), STRIVE Community Health, Emerge, 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 FY24	Planned FY25
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.	☑	☑
Disease-Specific Support Groups	Education and support are offered monthly in-person and virtually to those affected by specific diseases in the community. Current groups include: cancer, stroke and heart disease.	☑	☑
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.	☑	☑
Future Focused: Fentanyl Education and Awareness Campaign	Supported through the Community Health Improvement Grants Program, a partnership between Arrive Alive California Inc., California Chaplain Corp, Sacramento County District Attorney's Office (SCDA), and Sacramento County Department of Health Services to bring education and awareness of drug prevention, counterfeit pills and Fentanyl poisoning deaths to students and teachers inside the classroom, to parents and guardians in Parent workshops, and to community members with Town Hall meetings, virtual trainings, train the trainer opportunities.	☑	☑

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, Catholic Schools in Sacramento: St Philomene, St Robert and St Patrick Academy, Arrive Alive California Inc., California Chaplain Corp, Sacramento County District Attorney's Office (SCDA), and Sacramento County Department of Health Services (SCPH), 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 FY24	Planned FY25
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, Community HealthWorks, formerly known as 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.	☑	☑
Medical Legal Partnership	Supported through the Homeless Health Initiative, and in partnership with Legal Services of Northern California, the Medical Legal Partnership (MLP) will address the legal needs of patients at the hospitals and the Family Medicine Residency Program. MLP integrates and embeds lawyers into the healthcare setting to help clinicians, case managers and social workers address structural problems at the root of so many health inequities. This program will have a particular emphasis on addressing housing insecurities. This program sunsets in December 2024.	☑	☑
Care for the Undocumented	Dignity Health hospitals in Sacramento County partner with Sacramento County, other health systems 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	☑	☑
Newborn Hearing Diagnostic Program	Supported through the Community Health Improvement Grants Program, a partnership between Children's Choice for Hearing and Talking Sacramento (dba CCHAT Center), Northern California Hearing Coordination Center (NCHCC) -Department of Health Care Services (DHCS), UC Davis Health Audiology, Welcome Home Midwifery Services, Inc., California Birthing Center. This program ensures that babies throughout the greater Sacramento area have access to timely hearing screenings and hearing health resources that will help mitigate the negative impacts often associated with hearing loss.	☑	☑
Building Health Equity and Wellness through Collaborative Care	Supported through the Community Health Improvement Grants Program, a partnership between Community Against Sexual Harm (CASH), STRIVE Community Health, and Emerge. The grant project organizes wellness fairs, workshops, groups, and mentoring programs tailored to meet the unique needs of individuals from marginalized communities. It seeks to empower adults and youth with knowledge and skills to access available resources with the goal to ensure that all participants have equal opportunities to thrive and succeed, regardless of their circumstances.	☑	☑
Elk Grove Unified School District FIRST Foundation Project	Supported through the Community Health Improvement Grants Program, a partnership between Elk Grove Unified School District FIRST Foundation, Elk Grove Unified School District (EGUSD), and Sacramento Food Bank and Family Services. This program expands services provided through the EGUSD's Newcomer Welcome Centers (NWC), with emphasis on newcomer and refugee families new to the country and the US education system. This project seeks to enhance experiences for Moms Support Groups, increase the	☑	☑

	number of families receiving basic school supplies, and improve access to healthy food.		
Connect to Health -Supporting Healthy Newcomer Communities	Supported through the Community Health Improvement Grants Program, a partnership between International Rescue Committee, Inc., River City Food Bank, and One Community Health. This project aims to provide culturally and linguistically congruent health/mental health navigation services and psychosocial support to refugees and immigrants as an underserved community in Sacramento. This project directly addresses health disparities, promotes independent health access, enhances resilience and self-sufficiency, and connects refugees and immigrants to basic needs and resources.	☑	☑
The RAGE Healing Pipeline	Supported through the Community Health Improvement Grants Program, a partnership between The Race and Gender Equity Project, Flyte Studio, Sacramento City Unified School District (SCUSD) Foster Youth Services (FYS), and Monroe Howard Transformational Coaching.The RAGE Healing Pipeline will increase capacity of an intersectional youth-serving-youth cooperative to provide a network of healing, education, arts and leadership programs that work independently and collectively to increase Black youth wellbeing in the Sacramento region. This program will also develop and implement an infrastructure of support, resources and opportunities for Black youth to enter the behavioral health field through entrepreneurship and education/career pathways.	☑	☑

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 Community HealthWorks, other healthcare systems in the region, community clinics, Homeless Health Initiative, Community Solutions and Institute for Healthcare Improvement (IHI), Sacramento County, other health system and the Sierra Sacramento Valley Medical Society, Legal Services of Northern California, Elk Grove Unified School District FIRST Foundation, Elk Grove Unified School District (EGUSD), Sacramento Food Bank andFamily Services, International Rescue Committee, Inc., River City Food Bank, One Community Health, Children's Choice for Hearing and Talking Sacramento (dba CCHAT Center), Northern California Hearing Coordination Center (NCHCC) -Department of Health Care Services (DHCS), UC Davis Health Audiology, Welcome Home Midwifery Services, Inc., California Birthing Center, Community Against Sexual Harm (CASH), STRIVE Community Health, Emerge, and The Race and Gender Equity Project, Flyte Studio, Sacramento City Unified School District (SCUSD) Foster Youth Services (FYS), and Monroe Howard Transformational Coaching 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 FY24	Planned FY25

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.	☑	☑
Elk Grove Unified School District FIRST Foundation Project	Supported through the Community Health Improvement Grants Program, a partnership between Elk Grove Unified School District FIRST Foundation, Elk Grove Unified School District (EGUSD), and Sacramento Food Bank and Family Services. This program expands services provided through the EGUSD's Newcomer Welcome Centers (NWC), with emphasis on newcomer and refugee families new to the country and the US education system. This project seeks to enhance experiences for Moms Support Groups, increase the number of families receiving basic school supplies, and improve access to healthy food.	☑	☑
Skate Nights Youth Development Program	Supported through the Community Health Improvement Grants Program, a partnership between Project Lifelong, San Juan Unified School District (SJUSD): Family & Community Engagement Department, and Sacramento Inspiring Connections Outdoors, and SJUSD: School Site Social Workers. This project brings pop-up skateboarding parks on middle school campuses through the Skate Nights program, which incorporates Social Emotional Learning (SEL) to foster life skills and a sense of belonging.	☑	☑
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 medical clinics, food banks, affordable housing developments, senior centers, Elk Grove Unified School District FIRST Foundation, Elk Grove Unified School District (EGUSD), and Sacramento Food Bank and Family Services, Project Lifelong, San Juan Unified School District (SJUSD): Family & Community Engagement Department, and Sacramento Inspiring Connections Outdoors, 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 FY24	Planned FY25
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		
Safe Kids Program	The Safe Kids Greater Sacramento coalition, led by MSJMC, is composed of individuals and organizations that are committed to reducing preventable childhood injuries. Projects focus on: Child Passenger Safety; Bicycle Safety; Pedestrian Safety; Safe Sleep; Fire/Burn Prevention; and Drowning Prevention. MSJMC also leads a no cost car seat education program targeting families with children living in poverty, and to families with children in immigrant communities. The program provides: car seat classes; car seat checkup appointments; car seat distribution to families in need; and program phone lines are currently offered in English, Spanish, and Hmong. Car seat checkups are offered to the general public at several hospital sites.	☑	☑
Exodus Project Transitional Housing for Homeless Returning Citizen	Supported through the Community Health Improvement Grants Program, a partnership between Exodus Project, St. Vincent de Paul Sacramento, Sacramento Office of the Public Defender, and Boundless Freedom Project. This project enables low-income and homeless adults returning to society from jail in Sacramento County to regain their dignity and well-being. The project pilots the integration of case management, mindfulness training courses, and peer mentoring into the Exodus Project, St. Vincent de Paul Sacramento program's existing wrap-around support services of employment, emergency housing, counseling, and system navigation.	☑	☑
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, Exodus Project, St. Vincent de Paul Sacramento, Sacramento Office of the Public Defender, and Boundless Freedom Project, and other 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 FY24	Planned FY25

Disease-Specific Support Groups	Education and support are offered monthly in-person and virtually to those affected by specific diseases in the community. Current groups include: cancer, stroke and heart disease.	☑	☑
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.	☑	☑
Building Health Equity and Wellness through Collaborative Care	Supported through the Community Health Improvement Grants Program, a partnership between Community Against Sexual Harm (CASH), STRIVE Community Health, and Emerge. The grant project organizes wellness fairs, workshops, groups, and mentoring programs tailored to meet the unique needs of individuals from marginalized communities. It seeks to empower adults and youth with knowledge and skills to access available resources with the goal to ensure that all participants have equal opportunities to thrive and succeed, regardless of their circumstances.	☑	☑
Elk Grove Unified School District FIRST Foundation Project	Supported through the Community Health Improvement Grants Program, a partnership between Elk Grove Unified School District FIRST Foundation, Elk Grove Unified School District (EGUSD), and Sacramento Food Bank and Family Services. This program expands services provided through the EGUSD's Newcomer Welcome Centers (NWC), with emphasis on newcomer and refugee families new to the country and the US education system. This project seeks to enhance experiences for Moms Support Groups, increase the number of families receiving basic school supplies, and improve access to healthy food.	☑	☑
Cut to the Chase	Supported through the Community Health Improvement Grants Program, a partnership between Greater Sacramento Urban League, Capitol City Black Nurses Association, and Heart of the Matter Counseling. This project focuses on improving mental health for Black men and women in Del Paso Heights and Oak Park in Sacramento, California with ongoing advocacy for Black males and females to obtain required mental health services. To address the stigma around Black males and females seeking mental-emotional support, this program provides therapy in spaces that Black men and women already comfortably frequent such as local barbershops and beauty salons.	☑	☑
Connect to Health -Supporting Healthy Newcomer Communities	Supported through the Community Health Improvement Grants Program, a partnership between International Rescue Committee, Inc., River City Food Bank, and One Community Health. This project aims to provide culturally and	☑	☑

	linguistically congruent health/mental health navigation services and psychosocial support to refugees and immigrants as an underserved community in Sacramento. This project directly addresses health disparities, promotes independent health access, enhances resilience and self-sufficiency, and connects refugees and immigrants to basic needs and resources.		
The RAGE Healing Pipeline	Supported through the Community Health Improvement Grants Program, a partnership between The Race and Gender Equity Project, Flyte Studio, Sacramento City Unified School District (SCUSD) Foster Youth Services (FYS), and Monroe Howard Transformational Coaching.The RAGE Healing Pipeline will increase capacity of an intersectional youth-serving-youth cooperative to provide a network of healing, education, arts and leadership programs that work independently and collectively to increase Black youth wellbeing in the Sacramento region. This program will also develop and implement an infrastructure of support, resources and opportunities for Black youth to enter the behavioral health field through entrepreneurship and education/career pathways.	☑	☑
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 medical clinics, health ministry, congregations, senior centers, affordable housing developments, Community Against Sexual Harm (CASH), STRIVE Community Health, Emerge, International Rescue Committee, Inc., River City Food Bank, One Community Health, Greater Sacramento Urban League, Capitol City Black Nurses Association, and Heart of the Matter Counseling, Elk Grove Unified School District FIRST Foundation, Elk Grove Unified School District (EGUSD), Sacramento Food Bank and Family Services, The Race and Gender Equity Project, Flyte Studio, Sacramento City Unified School District (SCUSD) Foster Youth Services (FYS), and Monroe Howard Transformational Coaching and other local community based organizations to deliver an increased community connections.			

Health Need: Access to Specialty and Extended Care

Strategy or Program	Summary Description	Active FY24	Planned FY25
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.	☑	☑

Care for the Undocumented	Dignity Health hospitals in Sacramento County partner with Sacramento County, other health systems 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 training 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.	☑	☑
Newborn Hearing Diagnostic Program	Supported through the Community Health Improvement Grants Program, a partnership between Children's Choice for Hearing and Talking Sacramento (dba CCHAT Center), Northern California Hearing Coordination Center (NCHCC) -Department of Health Care Services (DHCS), UC Davis Health Audiology, Welcome Home Midwifery Services, Inc., California Birthing Center. This program ensures that babies throughout the greater Sacramento area have access to timely hearing screenings and hearing health resources that will help mitigate the negative impacts often associated with hearing loss.	☑	☑
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, other health system, the Sierra Sacramento Valley Medical Society, Children's Choice for Hearing and Talking Sacramento (dba CCHAT Center), Northern California Hearing Coordination Center (NCHCC) -Department of Health Care Services (DHCS), UC Davis Health Audiology, Welcome Home Midwifery Services, Inc., California Birthing Center 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.

Mercy Folsom, in collaboration with Mercy General Hospital, Mercy San Juan Medical Center and Methodist awarded the grants below totaling $966,274 in FY24. The hospital's specific share of the total was $113,441. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Health Needs Addressed	Amount
Arrive Alive California, Inc. (AAC)	Future Focused: Fentanyl Education and Awareness Campaign	• Access to Mental/ Behavioral Health and Substance-Use Services • Injury and Disease Prevention and Management	$80,000
Bridging Initiatives International	Bridging House for Women and Children Experiencing Homelessness	• Access to Basic Needs Such as Housing, Jobs, and Food • Access to Quality Primary Care Health Services	$75,000
Children's Choice for Hearing and Talking Sacramento (dba CCHAT Center)	Newborn Hearing Diagnostic Program	• Health Equity: Equal Access to Opportunities to be Healthy • Access to Specialty and Extended Care	$25,000
Community Against Sexual Harm (CASH)	Building Health Equity and Wellness through Collaborative Care	• Access to Mental/ Behavioral Health and Substance-Use Services • Increased Community Connections • System Navigation	$84,000
EGUSD FIRST Foundation	EGUSD FIRST Foundation Project	• Health Equity: Equal Access to Opportunities to be Healthy • Active Living and Healthy Eating • Increased Community Connections	$75,000
Exodus Project, St. Vincent de Paul Sacramento	Exodus Project Transitional Housing for Homeless Returning Citizens	• Access to Basic Needs Such as Housing, Jobs, and Food • System Navigation • Safe and Violence-Free Environment	$83,120

Grant Recipient	Project Name	Health Needs Addressed	Amount
Greater Sacramento Urban League	Cut to the Chase	• Access to Mental/ Behavioral Health and Substance-Use Services • Increased Community Connections	$100,000
International Rescue Committee, Inc.	Connect to Health -Supporting Healthy Newcomer Communities	• Access to Mental/ Behavioral Health and Substance-Use Services • Access to Basic Needs Such as Housing, Jobs, and Food • Health Equity: Equal Access to Opportunities to be Healthy • Increased Community Connections	$100,000
Mercy Holistic Ministries.	2024 Mercy Holistic Ministries Project	• Access to Basic Needs Such as Housing, Jobs, and Food	$75,000
Project Lifelong	Skate Nights Youth Development Program	• Access to Mental/ Behavioral Health and Substance-Use Services • Active Living and Healthy Eating	$35,566
Saint John's Program for Real Change	Basic Needs and Behavioral Health/SUD Services for Unhoused Women & Children	• Access to Mental/ Behavioral Health and Substance-Use Services • Access to Basic Needs Such as Housing, Jobs, and Food	$85,026
The Race and Gender Equity Project	The RAGE Healing Pipeline	• Access to Mental/ Behavioral Health and Substance-Use Services • Health Equity: Equal Access to Opportunities to be Healthy • Increased Community Connections	$75,000
Turning Point Community Programs	Opening Doors, Transforming Lives	• Access to Mental/ Behavioral Health and Substance-Use Services • Access to Basic Needs Such as Housing, Jobs, and Food	$73,562

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	In partnership with Lutheran Social Services and Centene, the hospital aims to assist patients experiencing homelessness with severe chronic health and mental health issues to obtain and retain housing, care and services designed to achieve stability in their lives. Hospital case managers work directly with Lutheran Social Services to identify individuals who are experiencing chronic homelessness and chronic disability and place them in stabilization housing units. Intensive case management and wrap-around supportive services are provided by Lutheran Social Services to help achieve stability. Once stable, individuals are transitioned into permanent/permanent supportive housing.
Population Served	The primary beneficiaries are individuals and families in Sacramento County that are experiencing chronic homelessness with chronic health and/or mental issues.
Program Goal / Anticipated Impact	Housing with Dignity aims to assist individuals experiencing homelessness with severe chronic health and mental health issues obtain and retain housing, care and services designed to achieve stability in their lives.
FY 2024 Report	
Activities Summary	Hospital case managers/social workers work directly with Lutheran Social Services case managers to identify patients being discharged from the hospital who are then housed in 24 supportive stable apartments and receive intensive case management and supportive social services.
Performance / Impact	57 patients were referred from Dignity Health hospitals and received program services in FY24. 22 patients moved out of the program during this time and were either reunified with family, placed in supportive housing/referred to other housing programs or found their own place to live.
Hospital's Contribution /	$194,796

Program Expense	
FY 2025 Plan	
Program Goal / Anticipated Impact	Housing with Dignity aims to assist individuals experiencing homelessness 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 2024 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	Healthier Living workshops were held virtually and in-person. There were 15 Healthier Living workshops conducted, including a reach of 185 community members and 130 participants completing the program. There are now 12 active leaders who could facilitate, Diabetes Empowerment Education Program, Chronic Disease Self-Management Program and Diabetes Self-Management Program.
Hospital's Contribution / Program Expense	$105,913 which is a shared expense by Dignity Health hospitals in Sacramento.
FY 2025 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.

	Newborn Hearing Diagnostic 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	This program is supported through the Community Health Improvement Grants Program, a partnership between Children's Choice for Hearing and Talking Sacramento (dba CCHAT Center), Northern California Hearing Coordination Center (NCHCC) -Department of Health Care Services (DHCS), UC Davis Health Audiology, Welcome Home Midwifery Services, Inc., California Birthing Center. This program ensures that babies throughout the greater Sacramento area have access to timely hearing screenings and hearing health

	resources that will help mitigate the negative impacts often associated with hearing loss.
Population Served	Newborns and infants in the greater Sacramento area.
Program Goal / Anticipated Impact	Ensures that babies throughout the greater Sacramento area have access to timely hearing screenings and hearing health resources that will help mitigate the negative impacts often associated with hearing loss.
FY 2024 Report	
Activities Summary	• Initial newborn hearing screenings • Diagnostic evaluation of infants within 3 months of birth.
Performance / Impact	From January and June 2024, 32 newborns have received an initial hearing screening, and 46 infants have obtained a diagnostic evaluation.
Hospital's Contribution / Program Expense	$25,000
FY 2025 Plan	
Program Goal / Anticipated Impact	Continue to ensure that babies throughout the greater Sacramento area have access to timely hearing screenings and hearing health resources that will help mitigate the negative impacts often associated with hearing loss. The goal of this project is to serve 55 newborns with hearing screenings and 50 infants with diagnostic evaluation.
Planned Activities	Continue to support newborn hearing screenings and diagnostic evaluations to ensure that once identified, the newborns can receive amplification and begin receiving vital intervention services to help mitigate the negative effects often associated with hearing loss.

	**Linked-Care 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	In partnership with community-based nonprofit mental health provider, El Hogar Community Services Inc., the program (formerly known as ReferNet

	Program) links Medicare, uninsured, undocumented and out of county Medi-Cal patients with appropriate ongoing behavioral health service providers as well as provide services to bridge the gap between patient and provider. 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 Medicare, uninsured, undocumented and out of county Medi-Cal patients not connected to mental services are 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 2024 Report	
Activities Summary	Hospital case managers/social workers work directly to schedule with El Hogar Community Services Inc. case managers to provide immediate and ongoing mental/behavioral health services and linkages.
Performance / Impact	48 patients successfully received intensive outpatient treatment through the program. All patients were referred through hospital social workers and El Hogar Community Services Inc. referred to other social service resources as needed.
Hospital's Contribution / Program Expense	$117,596
FY 2025 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 hospital 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 2024 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 a total of 826 patients and 367 patients were 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 2025 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 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 Patient Navigator Program represents a unique collaboration between Dignity Health and Sacramento Covered, a community-based nonprofit organization, and community clinics in the region. Patient Navigators assist 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 2024 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	6,492 patients were assisted and 34% 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	$774,715
FY 2025 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. Emphasis will be placed on screening and referrals for CalAIM Enhanced Care Management and Community Supports.

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.

- **Chicks in Crisis (CiC)** CiC provides access to emergency shelter and transitional housing, access to pregnancy care and needed baby supplies, crisis support and counseling, and adoption services to girls and women in Sacramento County—many of whom are low-income, pregnant and parenting, homeless, in the foster care system, victims of human trafficking, and/or recovering from recent addictions and abusive relationships. In November 2015 Dignity Health approved a loan of $325,000 for 5 years to CiC for the purchase of property (currently leased) to house its headquarters where staff can provide counseling and education. CiC primarily serves Elk Grove and South Sacramento—one of the six "Communities of Concern" identified by Dignity Health Methodist Hospital of Sacramento's Community Health Needs Assessment. The loan in the amount of $277,129 was extended in 2021 for five years

- **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 investments. 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 2017 and 2023 Dignity Health approved two 7-year loans totaling $7,000,000 respectively—the first as lending capital in a "FreshWorks" Fund for $1,000,000 supporting the bringing of grocery stores and other innovative forms of healthy food retail to underserved communities ("food deserts"), and the second $6,000,000 for lending capital for NCCLF's many projects.

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

Economic Value of Community Benefit

The economic value of all community benefit is reported at cost. Patient financial assistance (charity care) reported here is as reported to the Department of Health Care Access and Information in Hospital Annual Financial Disclosure Reports, as required by Assembly Bill 204. The community benefit of financial assistance, Medicaid, other means-tested programs and Medicare 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.

162 Mercy Hospital of Folsom
Complete Summary - Classified (Programs) Including Non Community Benefit (Medicare)
For period from 07/01/2023 through 06/30/2024

	Persons	Expense	Offsetting Revenue	Net Benefit	% of Expenses
Benefits for Poor					
Financial Assistance	1,750	$4,542,837	$0	$4,542,837	1.8%
Medicaid	19,979	$70,215,420	$51,319,703	$18,895,717	7.4%
Community Services					
A - Community Health Improvement Services	434	$681,840	$0	$681,840	0.3%
C - Subsidized Health Services	1,065	$753,275	$0	$753,275	0.3%
E - Cash and In-Kind Contributions	21	$283,962	$0	$283,962	0.1%
F - Community Building Activities	7	$38,196	$0	$38,196	0.0%
G - Community Benefit Operations		$66,792	$0	$66,792	0.0%
Totals for Community Services	1,527	$1,824,065	$0	$1,824,065	0.7%
Totals for Benefits for Poor	23,256	$76,582,322	$51,319,703	$25,262,619	9.9%
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	697	$27,172	$0	$27,172	0.0%
B - Health Professions Education	269	$854,937	$0	$854,937	0.3%
E - Cash and In-Kind Contributions		$21,489	$0	$21,489	0.0%
Totals for Community Services	966	$903,598	0	$903,598	0.4%
Totals for Broader Community	966	$903,598	$0	$903,598	0.4%
Totals - Community Benefit	24,222	$77,485,920	$51,319,703	$26,166,217	10.2%
Medicare	9,225	$62,316,937	$39,833,085	$22,483,852	8.8%
Totals Including Medicare	33,447	$139,802,857	$91,152,788	$48,650,069	19.0%

*For the Medicaid provider fee program effective for the two-year period of January 1, 2023 - December 31, 2024, the State of California received Centers for Medicare & Medicaid Services approval in December 2023. As such, during the fiscal year July 1, 2023 - June 30, 2024, the hospital recognized provider fee net income of $6,419,766 covering 18 months dating back to January 2023. Subtracting the six months of net provider fee attributable to the prior fiscal year, FY24 Medicaid net benefit would be $20,988,238 and total community benefit including Medicare would be $50,742,590.

Hospital Board and Committee Rosters

Dignity Health Sacramento Service Area Community Board

Larry Garcia, Chair Community Member, Lawyer	Marian Bell Holmes, Vice Chair Retired, Dignity Health Human Resources
Vacant, Secretary	Sister Eileen Enright Retired, Cristo Rey High School President
Cathy Rodriguez Aguirre President & CEO Sacramento Hispanic Chamber of Commerce	Dr. Lisa Cardoza President American River College
Pat Fong Kushida Community Member, President Asian Chamber of Commerce	Daniel Hahn Retired Law Enforcement
Sister Nora Mary Curtin RN, BSN, MSN Sisters of Mercy	Joseph Gagliardi Registered Civil Engineer
Murali Adusumalli, MD Chief of Staff Mercy Hospital of Folsom	Kevin Elliott, MD Chief of Staff Mercy San Juan Medical Center
Shaji Skaria Chief of Staff Mercy General Hospital	Laura Watters, MD Chief Of Staff Methodist Hospital of Sacramento