2025 Community Health Implementation Strategy and Plan

Adopted November 2025

Dignity Health®
St. Elizabeth Community Hospital

A member of CommonSpirit

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At-a-Glance Summary

Community Served 	St. Elizabeth Community Hospital is located in Red Bluff, California, and serves over 70,000 community members. The community served by the hospital is traversed by U.S. Interstate 5 (I-5) with the majority of the population residing along the I-5 corridor. The community served is nearly entirely within Tehama County except for a very small section of Shasta County along the Northern Tehama County border. The community served by St. Elizabeth Community Hospital resides in one of the following zip codes: 96021, 96022, 96035, 96055, 96078, 96080, and 96090.
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 the hospitals intends to address with strategies and programs are: • Access to primary care, specialists, and dental care • Access to behavioral health, including substance use disorder treatment • Basic needs – education, housing, transportation, and food insecurity • Navigation of care • Community belonging and freedom from violence
Strategies and Programs to Address Needs 	The hospital intends to take several actions and to dedicate resources to these needs, including: • Community Health Improvement Grants • Community Health Education Outreach • Human Trafficking/Violence Prevention • Medication for Indigent Patients • Transportation Services

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

This document is publicly available online at the hospital's website. Written comments on this strategy and plan can be submitted to St. Elizabeth Community Hospital's Community Health Office, 2550 Sister Mary Columba Dr., Red Bluff, CA 96080 or by e-mail to alexis.ross@commonspirit.org.

Our Hospital and the Community Served

About the Hospital

St. Elizabeth Community Hospital is a part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 2,200 care sites in 24 states coast to coast, serving patients in big cities and small towns across America. The hospital was opened in 1906 by the Sisters of Mercy serving the community of Red Bluff and Tehama County. The hospital has been serving Tehama County for more than 100 years and is dedicated to providing quality and compassionate patient care in a healing environment. The hospital currently has 76 acute care beds, including intensive, perinatal and emergency care services. The hospital has been operating at their current location since 1978 and provides the following specialized care, including:

- Certified Primary Stroke Center,
- Orthopedic, General Medicine and Minimally Invasive Surgical Services,
- Pediatric Care,
- Oncology Clinic,
- Cardiology Care, and
- Family Birth Center.

St. Elizabeth Community Hospital was also recognized as an LGBTQ+ Healthcare Equality High Performer in the Human Rights Campaign Foundation's 2024 Healthcare Equality Index (HEI).

Our Mission

The hospital's dedication to assessing significant community health needs and helping to address them in conjunction with the community is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Financial Assistance for Medically Necessary Care

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

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

Description of the Community Served

The hospital serves approximately 70,000 community members who primarily reside in the cities of Red Bluff and Corning along the interstate highway I-5 corridor in the Sacramento Valley and the surrounding rural foothills, agricultural and range land. The interstate highway I-5 corridor transects the community from south to north and connects the urban areas of the community. A summary description of the community is below, and additional details can be found in the CHNA report online.

The City of Red Bluff serves as the county seat of Tehama County and is home to 14,592 residents, making it the largest city (by population) in Tehama County. The hospital also serves the communities of Cottonwood, Lake California, Bend, Proberta, Tehama, Rancho Tehama Reserve, Richfield, and Corning. The community served by the Hospital includes the following zip codes, as geographically depicted in Figure 1:

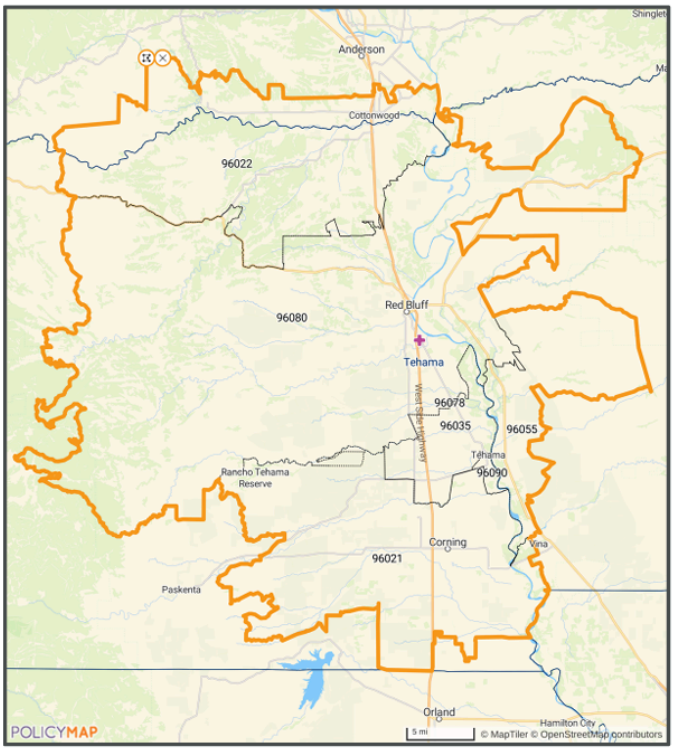
- 96021 (Corning)
- 96022 (Cottonwood)
- 96035 (Gerber)
- 96055 (Los Molinos)
- 96078 (Proberta)
- 96080 (Red Bluff)
- 96090 (Red Bluff)

The Hospital does not exclude any low-income or underserved populations and includes all members of the community. The communities served by the Hospital align with the residence location (contiguous zip codes) for more than 75% of all inpatient discharges. SECH is the only acute care hospital in Tehama County, however, Red Bluff and Cottonwood are also served by Dignity Health Mercy Medical Center Redding. The entire county is supported by Tehama County Public Health.

Demographics within St. Elizabeth Community Hospital's service area as derived from the U.S. Census include:

- Total population: 70,584
- Median age (years): 39.9
- Percent Hispanic or Latino(a): 26.4%
- Percent White alone, not Hispanic or Latino(a): 64.7%
- Median household income range: $34,813
- Percent of families living in poverty (below 100% federal poverty level): 14.2%
- Percent with less than a high school diploma, 25 years and over: 13.6%
- Percent, age 5 and older who speak English less than "very well": 7.0%
- Percent without health insurance: 6.0%
- No. of Partnership HealthPlan of California Members (Medi-Cal administrator): 31,250

Figure 1 - St. Elizabeth Community Hospital Communities Served



Community Assessment and Significant Needs

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

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

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

Significant Health Needs

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

Significant Health Need	Description	Intend to Address?
Access to primary care, specialists, and dental care	The community faces severe healthcare access issues, with a long-standing MUA designation and numerous provider shortages leading to residents traveling outside the county for basic and specialized care. This underservice is reflected in critical health disparities, including a dramatically higher physician-to-resident ratio compared to the state, and alarmingly high mortality rates for all causes and cancers. The lack of after-hours clinics and urgent care facilities exacerbates the problem, forcing residents to rely on the hospital's Emergency Department for non-emergent needs.	☑
Access to behavioral health, including substance use disorder treatment	Behavioral health is a critical, consistently identified need in Tehama County, which is designated as a mental health HPSA and exhibits high rates of anxiety, depression, and opioid overdoses. The county's severe behavioral health challenges are further compounded by a high prevalence of adverse childhood experiences (ACEs) among Medi-Cal members, indicating significant underlying trauma. These complex issues necessitate increased efforts to address mental health, substance abuse, and trauma-informed care for all residents.	☑
Basic needs – education, housing, transportation, and food insecurity	Limited access to affordable housing, education, and employment has created an economic crisis within the community. This scarcity directly impacts residents' ability to secure essential resources like transportation, safe housing, healthy food, education, and healthcare, contributing to generational cycles of poverty.	☑
Navigation of Care	The vulnerable members of the community have suffered an upheaval in their healthcare delivery and many were assigned primary care physicians outside of the county. While there is a system of requesting reassignment the process is not automatic and requires the ability to skillfully navigate the healthcare system. Individuals with lower educational attainment, those lacking stable transportation, or not speaking English fluently struggle with traversing the healthcare system.	☑

Significant Health Need	Description	Intend to Address?
Community belonging and freedom from violence	Civic engagement capacity and local, self-driven solutions are critical to addressing local needs. Community belonging and civic muscle refers to a community where an individual feels valued. A strong sense of belonging, where individuals feel valued and empowered to work together, fosters a thriving future and can play a crucial role in reducing community violence.	☑

2025 Implementation Strategy and Plan

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

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

Creating the Implementation Strategy

The hospital is dedicated to improving community health and delivering community benefit with the engagement of its staff, clinicians and board, and in collaboration with community partners. Hospital and health system participants include the Community Board which is composed of community members who provide stewardship and direction for the hospital as a community resource. These parties review community benefit plans and program updates prepared by the hospital's community health director and other staff.

Additionally, the Community Health and Outreach staff engage 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 and help define appropriate processes, procedures and methodologies for measuring outcomes.

The programs and initiatives described in this report were selected on the basis of a comprehensive set of criteria, aiming for strategic and impactful community health improvement. These criteria include:

- Alignment with Mission: Ensuring the initiatives support the hospital's core purpose.
- Best Practices Research: Incorporating evidence-based approaches.
- Community Readiness: Considering the community's capacity and willingness to act on the issue.
- Equity Focus: Prioritizing needs that disproportionately affect vulnerable populations and contribute to health disparities.
- Leveraging Existing Strengths: Identifying issues where existing infrastructure (programs, systems, staff) and established relationships with community partners are already in place.
- Measurability: Selecting issues where there is a clear ability to have a measurable impact.
- Problem Assessment: Evaluating the magnitude and severity of the health issues.
- Resource Availability: Assessing the availability of both hospital and external community resources.
- Sustainability: Ensuring there is ongoing investment and commitment of resources (staff time and financial) for the chosen initiatives.

Furthermore, selection involves research on best practices, alignment with local, state, or national health priorities, and a strong emphasis on collaboration with community stakeholders. Where possible, initiatives are designed to employ upstream prevention models to address the social determinants of health, with a critical focus on building and strengthening relationships with community-based providers to ensure long-term success and sustainability.

Community Health Core Strategies

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

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

Vital Conditions and the Well-Being Portfolio

Community health initiatives at CommonSpirit Health use the Vital Conditions framework and the Well-Being Portfolio[1] to help plan and communicate about strategies and programs.

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

Investments of time, resources, expertise and collaboration to improve health and well-being can take different approaches. And usually, no single approach can fully improve or resolve a given need on its own.

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

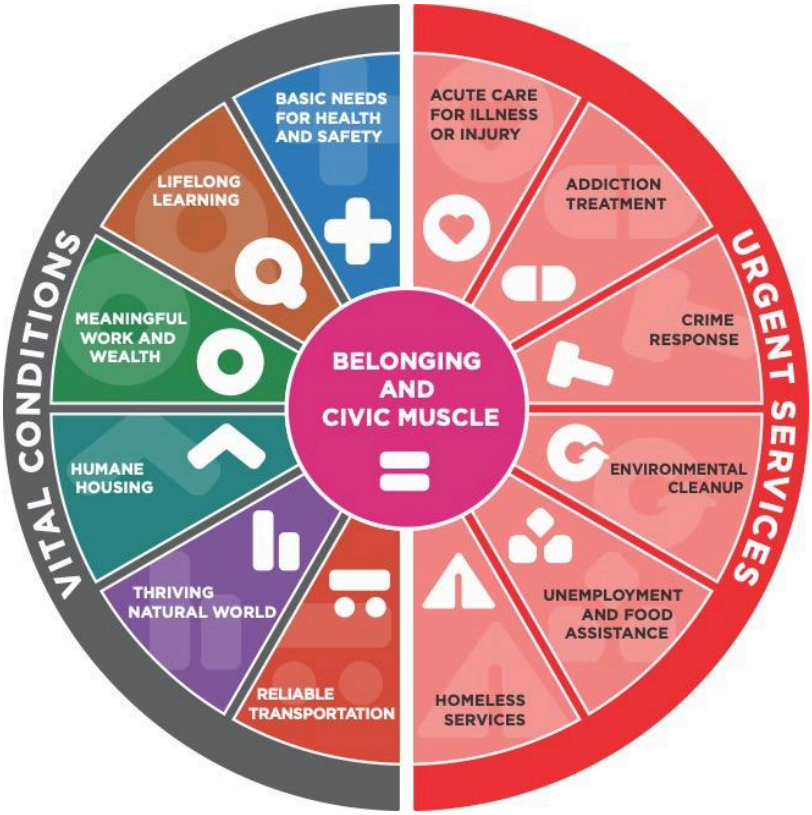
What are Vital Conditions?
These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions of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

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

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

Well-Being Portfolio in this Strategy and Plan

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



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

Strategies and Program Activities by Health Need

Health Need:	• Access to primary care, specialists, and dental care • Access to behavioral health, including substance use disorder treatment				
Population(s) of Focus:	Vulnerable populations with primary care, dental care needs, and behavioral health needs				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Financial Assistance	The hospital provides financial assistance for uninsured/underinsured and low-income residents. Rural health clinics offer sliding fee scale for patients who do not qualify for insurance.	☑	☐	☑	Basic Needs for Health and Safety (VC)
Community Outreach Events	The hospital regularly attends community outreach events, such as, LIFT (Poor and the Homeless Health Fair); Latino Multicultural Health Fair; Greenville Rancheria Wellness Fair; Senior Health Fair; Corning Olive Festival; Bi National Health Fairs offering nutrition services consultation, and blood pressure screenings. High school sports physicals for all area high schools are offered supported by the clinics and hospital staff when appropriate.	☐	☐	☑	Basic Needs for Health and Safety (VC)
Workforce Development	Identify and partner with community organizations who are leading workforce development efforts to increase access to a	☐	☐	☑	Meaningful Work and Health (VC)

Health Need:	• Access to primary care, specialists, and dental care • Access to behavioral health, including substance use disorder treatment				
	diverse and inclusive health care workforce—both in clinical and nonclinical/corporate settings and improve health equity				
Dental Care	Explore opportunities to partner with Tehama County Health and Human Services - Public Health Branch and other community partners to improve access to dental services.	☐	☐	☑	Basic Needs for Health and Safety (VC)
Education and Awareness	Provide education and awareness and reduce stigma in the community.	☐	☐	☑	Basic Needs for Health and Safety (VC)
Dignity Health Community Health Improvement Grants Program	Conducted annually by the hospital, the Dignity Health Community Health Improvement Grants Program provides financial support to nonprofit community-based organizations that are focused on increasing access to mental/behavioral health and substance use services and working collaboratively to provide a continuum of care to vulnerable individuals, families and children.	☑	☐	☑	Basic Needs for Health and Safety (VC)
Planned Resources:	The hospital will provide registered nurses, social workers, community health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators:	The hospital will partner with local medical clinics and local community based organizations to improve access to primary care, dental care, and behavioral health services.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increase access to care and reduce Social Determinants of Health barriers to accessing care	A decrease in the identification of social needs via the Social Determinants of Health screening	Electronic Health Record
Individuals experience better access to health care through improved health care utilization	Reduction in unnecessary ED visits and hospitalizations	Electronic Health Record
Increased awareness of mental health conditions and access to resources, trainings and treatments	Increase in the total number of individuals participating in educational events geared toward the general public and/or caregivers.	Hospital Community Benefit Data

Health Need:	• Basic needs – education, housing, transportation, and food insecurity • Navigation of care				
Population(s) of Focus:	Vulnerable populations with unmet vital condition needs				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Transportation Services	Enhances low-income patient and family access to care for those who have no form of transportation. This includes transportation to subacute nursing facility/rehab, home, mental health, a transitional living site, or outpatient appointments as part of a patient's discharge plan.	☐	☐	☑	Basic Needs for Health and Safety (VC)
PATH Transitional Care Program	Provides short-term transitional housing and coordinated care for homeless adults who are being discharged from the hospital and are recovering from a non-acute illness or injury condition that would be exacerbated by living unsheltered or in a place not suitable for recovery.	☐	☐	☑	Humane Housing (VC)
Community Health Worker Program	A collaboration with Dignity Health Connected Living to assist patients that rely on the emergency department for non-urgent needs by connecting them to local resources and help with navigation of care.	☑	☐	☑	Basic Needs for Health and Safety (VC)

Health Need:	● Basic needs – education, housing, transportation, and food insecurity ● Navigation of care				
Dignity Health Community Health Improvement Grants Program	Conducted annually by the hospital, the Dignity Health Community Health Improvement Grants Program provides financial support to nonprofit community-based organizations that are focused on increasing access to mental/behavioral health and substance use services and working collaboratively to provide a continuum of care to vulnerable individuals, families and children.	☑	☐	☑	Basic Needs for Health and Safety (VC)
Planned Resources:	The hospital will provide nurses, social workers, community health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators:	The hospital will continue to seek out partnerships with local organizations that respond to the health needs of our community. Community-based collaborations continue to be a priority for the hospital and will continue to drive community benefit efforts.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Improved coordination and access to basic needs, recuperative and respite services, and medical referrals.	A decrease in the identification of social needs via the Social Determinants of Health screening	Electronic Health Record
Improved health outcomes for those at-risk of and/or experiencing homelessness.	Reduction in unnecessary ED visits and hospitalizations	Electronic Health Record
Reduction of the prevalence of chronic disease in the community.	Reduction in unnecessary ED visits and hospitalizations related to chronic disease	Electronic Health Record

Health Need:	Community belonging and freedom from violence				
Population(s) of Focus:	Vulnerable populations who are at a higher risk of social exclusion, isolation, and loneliness (e.g. older adults, youth, LGBTQ+, racial and ethnic minorities, people with disabilities, people with low socioeconomic status, immigrants and refugees)				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Cultural Competency and Humility Training	Provide training opportunities for staff and community organizations that address the specific health needs of the community. This collaboration can improve care coordination and strengthen social connections.	☐	☐	☑	Belonging & Civic Muscle (VC)
Community Outreach	Foster an inclusive environment by participating in culturally responsive activities that celebrate diverse populations (e.g., youth summits, pride events, health fairs).	☐	☐	☑	Belonging & Civic Muscle (VC)
Community Engagement	Strengthen trust and relationships with key populations through targeted outreach, activities, and communication.	☐	☐	☑	Belonging & Civic Muscle (VC)
Human Trafficking	A Human Trafficking Taskforce made up of multidisciplinary leaders with a victim-centered approach on strategies, interventions and policies.	☑	☐	☑	Crime Response (US)

Health Need:	Community belonging and freedom from violence				
Mission and Ministry Fund, United Against Violence Grant	Facilitate strategy sessions and the development of a violence prevention/human trafficking coalition in Tehama County. This plan will build upon and align existing work identified during planned activities.	☐	☐	☑	Basic Needs for Health and Safety (VC)
Dignity Health Community Health Improvement Grants Program	Conducted annually by the hospital, the Dignity Health Community Health Improvement Grants Program provides financial support to nonprofit community-based organizations that are focused on increasing access to mental/behavioral health and substance use services and working collaboratively to provide a continuum of care to vulnerable individuals, families and children.	☐	☐	☑	Basic Needs for Health and Safety (VC)
Planned Resources:	The hospital will provide nurses, social workers, community health educators, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators:	Community Based Organizations				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Reduced disparities and enhanced community relations	Qualitative data from focus groups with key populations regarding their experiences of fairness, inclusion, and trust.	2028 Community Health Needs Assessment