Dignity Health
Mercy Medical Center
Redding

Mercy Medical Center Redding

Community Benefit 2018 Report and 2019 Plan

Dignity Health
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Redding

A message from

G. Todd Smith, president and CEO of Mercy Medical Center Redding, and Jim Cross, Chair of the Dignity Health North State 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 multi-pronged initiatives to improve community health include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital and with community partners, and investing in efforts that address social determinants of health.

Mercy Medical Center Redding shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The Community Benefit 2018 Report and 2019 Plan describes much of this work. This report meets requirements in California state law (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health produces these reports and plans for all of its hospitals, including those in Arizona and Nevada. 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 2018 (FY18), Mercy Medical Center Redding provided $10,628,527 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. The hospital also incurred $46,874,468 in unreimbursed costs of caring for patients covered by Medicare.

Mercy Medical Center Redding's Community Board reviewed, approved and adopted the Community Benefit 2018 Report and 2019 Plan at its October 11, 2018 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at 530.225.6114.

G. Todd Smith
President/CEO

Jim Cross
Chairperson, Board of Directors

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At-a-Glance Summary

Community Served	Shasta County is situated in the northern Sacramento Valley and is one of California's original counties. With a total area of 3,837 square miles, it is home to two national protected areas – Whiskeytown National Recreation Area and Shasta-Trinity National Forest and the state's largest water reservoir, Shasta Lake. There are three incorporated cities within Shasta County - Anderson, Redding and the City of Shasta Lake, which account for 62 percent of the total county population. The remainder of county residents live in outlying rural communities. Shasta County's population has grown by 9.3% between 2000 and 2014. Most (97.7%) of that growth was due to migration into the county. Due to its large land area and the high percent of residents living in rural areas, Shasta County has a population density five times lower than California. Furthermore, the county population is proportionally older and less racially diverse than the state. The county demographics are on a trend to become even older, while the racial makeup of residents is growing in diversity. The following zip codes make up the primary service area for MMCR: 96001, 96002, 96003, 96007, 96019, 96022, 96073, 96088 and 96093.
Economic Value of Community Benefit	$10,628,527 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits. $46,874,468 in unreimbursed costs of caring for patients covered by Medicare
Significant Community Health Needs Being Addressed	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Those needs are: • Access to Care • Cancer • Chronic Disease • Child Abuse • Obesity • Safety and Violence
FY18 Actions to Address Needs	In FY18, MMCR took numerous actions to help address identified needs. These included: • Lung cancer screening • Tobacco cessation classes • Diabetes Empowerment Education Program • Chronic Disease Self-Management Program

	• Diabetes Self-Management Program • Cancer: Thriving and Surviving Program • No-cost prostate cancer screening
Planned Actions for FY19	For FY19, the hospital plans to continue all of the above programs and explore the viability of providing the following additional initiatives: • Implementation of a North State Forensic Care Team dedicated to treating children and adults affected by violent crime(s) • Development of a Children's Legacy Center in Shasta County to provide services for children who are sexually or physically abused, trafficked, or are severely neglected

This document is publicly available at https://www.dignityhealth.org/north-state/locations/mercy-redding/about-us/community-benefit and a paper copy is available for inspection upon request at Mercy Medical Center Redding's Community Health Office.

Written comments on this report can be submitted to Mercy Medical Center Redding via the Community Health Office at 2175 Rosaline Ave, Redding, CA 96001 or by e-mail to Alexis Ross at Alexis.Ross@dignityhealth.org.

MISSION, VISION AND VALUES

Mercy Medical Center Redding is a part of Dignity Health, a non-profit health care system made up of more than 60,000 caregivers and staff who deliver excellent care to diverse communities in 21 states. Headquartered in San Francisco, Dignity Health is the fifth largest health system in the nation.

At Dignity Health, we unleash the healing power of humanity through the work we do every day, in hospitals, in other care sites and the community.

Our Mission

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

Our Vision

A vibrant, national health care system known for service, chosen for clinical excellence, standing in partnership with patients, employees, and physicians to improve the health of all communities served.

Our Values

Dignity Health is committed to providing high-quality, affordable healthcare to the communities we serve. Above all else we value:

Dignity - Respecting the inherent value and worth of each person.

Collaboration - Working together with people who support common values and vision to achieve shared goals.

Justice - Advocating for social change and acting in ways that promote respect for all persons.

Stewardship - Cultivating the resources entrusted to us to promote healing and wholeness.

Excellence - Exceeding expectations through teamwork and innovation.

OUR HOSPITAL AND THE COMMUNITY SERVED

About Mercy Medical Center Redding

The Hospital is located at the tip of the Sacramento River Valley in Redding, California and serves as a regional referral center for far Northern California. The Hospital offers major medical services including a Level II Trauma Center with a dedicated Orthopedic Traumatologist, Level III Neonatal Intensive Care Unit, Cardiovascular Services, and Oncology Services. Mercy Medical Center Redding is also the sole provider of obstetrical services in its primary service area. Mercy Medical Center Redding is licensed for 267-beds and has approximately 1,800 employees.

Description of the Community Served

Mercy Medical Center Redding's primary service area consists of the zip codes that make up 80% of the hospital's discharges. Of Shasta County's residents, 49.1% are male and 50.9% are female. 46.8% of Shasta County residents are adults over the age of 45 compared to 37.2% of statewide, making Shasta County's population older than that of California overall. Further, 18.1% of Shasta County residents are seniors over 65 compared to 12.1% statewide. Approximately 70.7% of Shasta County residents lived in urban areas while the remaining 29.3% lived in rural areas. By comparison, 95.0% of Californians lived in urban areas.

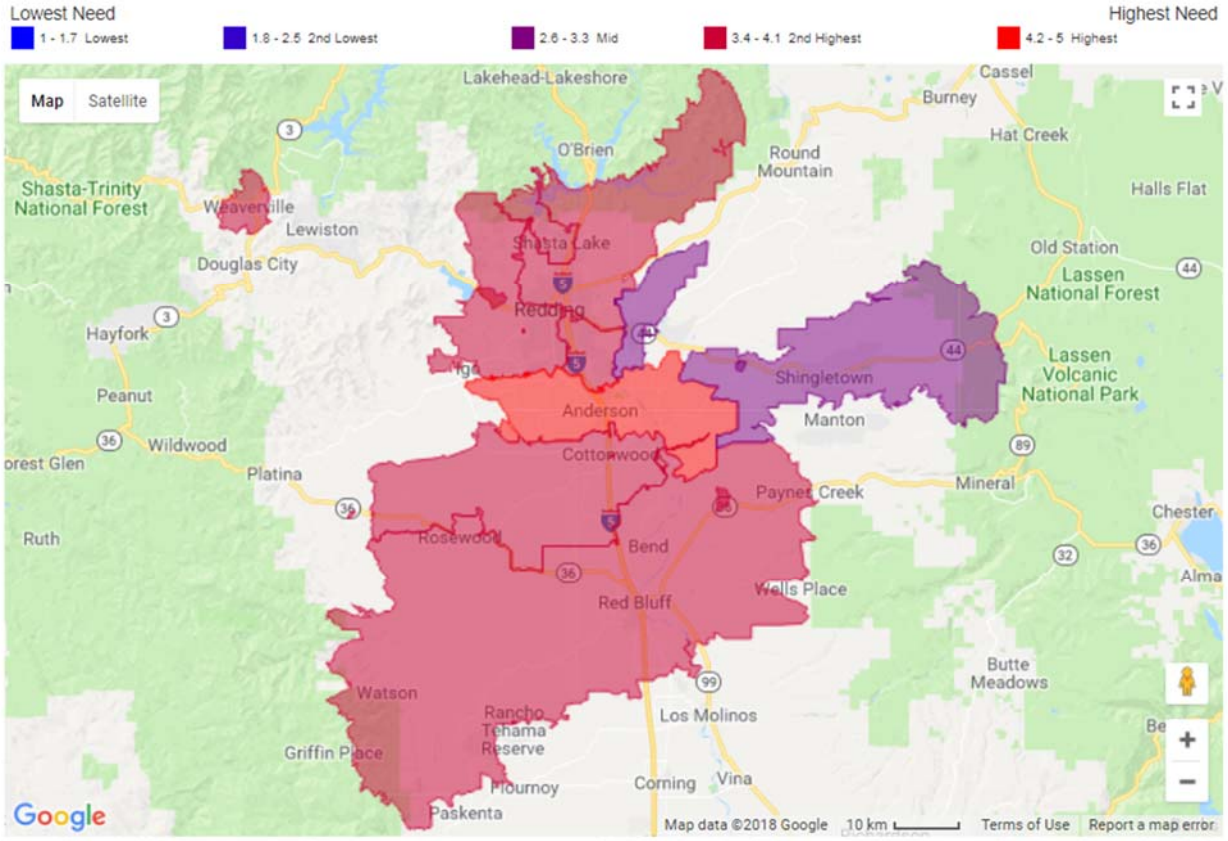
A summary description of community's demographic indicators for the hospital's primary service area is below (Source © 2018 IBM Watson Health Analytics) and additional details can be found in the CHNA report online.

- Total Population: 205,030
- Hispanic or Latino: 11.6%
- Race: 78.4% White, 1.0% Black/African American, 3.1% Asian/Pacific Islander, 5.9% All Others
- Median Income: $49,658
- Uninsured: 9.9%
- Unemployment: 4.1%
- No HS Diploma: 10.5%
- CNI Score Median: 3.6
- Medicaid Population: 30.9%
- Other Area Hospitals: 1
- Medically Underserved Areas or Populations: Yes

All of the communities in our primary service area are considered to have disproportionate unmet health care needs. In fact, the median CNI score for the primary service area is 3.6 indicating a high level of need. The most current CNI map can be found below. This is a major challenge for the hospital in planning and implementing community benefit programs and services. It is imperative that the hospital provide a leadership role in building local capacity with our community partners in our efforts to create healthy communities.

Community Need Index Map

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and Truven Health Analytics. The CNI analyzes data at the zip code level on five factors known to contribute or be barriers to health care access: income, culture/language, education, housing status, and insurance coverage. Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.



Mean(zipcode): 3.5 / Mean(person): 3.7 CNI Score Median: 3.6 CNI Score Mode: 3.4,3.6,3.8

Zip Code	CNI Score	Population	City	County	State
96001	3.4	34276	Redding	Shasta	California
96002	3.8	33701	Redding	Shasta	California
96003	3.6	45611	Redding	Shasta	California
96007	4.2	23014	Anderson	Shasta	California
96019	3.8	10100	Shasta Lake	Shasta	California
96022	3.6	15993	Cottonwood	Tehama	California
96073	2.6	4013	Palo Cedro	Shasta	California
96080	4	29524	Red Bluff	Tehama	California
96088	3	4995	Shingletown	Shasta	California
96093	3.4	3803	Weaverville	Trinity	California

COMMUNITY ASSESSMENT AND PLANNING PROCESS

The hospital engages in multiple activities to conduct its community benefit and 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; using five core principles to guide planning and program decisions; measuring and tracking program indicators and impact; and engaging the North State Service Area Board and other stakeholders in the development of an annual community benefit plan and triennial Implementation Strategy.

Community Health Needs Assessment

The significant needs that form the basis of the hospital's community health programs were identified in the most recent Community Health Needs Assessment (CHNA), which was adopted in May, 2018 (tax year 2017).

The hospital conducts a CHNA at least every three years to inform its community heath strategy and program planning. The CHNA report contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods, including: the data used; how the hospital solicited and took into account input from a public health department, members or representatives of medically underserved, low-income and minority populations; and the process and criteria used in identifying significant health needs and prioritizing them;
- Presentation of data, information and assessment findings, including a prioritized list of identified significant community health needs;
- Community resources (e.g., organizations, facilities and programs) potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

CHNA Significant Health Needs

The community health needs assessment identified the following significant community health needs:

- Access to Care
  - Shasta County does not meet the national benchmark ratio of people to primary care physicians. There are not enough physicians to serve the population, especially people on Medi-Cal.
  - Access to psychiatry resources and services is inadequate.
  - 8.5% of Shasta County children are still uninsured.
  - Shasta County does not meet the national benchmark for the number of dentists per resident.
  - Among low-income residents with Medi-Cal's dental insurance, there are twice as many people for every dentist accepting this insurance.

- Alcohol and Other Substance Abuse
  - Shasta County consistently has almost twice the rate of adult smoking rates when compared to the rest of California.

- Prenatal substance abuse is a problem in Shasta County. From 2010-2014, there were 800 babies born affected by drugs.
- Shasta County has higher rates of chronic drinking among adults than California, but not higher binge drinking rates.
- Drug related deaths and non-fatal emergency department visits and hospitalizations have increased in Shasta County in recent years and has been consistently higher than the state.
- The number of alcohol and drug treatment admissions where heroin is the primary drug of choice has increased.

- Cancer
  - In 2008-12, Shasta County ranked fourth out of 58 California counties for cancer death rates.
  - High incidence of lung, bronchial, esophageal cancer with mortality rates that are higher than California for lung, bronchus, esophagus, liver, bile duct and melanoma cancer.

- Child Abuse
  - Child abuse and foster care rates are higher in Shasta County than in California, especially among infants (less than one year old).
  - In 2010-14, there was an average of 699 substantiated cases of reported maltreatment for children under 18 years old. This is a 5-year average rate of 18.0 per 1,000 Shasta County children.
  - In 2014 the rate of child maltreatment for children under the age of 1 was more than double the state rate and equates to almost 1 in every 20 Shasta County infants.

- Chronic Disease
  - More than 60% of people in Shasta County have diabetes or pre-diabetes and it was the 7th most common cause of death.
  - In 2012-14, diseases of the heart were the leading cause of death among Shasta County residents and killed an average of 491 Shasta County residents per year.
  - After heart disease and cancer, more Shasta County residents die of chronic lower respiratory diseases (CLRD) than any other condition. CLRD made up 2.0% of all hospitalizations of Shasta County residents in 2010-14 and nearly 1 in 10 deaths in 2012-14.

- Communicable Diseases
  - Rates of reported cases of gonorrhea has dramatically increased and the rates of syphilis reported in recent years has also increased, making it an emerging concern.
  - Shasta County has low childhood immunization rates compared to California.

- Mental Health Problems
  - Mental illness made up 4.4% of all hospital discharges, an average of more than 1,000 per year.
  - The suicide rate is consistently twice as high in Shasta County than in California.

- Obesity and Physical Activity
  - One in three Shasta County adults is obese, slightly higher than the state. People living below 200% of the federal poverty level are more likely to be obese.

- A lower percentage of Shasta County adults meet physical activity recommendations than in California and the rest of the United States.

- Safety and Violence
  - Domestic violence calls for assistance are much more common per capita in Shasta County than in California.
  - While Shasta County has consistently had a lower homicide rate than the state, in the most recent year of data, Shasta County's homicide rate surpassed California.

The community has many marginalized, under represented individuals. In order to reach out to the underrepresented individuals, open collaboration needs to begin with community organizations, local government, local business leaders and other institutions in order to make a substantial and upstream impact. While there are potential resources available to address all of the identified needs of the community, the needs are too significant and diverse for any one organization. Mercy Medical Center Redding does not have the capacity or resources to address all identified significant health needs. The hospital is not directly planning interventions that would fully address mental health, substance abuse, homicide, or communicable diseases. Shasta County is home to a wealth of organizations, businesses, and nonprofits that currently offer programs and services in several of the identified significant health needs areas. MMCR will continue to build community capacity by strengthening partnerships among local community based organizations.

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

Creating the Community Benefit Plan

Rooted in Dignity Health's mission, vision and values, Mercy Medical Center Redding is dedicated to improving community health and delivering community benefit with the engagement of its management team, Advisory Council and Community Board. The board and committee are composed of community members who provide stewardship and direction for the hospital as a community resource (see Appendix A). These parties review community benefit plans and program updates prepared by the hospital's community health director and other staff.

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

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

A broad approach with multi-disciplinary teams is taken when planning and developing initiatives to address priority health issues. During the initiative inception phase, Community Health Staff engages a core internal team that may include clinical staff, care coordinators and social workers, members of leadership teams at both the service area and local levels from Mission Integration, IT, Legal,

Administration, Strategy, and Finance. These core teams help shape initiatives, provide internal perspective on issues, and help define appropriate processes, procedures and methodologies for measuring outcomes. In addition to internal core teams, Mercy Medical Center Redding also widens the scope of program design and elicits design input, feedback, recommendations, and concerns from the following groups:

- North State Community Board
- Mercy Medical Center Redding Advisory Council
- Local Area Community Grant Committee

2018 REPORT AND 2019 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 FY18 and planned activities for FY19, with statements on anticipated impacts, planned collaboration, and patient financial assistance for medically necessary care. Program Digests provide detail on select programs' goals, measurable objectives, expenses and other information.

Report and Plan Summary

The initiatives listed below are regularly monitored for performance and quality with ongoing improvements to facilitate their success by the Service Area Director of Community Health. Additionally, regular updates are provided to the Dignity Health North State Community Board, Advisory Council, as well as, shared with hospital leaders during the monthly management team meetings.

This report specifies planned activities consistent with the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

Health Need: Access to Care			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned**
Care navigation for vulnerable populations	Care navigation and electronic referrals to community based organizations through the Coordinated Community Network Initiative (CCNI)	☒	☒
Emergency Department Based Patient Navigation	The Patient Navigator program focuses on assisting patients who rely on the emergency department for non-urgent needs. The navigators assist patients with scheduling follow-up appointments and any other barriers that may create obstacles with accessing care. This program represents a unique collaboration between Partnership Health Plan, a Medi-Cal insurance plan, and the hospital.	☒	☒
Coalition	Participate on the Health Alliance of Northern California (HANC) coalitions. HANC is a network of community	☒	☒

	health centers working to promote the health and well-being of communities in Northeastern rural and frontier California.		
Anticipated Impact: The goal of these activities is to improve access to high quality health services, primary care and specialty services, which is historically a challenge in our rural location.			

Health Need: Cancer			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned**
Health Education	Tobacco cessation classes	☒	☒
Health Screening	Lung Cancer Screenings	☒	☒
Support Group	Hospital-sponsored support groups for cancer provide an opportunity for patients and family members to share their concerns while learning to manage their condition	☒	☒
Health Screening	Annual no-cost prostate screenings are provided to the community and allow routine screening for low-income/vulnerable populations.	☒	☒
Health Education	Through a partnership with the local FQHC, the Stanford Self-Management Resource Center's Cancer Thriving and Surviving program is offered on-site at the hospital.	☒	☒
Anticipated Impact: Offering screenings and establishing partnerships in support of a healthcare continuum ensures that community residents have access to vital support services.			

Health Need: Chronic Disease Prevention, Management, and Treatment			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned**
Cardiac Rehabilitation	Exercise and education provided to patients during rehabilitation from a cardiac related event or surgery	☒	☒
Complex Discharge Management Assistance	Care Coordination provides a number of services to patients at discharge with challenges accessing resources necessary to healing including transportation, clothing, medication, and durable medical equipment.		
Community Health Education	The Stanford Model Chronic Disease Self-Management Program (CDSMP) titled Healthier Living, is an evidence-based chronic disease education program. This six-week long workshop is intended to educate participants about lifestyles changes and increase their self-efficacy managing their chronic disease(s) increasing their quality of life.	☒	☒
Community Health Education	The Diabetes Empowerment Education Program (DEEP) is an evidence-based diabetes education program for people with diabetes or pre-diabetes. This six-week long workshop is intended to educate participants about	☒	☒

	lifestyles changes and the day-to-day challenges of living with diabetes and the way it affects your quality of life.		
Anticipated Impact: the anticipated result of offering these activities is a reduction of hospital admissions related to chronic disease; improve the health and quality of life for those who suffer from chronic illness; enable participants to better manage their disease; and create a supportive environment for individuals to learn critical skills and enhance their knowledge on self-management.			

Health Need: Obesity, Physical Activity, and Nutrition			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned**
Collaborative	Participate on the Health Shasta Collaborative that promotes healthy eating and physically active lifestyles through environmental, policy, and organizational changes.	☒	☒
Nutrition	Nutrition classes with Registered Dietician	☐	☒
Physical Activity	Research evidence-based physical activity programs and explore viability of offering to community through partnerships.	☐	☒
Anticipated Impact: improve the health of the community and create a supportive environment for individuals to learn critical skills and enhance their knowledge of healthy behavior change.			

Health Need: Safety and Violence			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned**
Human Trafficking	The Human Trafficking (HT) initiative focuses on: ▪ Educating staff to identify and respond to victims 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	☒	☒
Child Abuse and Violence	Explore implementation and support of a North state Forensic Care Team dedicated to treating children and adults affected by violent crime(s).	☐	☒
Child Abuse	Continue collaboration with a local non-profit organization for the development of a Children's Legacy Center to ensure that children who are sexually or physically abused, trafficked, or are severely neglected receive services in a compassionate manner that does not re-traumatize the victim.	☐	☒
Anticipated Impact: prevent unsafe environments, improve safety for the population served; provide education to all hospital staff on trauma informed care; and increase awareness of services available			

Community Grants Program

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

In FY18, the hospital awarded four grants totaling $205,200. Below is a complete listing of FY18 grant projects; some projects may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Empire Recovery Center	Assisting homeless/indigent addicts in the Detox Program	$100,000
Northern California Center for Family Awareness	Kids Turn to Peer Mentoring	$30,000
Tri-County Community Network	Help Me Grow	$50,000
United Way	2-1-1 Digital Health Information and Referral	$25,200

Anticipated Impact

The anticipated impacts of the hospital's activities on significant health needs are summarized above, and for select program initiatives are stated in the Program Digests on the following pages. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospital is committed to measuring and evaluating key initiatives. The hospital creates and makes public an annual Community Benefit Report and Plan, and evaluates impact and sets priorities for its community health program in triennial Community Health Needs Assessments.

Planned Collaboration

Mercy Medical Center Redding maintains collaborative partnerships with Shasta County Public Health agencies. MMCR is a founding member of the Healthy Shasta collaborative in partnership with Shasta County Public Health. The collaborative is still going strong over 10-years later and its goal is to reduce childhood obesity and reduce the prevalence of chronic disease.

MMCR also participated in Shasta County Public Health's community-wide assessment process as part of their accreditation requirements. In addition to the relationships with the County, MMCR is actively involved with other community organizations and Boards. Hospital Executives have a seat on the Board Shasta Community Health Center, a Federally-Qualified Health Center, as well as, the YMCA, and SHARC Collaborative.

Financial Assistance for Medically Necessary Care

Mercy Medical Center Redding delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services. A plain language summary of the hospital's Financial Assistance Policy is in Appendix C. The amount of financial assistance provided in FY18 is listed in the Economic Value of Community Benefit section of this report.

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

- providing a paper copy of the plain language summary of the Policy to patients as part of the intake or discharge process;
- providing patients a conspicuous written notice about the Policy at the time of billing;
- posting notices and providing brochures about the financial assistance program in hospital locations visible to the public, including the emergency department and urgent care areas, admissions office and patient financial services office;
- making the Financial Assistance Policy, Financial Assistance Application, and plain language summary of the Policy widely available on the hospital's web site;
- making paper copies of these documents available upon request and without charge, both by mail and in public locations of the hospital; and
- providing these written and online materials in appropriate languages
- the policy is shared on an annual basis with our Advisory Council and with the Northstate Service Area Board

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs in the most recent CHNA report. The digests include program descriptions and intervention actions, statements of which health needs are being addressed, any planned collaboration, and program goals and measurable objectives.

Access to Care	
Significant Health Needs Addressed	✓ Access to care ❑ Cancer ❑ Chronic Disease ❑ Obesity, Physical Activity, & Nutrition ❑ Safety & Violence
Core Principles Addressed	✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Program Description	Care navigation for vulnerable populations

Community Benefit Category	A – Community Health Improvement Services
FY 2018 Report	
The initiatives and measurable objectives addressing access to care are new for FY19 and therefore did not have any associated activities listed in FY18 and nor any reportable outcomes.	
FY 2019 Plan	
Program Goal / Anticipated Impact	Care navigation and electronic referrals to community based organizations through the Coordinated Community Network Initiative (CCNI). The goal of these activities is to improve access to high quality health services, primary care and specialty services, which is historically a challenge in our rural location.
Measurable Objective(s) with Indicator(s)	Increase the number of participating community-based organizations and community partners to expand use of CCNI
Intervention Actions for Achieving Goal	▪ Extend outreach for participation in CCNI to community-based organizations ▪ Build community partnerships to expand participation in CCNI ▪ In conjunction with Care Coordinators, continue to identify community organizations and partnerships for growth ▪ Increase the number of electronic referrals provided to community-based organizations
Planned Collaboration	Participation in CCNI requires collaboration with an internal multi-disciplinary team as well as collaboration with a variety of community-based non-profit organizations to expand participation in CCNI.

Chronic Disease	
Significant Health Needs Addressed	❑ Access to care ❑ Cancer ✓ Chronic Disease ❑ Obesity, Physical Activity, & Nutrition ❑ Safety & Violence
Program Emphasis	✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Program Description	Chronic disease workshops are designed for adults who have a chronic disease and those that care for them. The workshop participants learn how to manage stress, fight fatigue and pain, learn how to communicate with their doctor and family members and set goals and learn problem solving techniques. This program is funded and staffed through the Community Health Department as is offered at low or no cost to community members.
Community Benefit Category	A – Community Health Improvement Services
FY 2018 Report	
Program Goal / Anticipated Impact	Provide education and skills management to help community members living with chronic disease by increasing/enhancing their self-efficacy,

	thereby, increasing their quality of life which may lead to preventing or reducing unnecessary admissions to the Hospital.
Measurable Objective(s) with Indicator(s)	Develop new lay leaders and community partners to expand sustainability of the chronic disease programs. Increase the number of participants in each chronic disease program.
Intervention Actions for Achieving Goal	▪ Conduct at least one Healthier Living workshop during the next fiscal year ▪ Host one leader trainer during FY18 to train additional leaders to increase CDSMP sustainability within the community ▪ Offer at least one Diabetes Empowerment Education Program workshops ▪ Community Health Manager to become a trained facilitator for the Diabetes Self-Management Program (DSMP) ▪ Offer at least one DSMP workshop ▪ Explore viability of offering two complementary diabetes programs ▪ Explore viability of Community Health Manager becoming a trained facilitator for other Stanford Self-Management modules such as pain management, cancer, and mental health
Planned Collaboration	None
Program Performance / Outcome	▪ Due to facilitator challenges the Healthier Living workshop was not able to be offered in FY18. ▪ A leader training was conducted and a total of 8 leaders were trained. Leader trainings enhance partnerships and create sustainability for the Healthier Living program within the community. ▪ The Community Health Manager attended training and became a trained facilitator for the Diabetes Self-Management Program (DSMP) ▪ Both the DEEP and DSMP programs were offered to the community, however no participants registered for the programs. This will remain and FY19 goal with emphasis on partnering with community based organizations, Dignity Health Medical Foundation and North State Clinical Integration Network to create a process for referrals for appropriate community members. ▪ The Community Health Manager becoming a trained facilitator for other Self-Management modules such as pain management, cancer, and mental health was explored and determined to be cost-prohibitive during FY18 due to limited resources both financial and human.
Hospital's Contribution / Program Expense	$2,000
FY 2019 Plan	
Program Goal / Anticipated Impact	Provide education and skills management to help community members living with chronic disease by increasing/enhancing their self-efficacy, thereby, increasing their quality of life which may lead to preventing or reducing unnecessary admissions to the Hospital.
Measurable Objective(s) with Indicator(s)	Develop new lay leaders and community partners to expand sustainability of the chronic disease programs. Increase the number of participants in each chronic disease program.
Intervention Actions for Achieving Goal	▪ Outreach to the community clinics and other non-profit agencies regarding the CDSMP and DEEP programs ▪ Continue to build community partnerships to expand workshops

	▪ Continue to identify community lay leaders and partnerships for growth
Planned Collaboration	Workshops are conducted in collaboration with a variety of community organizations and are held in locations that are accessible to residents.

Cancer Programs	
Significant Health Needs Addressed	✓ Access to care ✓ Cancer ❑ Chronic Disease ❑ Obesity, Physical Activity, & Nutrition ❑ Safety & Violence
Program Emphasis	✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Program Description	Provide services/programs that respond to the cancer needs of the community as identified in the community health needs assessment to help improve community health.
Community Benefit Category	A – Community Health Improvement Services
FY 2018 Report	
Program Goal / Anticipated Impact	Provide health education, cancer screenings, and other educational opportunities to increase awareness about risk factors and early identification of cancer in an effort to reduce preventable cancer-related deaths.
Measurable Objective(s) with Indicator(s)	Offer free tobacco cessation classes. Cross-market the CDSMP to assist with the referral of participants to the Healthier Living Workshops to identify improvement in symptom management.
Intervention Actions for Achieving Goal	▪ Continue to offer and promote the Quit for Good tobacco cessation classes throughout FY2018. ▪ Refer community members to the Healthier Living Workshops as appropriate to help community members learn strategies for symptom management and increase self-efficacy. ▪ Offer free prostate screening for early intervention of prostate cancer.
Planned Collaboration	None
Program Performance / Outcome	▪ Dignity Health Mercy Medical Center Redding in collaboration with Shasta Community Health Center offered a free Tobacco Recovery workshop to the community. This was the second workshop offered in 2018. Mercy Regional Cancer Center coordinated and managed enrollment, meeting space, marketing, and a trained Tobacco Recovery staff member from Shasta Community Health Center facilitated workshops. ▪ Tobacco Recovery is a self-management workshop based on a program developed by the University of Colorado. Each workshop is 2 hours per week for 6 weeks and empowers participants to identify triggers, find alternatives to tobacco, and provide support to one another.

	▪ Marketing began November 2017 and was distributed to community clinics, physician offices, respiratory department at Mercy Medical Center Redding, and at community events including Great American Smokeout on November 16th, 2017, Redding Health Expo on January 6th, 2018 and Heritage Health Fair May 6th, 2018. ▪ Outcomes: o 6 participants started workshop and 5 participants completed workshop o 100% of participants that completed self-assessment tool reduced their tobacco intake o 1 returning participant from previous workshop has remained tobacco free ▪ Through a partnership with the local FQHC, the Stanford Self-Management Resource Center's Cancer Thriving and Surviving program is offered on-site at the hospital annually. In FY18, eight individuals completed the workshop series. ▪ A low-cost prostate screening was offered and over 100 men were screened for early detection of prostate cancer
Hospital's Contribution / Program Expense	$3,000
FY 2019 Plan	
Program Goal / Anticipated Impact	Provide health education, cancer screenings, and other educational opportunities to increase awareness about risk factors and early identification of cancer in an effort to reduce preventable cancer-related deaths.
Measurable Objective(s) with Indicator(s)	Offer tobacco cessation classes. Cross-market the Cancer, Thriving and Surviving workshops and other chronic disease workshops to assist with the referral of participants and improvement in symptom management. Offer low to no-cost cancer screenings – e.g. lung, skin, prostate
Intervention Actions for Achieving Goal	▪ Host a training session with facilitators from University of Colorado in the Tobacco Free program. Community partners and organizations would be invited to attend and once trained, they would be able to train within their facility. ▪ Continue to offer and promote the tobacco cessation program throughout FY2019. ▪ Refer community members to the Cancer Thriving and Surviving workshop as appropriate to help community members learn strategies for symptom management and increase self-efficacy. ▪ Explore option of training community health staff in the Cancer Thriving and Surviving module to expand offering the workshop more than once a year. ▪ Offer low to no-cost cancer screenings for early interventions (e.g. prostate, skin, lung, etc.).
Planned Collaboration	Mercy Oncology Center, Redding Urologic Association, Mercy Family Health Center, Shasta Community Health Center, and other hospital staff and community members as appropriate such as: Physicians, Residency, Community Health, etc.

Chronic Pain, Substance Abuse, and Mental Health Programs	
Significant Health Needs Addressed	❑ Mental Health ❑ Obesity ✓ Cancers ❑ Aging problems ❑ Diabetes ❑ Heart disease and/or stroke ❑ Poor eating habits, ❑ Lack of exercise
Program Emphasis	✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Program Description	Develop and implement an educational campaign and support investments to increase awareness and identification of risk factors that can contribute to unhealthy behaviors.
Community Benefit Category	A – Community Health Improvement Services
FY 2018 Report	
Program Goal / Anticipated Impact	Increase awareness by offering educational opportunities regarding identification of risk factors that can contribute to unhealthy behaviors and leverage community resources.
Measurable Objective(s) with Indicator(s)	Offer chronic disease workshops to community members as appropriate. Increase the number of participants in the CSDMP program to identify improvement in symptom management. Build community partnerships and develop a partnership strategy for addressing the needs of the community.
Intervention Actions for Achieving Goal	▪ Explore the ability to offer a more specialized area of this program e.g. mental health and pain management. ▪ Refer community members to the Healthier Living Workshops as appropriate to help community members self-manage their condition
Program Performance / Outcome	▪ Due to limited resources and facilitator challenges training additional staff in specialized modules was not feasible. ▪ The general chronic disease self-management program leader training was offered in FY18. An additional eight of leaders were training creating community sustainability for the program, ▪ In addition to referring community members to the CDSMP program, the Hospital provided a community grant to Empire Recovery Center for their detox program that provides detox services for homeless and indigent addicts.
Hospital's Contribution / Program Expense	$100,000
FY 2019 Plan	
Due to resource limitations, the hospital will discontinue efforts to research and implement specialized Stanford program modules for mental health and pain management. Remaining resources will be leveraged in order to help establish and sustain programs in the other listed significant health need areas identified in the FY 18 community health needs assessment.	

Obesity, Nutrition, & Physical Activity	
Significant Health Needs Addressed	❑ Access to care ❑ Cancer ✓ Chronic Disease ✓ Obesity, Physical Activity, & Nutrition ❑ Safety & Violence
Program Emphasis	✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Program Description	Improve the health of the community and create a supportive environment for individuals to learn critical skills and enhance their knowledge of healthy behavior change.
Community Benefit Category	A – Community Health Education
FY 2018 Report	
Specific initiatives and measurable objectives addressing obesity, nutrition, and physical activity are new for FY19 and therefore did not have any associated activities listed in FY18 and nor any reportable outcomes.	
FY 2019 Plan	
Program Goal / Anticipated Impact	Improve the health of the community and create a supportive environment for individuals to learn critical skills and enhance their knowledge of healthy behavior change.
Measurable Objective(s) with Indicator(s)	Completion of annual Healthy Shasta strategic plan goals. Develop new community partners to expand sustainability of nutrition programs. Increase the number of participants in each program offered. Determination of viability for hospital-sponsored physical activity program(s).
Intervention Actions for Achieving Goal	▪ Continue support of the Healthy Shasta Collaborative and participation on the Steering Committee to help the collaborative fulfil its strategic plan goals ▪ Increase participation in community-based nutrition classes offered ▪ Research evidence-based physical activity programs and explore viability of offering to community through partnerships
Planned Collaboration	Healthy Shasta initiatives are being conducted in partnership with Shasta County Public Health and other community agencies involved with Healthy Shasta

Safety & Violence	
Significant Health Needs Addressed	❑ Access to care ❑ Cancer ❑ Chronic Disease ❑ Obesity, Physical Activity, & Nutrition ✓ Safety & Violence
Program Emphasis	✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care

	✓ Build Community Capacity ✓ Collaborative Governance
Program Description	Prevent unsafe environments, improve safety for the population served; provide education to all hospital staff on trauma informed care; and increase awareness of services available
Community Benefit Category	A – Community Health Improvement Services
FY 2018 Report	
Specific initiatives and measurable objectives addressing safety and violence are new for FY19 and therefore did not have any associated activities listed in FY18 and nor any reportable outcomes.	
FY 2019 Plan	
Program Goal / Anticipated Impact	Prevent unsafe environments, improve safety for the population served; provide education to all hospital staff on trauma informed care; and increase awareness of services available
Measurable Objective(s) with Indicator(s)	Increased knowledge among community members regarding services available measured by the number of attendees at community education event.
Intervention Actions for Achieving Goal	▪ Community education event to education the community to identify and refer victims to appropriate interventions ▪ Collaborate with community agencies to improve coordination of initiatives ▪ Provide and support innovative programs for recovery ▪ Explore implementation and support of a North state Forensic Care Team dedicated to treating children and adults affected by violent crime(s) ▪ Continue collaboration with a local non-profit organization for the development of a Children's Legacy Center in Shasta County
Planned Collaboration	Efforts in this area require collaboration with an internal multi-disciplinary team as well as collaboration with a variety of community-based non-profit organizations.

ECONOMIC VALUE OF COMMUNITY BENEFIT

The economic value of community benefit for patient financial assistance is calculated using a cost-to-charge ratio, and for Medicaid and other categories of community benefit using a cost accounting methodology.

Mercy Medical Center Redding
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2017 through 6/30/2018

	Persons Served	Net Benefit	% of Org. Expenses
Benefits for Living in Poverty			
Financial Assistance	**1,885**	**3,676,841**	**0.8**
Medicaid *	**44,253**	**0**	0.0
Means-Tested Programs	**9**	**0**	0.0
Community Services			
A - Community Health Improvement Services	444	53,048	0.0
E - Cash and In-Kind Contributions	1,440	2,077,154	0.4
G - Community Benefit Operations	0	86,771	0.0
Totals for Community Services	**1,884**	**2,216,973**	**0.5**
Totals for Living in Poverty	**48,031**	**5,893,814**	**1.3**
Benefits for Broader Community			
Community Services			
A - Community Health Improvement Services	191	8,446	0.0
B - Health Professions Education	72	4,522,216	1.0
C - Subsidized Health Services	5	2,486	0.0
E - Cash and In-Kind Contributions	258	121,965	0.0
F - Community Building Activities	3	79,600	0.0
Totals for Community Services	**529**	**4,734,713**	**1.0**
Totals for Broader Community	**529**	**4,734,713**	**1.0**
Totals - Community Benefit	**48,560**	**10,628,527**	**2.3**
Medicare	**46,573**	**46,874,468**	**10.1**
Totals with Medicare	**95,133**	**57,502,995**	**12.3**

Net Benefit equals costs minus any revenue from patient services, grants or other sources.

*The hospital was required to record some Medicaid Provider Fee revenue in FY18 that was attributable to FY17 services. This resulted in the hospital receiving more Medicaid revenue than expense incurred, and thus $0 net benefit. If all FY17 Medicaid Provider Fee revenue had been recorded in FY17, the hospital's FY18 net benefit for Medicaid would have been $3,596,472.

APPENDIX A: COMMUNITY BOARD AND COMMITTEE ROSTERS

FY 2019
DIGNITY HEALTH NORTH STATE SERVICE AREA
COMMUNITY BOARD MEMBERS

Jim Cross, Chairperson

Ryan Denham, Secretary

Mark Korth, North State Service Area President

Fernando Alvarez, M.D.

Diane Brickell

Sister Clare Marie Dalton

Sandra Dole

Robert Evans, M.D.

Alan Foley

Eva Jimenez

Hillary Lindauer

Sister Bridget McCarthy

Patrick Quintal, M.D.

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

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

7/1/18

MERCY MEDICAL CENTER REDDING
ADVISORY COUNCIL MEMBERS
2018

Jonathan Anderson, Chair (Good News Rescue Mission)

Les Baugh (Shasta County Board of Supervisors)

Stacey Carman (Redding Rancheria)

Jim Cloney (Shasta Unified School District)

Steve Craft (Coldwell Banker C&C Properties)

Donnell Ewert (Shasta County Public Health)

Gordon Flinn, Vice Chair (GoForth Consulting)

Jean King (Community Member)

April LaFrance, Secretary (Chartwell Consulting Group)

Jake Mangas (Redding Chamber of Commerce)

Julie McClelland, MD (Anesthesiologist/Critical Care Medicine)

Matt Moseley (Cornerstone Community Bank)

Scott Putnam (Apex Technology Management Inc.)

Laura Redwine (City of Shasta Lake)

Mark Rincon (FIT Physical Therapy)

Todd Smith (President, Mercy Medical Center Redding)

Lea Tate, Psy.D. (Patients' Hospital of Redding)

Joe Wyse (Shasta College)

APPENDIX B: OTHER PROGRAMS AND NON-QUANTIFIABLE BENEFITS

The hospital delivers a number of community programs 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.

- Healthy Shasta Collaborative – Mercy Medical Center Redding is a founding member of the collaborative. Healthy Shasta Healthy Shasta is a community collaborative that promotes healthy eating and physically active lifestyles through environmental, policy, and organizational changes.

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

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

- Whole Person Care – The Whole Person Care (WPC) program is an opportunity to increase the level and scope of services provided to homeless and at-risk Medi-Cal beneficiaries who are frequent users of emergency health care and who have complex medical, behavioral health, and/or substance abuse challenges. Shasta County Health and Human Services is administering the program and has engaged a variety of partners including Mercy Medical Center Redding to create a pilot that supports care coordination and improves wrap around services for the target population.

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

Additionally, members of the hospital's leadership and management teams volunteer significant time and expertise as board members of nonprofit health care organizations and civic and service agencies such as Shasta Community Health center, Empire Recovery Center, Connected Living, North State Cancer League, and Redding Chamber of Commerce. Annual sponsorships also support multiple programs, services and fund-raising events of organizations; among them Economic Development Council, Good News Rescue Mission, Leadership Redding, Northern Valley Catholic Social Services, One Safe Place, Redding Rancheria, Shasta County Public Health, Simpson University, and Turtle Bay Exploration Park.

APPENDIX C: FINANCIAL ASSISTANCE POLICY SUMMARY

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

Free Care

- If you are uninsured or underinsured with a family income of up to 200% of the Federal Poverty Level you may be eligible to receive hospital services at no cost to you.

Discounted Care

- If you are uninsured or underinsured with an annual family income between 200-350% of the Federal Poverty level, you may be eligible to have your bills for hospital services reduced to the highest amount reasonably expected to be paid by a government payer, which is usually the amount that Medicare would pay for the same services.
- If you are uninsured or underinsured with an annual family income between 350-500% of the Federal Poverty level you may be eligible to have your bills for hospital services reduced to the Amount Generally Billed, which is an amount set under federal law that reflects the amount that would have been paid to the hospital by private health insurers and Medicare (including co-pays and deductibles) for the medically necessary services.

If you are eligible for financial assistance under our Financial Assistance Policy you will not be required to pay more than the Amount Generally Billed described above. If you qualify, you may also request an interest-free extended payment plan. You will never be required to make advance payment or other payment arrangements in order to receive emergency services.

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

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

Dignity Health Financial Counselors are available to answer questions, provide information about our Financial Assistance Policy and help guide you through the financial assistance application process. Our staff is located in the hospital's Admitting area and can be reached at the address and telephone number listed here – Mercy Medical Center Redding, 2175 Rosaline Ave., Redding, CA 96001; **Financial Counseling** 530-225-6312; **Patient Financial Services** 888-488-7667 or by visiting www.dignityhealth.org/mercy-redding/paymenthelp.