Dignity Health
Mercy San Juan Medical Center

Mercy San Juan Medical Center

Community Benefit 2018 Report and 2019 Plan

A message from

Michael Korpiel president and CEO of Mercy San Juan Medical Center and Gil Albiani, 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 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 San Juan Medical Center (Mercy San Juan) 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 San Juan provided $19,517,278 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. The hospital also incurred $50,216,366 in unreimbursed costs of caring for patients covered by Medicare.

Mercy San Juan's Community Board reviewed, approved and adopted the Community Benefit 2018 Report and 2019 Plan at its October 25th, 2018 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at (916) 851-2005.

Michael Korpiel
President/CEO

Gil Albiani
Chairperson, Board of Directors

TABLE OF CONTENTS

At-a-Glance Summary 3

Mission, Vision and Values 5

Our Hospital and the Community Served 6

Community Assessment and Planning Process
- Community Health Needs Assessment 10
- CHNA Significant Health Needs 10
- Creating the Community Benefit Plan 11

2018 Report and 2019 Plan
- Report and Plan Summary 13
- Community Grants Program 19
- Anticipated Impact 20
- Planned Collaboration 20
- Financial Assistance for Medically Necessary Care 22
- Program Digests 23

Economic Value of Community Benefit 31

Appendices
- Appendix A: Community Board and Committee Rosters 32
- Appendix B: Other Programs and Non-Quantifiable Benefits 34
- Appendix C: Financial Assistance Policy Summary 35

At-a-Glance Summary

Community Served	Founded in 1967, Mercy San Juan Medical Center is a nationally recognized not-for-profit hospital located in Carmichael, CA, and serves the areas of north Sacramento and south Placer County. The hospital has 2,480 employees 580 active medical staff, 370 licensed acute care beds, and 31 emergency department beds. The hospital's primary service area is comprised of 28 zip codes and nearly 30 percent of these residents are Medi-Cal-insured. While the 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.
Economic Value of Community Benefit	$19,517,278 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits. $50,216,366 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: 1) Access to Behavioral Health Services 2) Access to High Quality Health Care and Services 3) Active Living and Healthy Eating 4) Disease Prevention, Management and Treatment 5) Safe, Crime and Violence Free Communities 6) Basic Needs (Food Security, Housing, Economic Security, and Education)
FY18 Actions to Address Needs	• In FY18, Dignity Health's Greater Sacramento Service Area made a $1.65 million investment to support the City of Sacramento efforts to address homelessness. This commitment is in addition to the hospital's other programs addressing homelessness, which include the Interim Care Program and Housing with Dignity. • To address Active Living and Healthy Eating, the Community Grants funded Food Exploration and School Transformation (FEAST) which focuses on serving communities in underserved regions by teaching food literacy and increased exposure to healthy options that are available within the community. • Mercy San Juan has partnered with a variety of community organizations including TLCS, Turning Point, El Hogar Community Services to increase access to behavioral health services including substance use. Efforts include bringing community partners into the hospital setting and having the ability to schedule outpatient appointments to minimize barriers and improve immediate access to services. • The Human Trafficking Response program remained a priority with a focus on providing trauma informed care through a collaboration of community organizations, law enforcement, the District Attorney's office and Dignity Health hospitals. This included strengthening key community partnerships and

	launching the Mobile Trauma Therapy program in collaboration with the Sacramento Regional Family Justice Center. • 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 of charge 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.
Planned Actions for FY19	For FY19, the hospital plans to build upon many of the FY18 initiatives and explore new partnership opportunities with Sacramento County and the different cities, health plans and community organizations. Efforts to enhance patient navigation services in partnership with Sacramento Covered, TLCS and Turning Point will continue with specific focus on improving the linkages to community resources and the number of real-time referrals which will result in more face to face interactions between the navigators and the patients. Mercy San Juan will play an active role in developing innovative strategies to address the growing number of individuals experiencing homelessness including the expansion of the Interim Care Program, active engagement with the City of Sacramento's Pathways to Health + Housing (Whole Person Care) and working in partnership with both the city and county to improve our relationship with the shelters.

This document is publicly available at dignityhealth.org/sacramento/about-us/community-health-and-outreach/health-needs-assessment. It will be distributed to hospital leadership, members of the Community Board and Health Committee and widely to management and employees of the hospital, as it serves as a valuable tool for ongoing community benefit awareness and training. The document will also be broadly distributed externally to Community Health Needs Assessment partners, community leaders, government and public health officials, program partners and other agencies and businesses throughout the region.

Written comments on this report can be submitted to the Mercy San Juan's Community Health and Outreach Department at 3400 Data Drive, Rancho Cordova, CA 95670 or by e-mail to DignityHealthGSSA_CHNA@dignityhealth.org.

MISSION, VISION AND VALUES

Mercy San Juan Medical Center 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 San Juan Medical Center

Founded in 1967, Mercy San Juan Medical Center is a nationally recognized not-for-profit hospital located in Carmichael, CA, and serves the areas of north Sacramento and south Placer County. The hospital has 2,480 employees 580 active medical staff, 370 licensed acute care beds, and 31 emergency department beds. Mercy San Juan offers hospital-based hyperbaric oxygen (HBO) treatment. Providing HBO services in a hospital setting gives patients added safety and comfort, knowing they are surrounded by a team of highly trained nurses, physicians and HBO therapists. The Neonatal Intensive Care Units (NICU) has long been a leader in caring for the smallest of newborns. Mercy San Juan's NICU includes 26 licensed beds and is equipped to provide specialized care including invasive monitoring, conventional ventilation, surgery, transport service, inhaled nitric oxide and high frequency oscillator ventilation.

Recent Healthgrades recognition for high quality care includes being named one of Healthgrades' America's 100 Best Hospitals (2016-2018) and a Distinguished Hospital Award for Clinical Excellence (2016-2018). Additionally, The Joint Commission awarded Mercy San Juan four certifications including Comprehensive Stroke Center, Perinatal Care Certificate of Excellence, Certificate of Excellence for Hip- and Knee- Replacement and Chest Pain Center Certification. Mercy San Juan Medical Center has been designated as a Community Hospital Center of Excellence by the Addario Lung Cancer Foundation and received the Integrated Cancer Network Accreditation by the Commission on Cancer (COC).

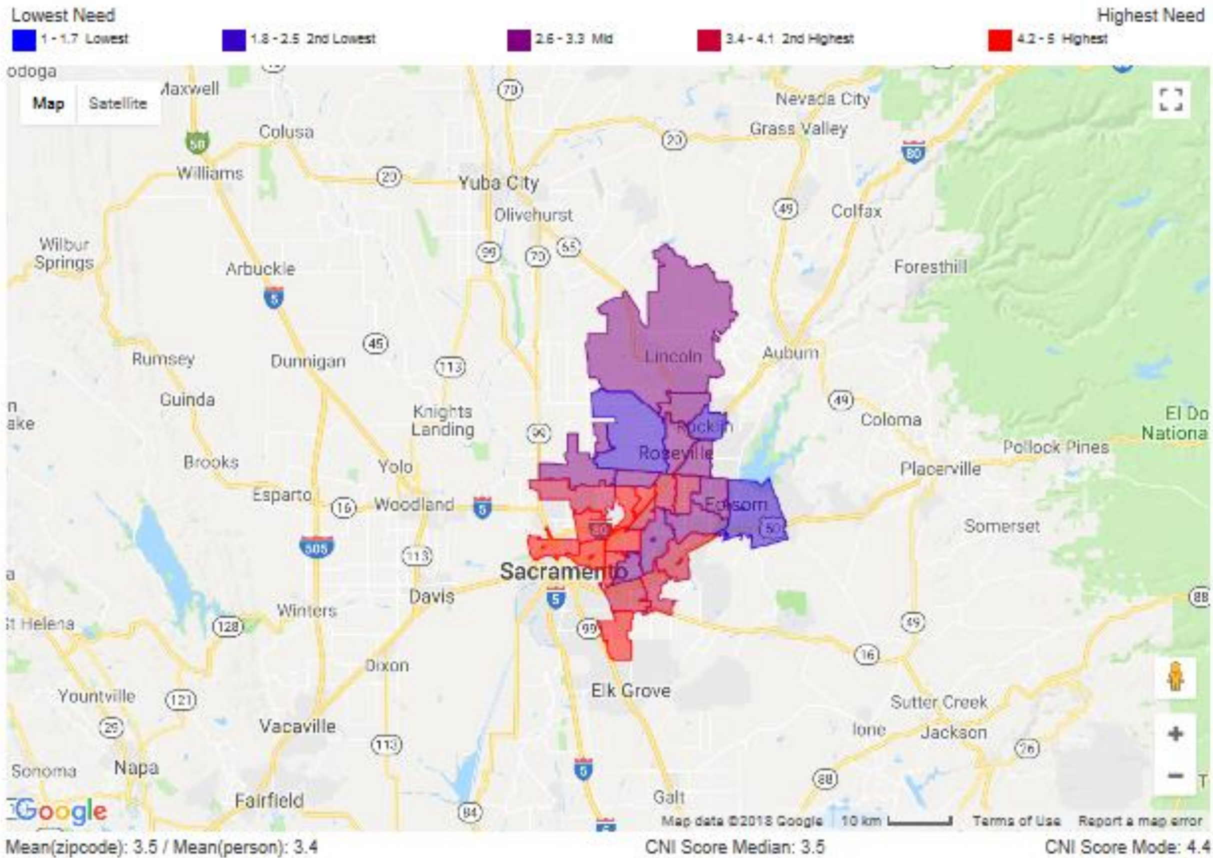
Description of the Community Served

Mercy San Juan is one of the area's largest and most comprehensive medical centers. The hospital is part of the region historically known for its lack of safety net providers to serve low-income and vulnerable residents. The hospital's primary service area is comprised of 28 zip codes and home to over one million residents; nearly 30 percent of these residents are Medi-Cal-insured. While the 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 San Juan 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. A summary description of the community is below, and additional community facts and details can be found in the CHNA report online.

Demographics within the Mercy San Juan hospital service area are as follows, derived from estimates provided by Truven Health Analytics data:

- Total Population: 1,094,981
- Hispanic or Latino: 20.2%

- Race: 57.5% White, 6.4% Black/African American, 10.7% Asian/Pacific Islander, 5.2% All Other.
- Median Income: $69,895
- Uninsured: 7.9%
- Unemployment: 5.3%
- No HS Diploma: 10.5%
- CNI Score: 3.5
- Medicaid Population: 26.9%
- Other Area Hospitals: 7
- Medically Underserved Areas or Populations: Yes



Zip Code	CNI Score	Population	City	County	State
95608	3.2	61064	Carmichael	Sacramento	California
95610	3.6	45840	Citrus Heights	Sacramento	California
95621	3.4	41484	Citrus Heights	Sacramento	California
95626	3.2	6054	Elverta	Sacramento	California
95628	2.8	41853	Fair Oaks	Sacramento	California
95630	2.4	80938	Folsom	Sacramento	California
95648	2.6	55702	Lincoln	Placer	California
95660	4.4	31923	North Highlands	Sacramento	California
95661	2.8	31721	Roseville	Placer	California
95662	2.6	32784	Orangevale	Sacramento	California
95670	3.6	56272	Rancho Cordova	Sacramento	California
95673	3.8	15988	Rio Linda	Sacramento	California
95677	2.4	24780	Rocklin	Placer	California
95678	3.2	44539	Roseville	Placer	California
95747	2	62730	Roseville	Placer	California
95765	2.6	40787	Rocklin	Placer	California
95815	5	25076	Sacramento	Sacramento	California
95821	4.4	34303	Sacramento	Sacramento	California
95825	4.4	31256	Sacramento	Sacramento	California
95826	3.8	38458	Sacramento	Sacramento	California
95827	3.6	21990	Sacramento	Sacramento	California
95828	4.4	61904	Sacramento	Sacramento	California
95833	4.2	40370	Sacramento	Sacramento	California
95838	5	39827	Sacramento	Sacramento	California
95841	4	20115	Sacramento	Sacramento	California
95842	4.4	33633	Sacramento	Sacramento	California
95843	3.2	49532	Antelope	Sacramento	California
95864	2.8	24058	Sacramento	Sacramento	California

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.

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 Community Health Committee 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 June, 2016.

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:

1. **Access to Behavioral Health Services:** Includes access to mental health and substance abuse prevention and treatment services.
2. **Access to High Quality Health Care and Services:** Encompasses access to primary care and specialty care, dental care and maternal and infant care.
3. **Active Living and Healthy Eating:** Encompasses all components of active living and healthy eating including health behaviors, associated health outcomes and aspects of physical environment/living conditions.
4. **Disease Prevention, Management and Treatment:** Contains health outcomes that require disease prevention and/or management and treatment including: cancer, cardiovascular disease/stroke, HIV/AIDS/STDs and asthma.
5. **Safe, Crime and Violence Free Communities:** Consists of safety from violence and crime including violent crime, property crimes and domestic violence.
6. **Basic Needs (Food Security, Housing, Economic Security, and Education):** Includes economic security, food security/insecurity, housing, education and homelessness.

7. **Affordable and Accessible Transportation:** Includes the need for transportation options, transportation to health services and options for person with disabilities.
8. **Pollution-Free Living and Working Environments:** Contains measures of pollution such as air and water pollution levels.

Mercy San Juan does not have the capacity or resources to address all priority health issues. The hospital is not directly addressing affordable and accessible transportation or pollution-free living and working environments. Many of the current initiatives include a transportation component, although services are limited. Sacramento Area Council of Governments (SACOG), an association of local governments in the six-county Sacramento Region, focuses on initiatives around transportation planning and clean air initiatives. The hospital will also continue to seek new partnership initiatives to address priority health issues when there are opportunities to make a meaningful impact on health and quality of life in partnership with others.

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at dignityhealth.org/sacramento/about-us/community-health-and-outreach/health-needs-assessment 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 San Juan is dedicated to improving community health and delivering community benefit with the engagement of its management team, Community Board and Community Health Committee. 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 general approach is taken when planning and developing initiatives to address priority health issues. At the onset, Community Health and Outreach staff engages a core internal team that may include clinical staff, care coordinators and social workers, members of the Mercy San Juan 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.

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.

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.

Report and Plan Summary

Health Need: Access to Behavioral Health Services			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
ReferNet Intensive Outpatient Mental Health Partnership	In collaboration with community-based nonprofit mental health provider, El Hogar, the program provides a seamless process for patients 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. The program also assists with navigation and transportation through a partnership with Heart of Gold Medical Transport.	☒	☒
Navigation to Wellness	Through our Community Grants, this initiative engages nonprofit mental health provider, Turning Point, to improve the quality of care for patients in mental health crisis. Clinical social workers from Turning Point work side by side hospital social workers to ensure patients are linked to appropriate public and community behavioral health services needed for wellness when they are discharged. The program provides ongoing support for up to 60 days post-discharge.	☒	☒
Mental Health Consultations and Conservatorship Services	The hospital provides psychiatric consultations at no cost for all patients who require evaluations while hospitalized, as well as patient conservatorship services to those who lack capacity or family help to make decisions.	☒	☒
TLCS Triage Navigator	In partnership with Sacramento County and TLCS, the Triage Navigator 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. Triage Navigators are placed in hospital emergency departments	☒	☒

	as well as the county jail and Loaves & Fishes to assist patients in accessing outpatient mental health services and other resources. In FY19, program services will be expanding to serve the inpatient population.		
Co-Occurring Substance Disorder Treatment Program	A partnership between TLCS, TCORE, Loaves & Fishes, Harm Reduction Services and WellSpace Health, this community grant collaboration offers access to a broad array of co-occurring treatment options for a population with numerous challenges, including those experiencing homelessness. Partners provide a warm hand off in which patients receive a safe and non-judgmental venue to discuss current struggles around substance use and homelessness. The program provides substance use disorder assessments, group and individual treatment onsite, and education for program staff around all forms of Medication-Assisted Treatment (MAT) options.	☒	☒
Anticipated 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.			

Health Need: Access to High Quality Health Care and Services			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
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 Health Net, a Medi-Cal Managed Care insurance plan, Sacramento Covered, a community-based nonprofit organization, and community clinics in the region.	☒	☒
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 around their diagnosis and treatment options. The Navigation program also provide referrals for nutritional and psycho-social support as well hosting multiple cancer support groups across the region.	☒	☒

Sacramento Physicians' Initiative to Reach Out, Innovate and Teach (SPIRIT)	Operated under the Sierra Sacramento Valley Medical Society, the program exists as a vehicle to involve physicians in the community. SPIRIT recruits and places physician volunteers in local clinics to provide free specialty medical care to the uninsured and coordinates and case manages surgical procedures donated at local hospitals and ambulatory surgery centers. This collaboration is between the Sierra Sacramento Valley Medical Society, Mercy San Juan, sister Dignity Health hospitals, Sacramento County, and other health systems in the region.	☒	☒
School Nurse Program	Nearly 750 students and their family members received health services annually within the Catholic Diocese of Sacramento through the hospital's School Nurse program. Services include first aide, chronic disease management and care plans, mandated health screenings and education for students, families and school staff.	☒	☒
Care for the Undocumented	Mercy San Juan and the other Dignity Health hospitals in Sacramento County partnered with Sacramento County, other health system and the Sierra Sacramento Valley Medical Society to develop an initiative that launched in FY16 to provide primary and specialty care, including surgery, to the region's undocumented immigrants who currently have no insurance or access to care. In FY18, the hospital helped advocate for expanded enrollment and increasing the age range to ensure more individuals could access primary care and limited specialty care services.	☒	☒
Salud con Dignidad (Health with Dignity)	Under the Community Grants community grants, Latino Coalition for a Healthy California focuses on providing underserved, undocumented individuals and families access to an array of culturally and linguistically competent health and wellness services. This collaborative will deliver the "Know your Health Care Rights" curriculum via promotores and provide access to both primary care and behavioral health services, including dance therapy, to the Undocumented population. Additional partners include Vision y Compromiso, La Familia Counseling Center and Sacramento Native American Health Center.	☒	☒
Anticipated 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 health care system; increased primary care "medical homes" among those reached by navigators; reduce barriers to care; and improve collaborative efforts between all health care providers.			

Health Need: Active Living and Healthy Eating			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Food Exploration and School Transformation (FEAST)	Under the Community Grants, Mercy San Juan supports this organization's efforts to teach food literacy and nutrition through cooking classes at underserved elementary schools. The program offers strategies to create behavior change and prevent childhood obesity through two core programs, which together provide a complete, scalable and replicable solution to the problem: 1) teaching food literacy to low-income pre-K through 6th graders, and 2) training community members as food literacy instructors. Through collaboration with Health Education Council, FEAST expanded their reach to parents and families.	☒	☒
Anticipated 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.			

Health Need: Disease Prevention, Management and Treatment			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Healthier Living	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. Workshops are offered in English, Spanish, and Hmong and include these program topics: • Chronic Disease Self-Management Program • Chronic Pain Self-Management Program • Coping with Cancer: Thriving and Surviving • Building Better Caregivers • Diabetes Empowerment Education Program (DEEP™) • A Matter of Balance (a fall prevention class) • HIV: Positive Self-Management Program	☒	☒
Congestive Heart Active Management	This unique program keeps individuals with heart failure connected to the medical world through symptom and medication monitoring and education. CHAMP®	☒	☒

Program (CHAMP®)	establishes a relationship with patients who have heart disease after discharge from the hospital through: 1) Regular phone interaction to help support and educate patients in managing their disease; 2) Monitoring of symptoms or complications and recommendations for diet changes medicine modifications or physician visits. In FY18, the program received a Mercy Foundation grant for the purchase of scales, blood pressure cuffs and oximeter to better evaluate patients during phone consultations.		
Mercy Faith and Health Partnership	This interfaith community outreach program supports the development of health ministry programs including healthcare professionals, clergy and other interested members who have a desire to focus on health promotion and disease prevention programs within their congregations. Providing education, advocacy and referrals for available resources within the congregation, health ministry teams do not duplicate available services, such as nursing or medical care, but seek to creatively bridge gaps in healthcare.	☒	☒
Dementia Care and Support Navigation	The collaboration between Alzheimer's Association of Northern California, Del Oro Caregiver Resource Center, Rebuilding Together and Mercy Medical Group focuses on connecting patients with Alzheimer's or other cognitive impairments and their caregivers to community services. Integrating education, emotional support, economic assistance and safety services will improve the lives of persons with Alzheimer's and caregivers**.**	☒	☒
Anticipated 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.			

Health Need: Safe, Crime and Violence Free Communities			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Human Trafficking Response Program	The Human Trafficking Response Program 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.		
Healthy Women and Families	Through our community grants and in partnership with Community Against Sexual Harm (CASH), City of Refuge, and Chicks in Crisis, the program provides an easily accessible, strong safety net to victims of commercial sexual exploitation and at-risk young women. The program helps stabilize and ensure that the most vulnerable receive a coordinated system of support capable of addressing the individual and family needs that often lead to a pattern of continued abuse, exploitation, and poor health outcomes.	☒	☒
Initiative to Reduce African American Child Deaths	Mercy San Juan and Dignity Health hospitals in Sacramento County have all implemented the program which creates a consistent method for assessing safe sleep environments, ensuring children have a safe sleeping environment by providing appropriate cribs and providing consistent education partnership with the Sacramento County Child Abuse Center. The hospital is also represented on the Sacramento County Steering Committee on Reduction of African American Child Deaths, which is chartered to develop strategy and oversight for all county-wide efforts to reduce child deaths among this target population between 10 and 20 percent by 2020.	☒	☒
Outreach and Services for Individuals and Families Experiencing Abuse and Trauma	Through the hospital's community grants and in partnership with Stand Up Placer, Inc., KidsFirst, and Ride to Walk, the Outreach and Services for Individuals and Families Experiencing Abuse and Trauma program conducts outreach and training for care providers, first responders, and community partners. The training focuses on direct outreach and identifying individuals and families who may victims of violence, abuse and trauma. The program also provides services to address victims' immediate needs for crisis-based services, basic needs, and needs other services as needed to promote recovery and healing from their trauma.	☒	☒
Safe Kids Program	Child death due to vehicle accidents is one of the leading causes of death in Sacramento County for families living in poverty, particularly within the Russian, Hmong and Spanish immigrant communities, largely due to lack of appropriate car restraints and education. The Safe Kids program provides free car seats and educational classes in the community and to all leaving the hospital with a newborn infant.	☒	☒

Anticipated 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.

Health Need: Basic Needs (Food Security, Housing, Economic Security and Education)			
Strategy or Activity	**Summary Description**	**Active FY18**	**Planned FY19**
Interim Care Program	The hospital is an active partner in the Interim Care Program (ICP). This collaborative engages other Dignity Health hospitals and health systems in the region, Sacramento County and Federally Qualified Health Center, WellSpace Health, and provides a respite care shelter for homeless patients with available physical and mental health, and substance abuse treatment. The program provides case management services to assist participants in connecting with outpatient services and community resources. All partners are currently working together to identify expansion opportunities to respond to the growing need.	☒	☒
Housing with Dignity	In partnership with Lutheran Social Services, Mercy San Juan 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. Ongoing health care for these participants is provided by a variety of Dignity Health and community resources with the goal of transitioning participants into permanent housing.	☒	☒
Anticipated 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.			

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 four hospitals located within Sacramento County including Mercy San Juan, Mercy Hospital of Folsom, Mercy General Hospital and Methodist Hospital of Sacramento collectively awarded eight grants totaling $700,516. Below is a complete listing of FY18 grant projects; some projects may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Alzheimer's Association	Dementia Care and Support Navigation	$100,000
American River Parkway Foundation	Recreate for Health	$50,516
Community Against Sexual Harm	Healthy Women and Families	$100,000
Food Literacy Center	FEAST	$100,000
Latino Coalition for a Healthy California	Salud Con Dignidad	$50,000
Stand Up Placer	Outreach for Families Experiencing Abuse and Trauma	$100,000
TLCS	Co-Occurring Substance Disorder Treatment Program	$100,000
Turning Point Community Programs	Navigation to Wellness	$100,000

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

Pathways to Health + Housing (Whole Person Care)
The Pathways to Health + Housing is the City of Sacramento's Whole Person Care (WPC) which is a statewide pilot program administered by the State Department of Health Care Services, under the federal authority of the Centers for Medicare and Medicaid Services. Launched in late 2018, Pathways 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. The program allows communities to create programs that coordinate health, behavioral health and social services for vulnerable Medi-Cal patients in an effort to improve the long term health and well-being of the patient and to create purposeful collaborations among services supporting the patient. Sacramento has engaged a variety of partners including all four Dignity Health hospitals in Sacramento County to create a pilot that supports care coordination and improves wrap around services for the target population. The program is not limited to city boundaries and will be expanded in FY19.

Pathways to Health + Housing partners include:

- All Geographic Managed Care Medi-Cal plans
- Medi-Cal Dental plans
- UC Davis Health Center
- Sutter Health
- Kaiser Permanente
- Federally Qualified Health Centers
- Homeless Service Providers
- Housing Organizations
- Community and Advocacy Organizations
- EMS
- Law Enforcement Organizations

In FY18, Dignity Health's Greater Sacramento Service Area made an additional $1.65 million investment to support the City of Sacramento efforts to address homelessness. The investment helped to extend the City of Sacramento's Triage Homeless Shelter. This is a low-barrier shelter allows for individuals experiencing homelessness to receive wrap around services and get connected to other community-based programs and services including Pathways. The investment will also support the transition into permanent housing.

Care for the Undocumented

Mercy San Juan and the other Dignity Health hospitals in Sacramento County have taken an active role in an initiative to reinstate health care for the undocumented, a population that has gone ignored in the community since County officials eliminated health coverage in 2009. A pilot program launched in FY16 addressing the need for basic primary care as well as specialty care and surgery. The pilot involves the innovative use of space at the County's Primary Care Center and hospital ambulatory care surgery centers and intensive care coordination. In FY18, the hospital helped advocate for expanded enrollment and increasing the age range to ensure more individuals could access primary care and limited specialty care services. Stakeholders in this collaborative effort include:

- Sierra Sacramento Valley Medical Society
- Sacramento County
- UC Davis Health Center
- Sutter Health
- Kaiser Permanente
- Federally Qualified Health Centers
- Community and Advocacy Organizations

Human Trafficking Response Program

Since initiative launch in FY15, nearly 9,500 employees within the service area have received education on red flag and response protocols to identify and connect vulnerable patients with qualified community resources. The rollout and implementation of Mobile Mental Health Trauma Team occurred in FY18. An effort supported by Dignity Health Foundation and Mercy Foundation, the program provides crisis intervention, individual therapy, group counseling, and art classes to human trafficking victims.

FY19 will continue to expand on education along with implementing advanced training on victim-centered and trauma-informed care within emergency department, family birth center, care coordination, and spiritual care staff. The hospital will continue to strengthen meaningful collaboration with community stakeholders that focus on health care services, treatment, recovery, prevention and reintegration. Partners include:

- 3Strands Global Foundation
- Community Against Sexual Harm
- Opening Doors
- Sacramento Regional Family Justice Center
- WEAVE
- My Sister's House
- City of Refuge
- The Bridge Network
- Sacramento County District Attorney's Office
- Law Enforcement
- Chicks in Crisis

In FY19, the hospital will continue to strengthen meaningful collaboration with community stakeholders that focus on recovery, prevention and reintegration.

Financial Assistance for Medically Necessary Care

Mercy San Juan 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.

Mercy San Juan Hospital also includes the Financial Assistance Policy in the reports made publicly available, including the annual Community Benefit reports and triennial Implementation Strategies.

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.

Patient Navigator	
Significant Health Needs Addressed	☐ Access to Behavioral Health Services ✓ Access to High Quality Health Care and Services ☐ Active Living and Healthy Eating ✓ Disease Prevention, Management, and Treatment ☐ Safe, Crime and Violence Free Communities ☐ Basic Needs
Core Principles Addressed	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	Assists patients who rely on emergency departments for non-urgent needs. The navigators help patients by connecting them to a primary care medical home and assisting them with scheduling a follow up appointment along with any other barriers that may create obstacles with accessing care.
Community Benefit Category	A3-e Health Care Support Services – Information & Referral.
FY 2018 Report	
Program Goal / Anticipated Impact	Assist underserved patients admitting 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.
Measurable Objective(s) with Indicator(s)	Nearly 50% of all emergency department visits are for primary care and could be avoided if care were received in a physician's office or clinic. Program will be measured by improved access for patients; reduced emergency department primary care visits; and reduced costs.
Intervention Actions for Achieving Goal	Work with emergency department staff, patient registration and Sacramento Covered to strengthen a comprehensive program that responds to the growing Medi-Cal population and engage health plans, IPA, and community clinics to address the need for improved access to primary care. Provide education regarding Urgent Care access, mental health, transportation and dental services.
Planned Collaboration	The program is a collaborative initiative between the hospital, Health Net, Sacramento Covered and community health centers. Health Net has increased their engagement in FY18 which resulted in a greater unified effort between Health Net and Dignity to ensure program success.
Program Performance / Outcome	7,740 patients were assisted in FY18 and 50% 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. Outcomes show a decrease in low to mid acuity level ED visits by 40% for the population served.
Hospital's Contribution / Program Expense	$79,041 which is a shared expense by Dignity Health hospitals in Sacramento County.
FY 2019 Plan	
Program Goal / Anticipated Impact	Continue to assist underserved patients admitting 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.
Measurable Objective(s) with Indicator(s)	For FY19, the program will at least serve 70% of weekday high-utilizers defined as those with three (3) or more ER visits at a participating Dignity Health facility within a 90 day period below and 60% of total volume of the weekday non-urgent/non-emergent.
Intervention Actions for Achieving Goal	Continue to work with emergency department staff, patient registration, and Sacramento Covered to build a comprehensive program that responds to the growing Medi-Cal population and engage other plans, IPA, and community clinics to work collectively in addressing the need for improved access to primary care. To meet the new metrics, emphasis will be on increasing referrals and strengthening collaboration with Health Net to ensure patients have the most current information and resources.
Planned Collaboration	The program is a collaborative initiative between the hospital, Health Net, Sacramento Covered and community health centers.

Interim Care Program (ICP)	
Significant Health Needs Addressed	✓ Access to Behavioral Health Services ✓ Access to High Quality Health Care and Services ✓ Active Living and Healthy Eating ✓ Disease Prevention, Management, and Treatment ✓ Safe, Crime and Violence Free Communities ✓ Basic Needs
Core Principles Addressed	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	The Interim Care Program (ICP) provides homeless men and women a safe environment for recovery when they are ready to be discharged from the hospital. Participants receive mental health care, substance abuse treatment, and social services support to transition to a healthier lifestyle.
Community Benefit Category	A2-e Community Based Clinical Services - Ancillary/other clinical services
FY 2018 Report	
Program Goal / Anticipated Impact	Increase access to a continuum of care and social support services to meet the special needs of homeless individuals necessary to improve their health status, and reduce their need to admit/readmit to the hospital.
Measurable Objective(s) with Indicator(s)	Increase number of successful ICP referrals, improve housing outcomes, and provide additional supportive services while patients are in the program such as substance abuse.
Intervention Actions for Achieving Goal	Work with all partners to improve number of successful referrals. Emphasis will be focused on improving communication between hospital and ICP staff. The hospital will continue to meet with WellSpace Health and Sacramento County to build stronger relationships and increase successful referrals.
Planned Collaboration	ICP is a partnership with Mercy San Juan, sister Dignity Health Hospitals, other health systems, Sacramento County, and WellSpace Health which is a Federally Qualified Health Center (FQHC).
Program Performance / Outcome	79 persons served in FY18 with an average length of stay of 29 days, which otherwise would have been days spent in hospital.
Hospital's Contribution / Program Expense	$93,232 which is a shared expense by Dignity Health Hospitals in Sacramento County.
FY 2019 Plan	
Program Goal / Anticipated Impact	Continue to increase access to a continuum of care and social support services to meet the special needs of homeless individuals necessary to improve their health status, and reduce their need to admit/readmit to the hospital.
Measurable Objective(s) with Indicator(s)	Increase number of successful ICP referrals, improve housing outcomes, and provide additional supportive services while patients are in the program such as mental health substance abuse resources. Ensure patients are connected to a medical home while in interim care.
Intervention Actions for Achieving Goal	Continue to work with all partners to improve number of successful referrals. Emphasis will be focused on improving communication between hospital and ICP staff. The hospital will continue to meet with WellSpace Health and Sacramento County to build stronger relationships and increase successful referrals. Emphasis will be placed on coordinating ICP referrals with other referrals such as Housing with Dignity and Pathways to Health + Housing to improve coordination of services. Explore opportunities to increase bed capacity.
Planned Collaboration	ICP is a partnership with Mercy San Juan, sister Dignity Health Hospitals, other health systems, Sacramento County, and WellSpace Health which is a Federally Qualified Health Center (FQHC).

Safe Kids Car Seat and Health/Safety Education	
Significant Health Needs Addressed	☐ Access to Behavioral Health Services ☐ Access to High Quality Health Care and Services ☐ Active Living and Healthy Eating ☐ Disease Prevention, Management, and Treatment ✓ Safe, Crime and Violence Free Communities ☐ Basic Needs
Core Principles Addressed	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	Infant and child car seat and health/safety education classes are provided at no cost to families with children living in poverty and to families with children in immigrant communities, where the need is greatest. Safe Kids health and safety fairs are part of the overall program. These offer a venue to provide safety education to parents, care-givers and children in the community. The hospital is the only provider offering car seat education to the largest non-English speaking populations in the region – Hispanic, Russian and Hmong.
Community Benefit Category	A1-a Community Health Education - Lectures/Workshops
FY 2018 Report	
Program Goal / Anticipated Impact	Improve the public awareness of child safety and provide education workshops for families living in poverty and immigrant communities.
Measurable Objective(s) with Indicator(s)	Lead a coalition of over 30 local agencies devoted to preventing childhood injury and death with ongoing engagement of additional agencies that share the same mission. Continue to offer classes/educational opportunities and car seat checks in areas of need.
Intervention Actions for Achieving Goal	Conduct regular coalition meeting and provide outreach, education and resources to targeted communities.
Planned Collaboration	The Safe Kids program leads a coalition of over 30 local agencies, including hospitals, fire, police, state and county agencies devoted to preventing childhood injury and death.
Program Performance / Outcome	3,415 community members served which includes 232 car seat checks and distribution of 57 car seats.
Hospital's Contribution / Program Expense	$289,925
FY 2019 Plan	
Program Goal / Anticipated Impact	Improve the public awareness of child safety and provide education workshops for families living in poverty and immigrant communities.
Measurable Objective(s) with Indicator(s)	Continue leading a coalition of over 30 local agencies devoted to preventing childhood injury and death with ongoing engagement of additional agencies that share the same mission. Continue to offer classes/educational opportunities and car seat checks in areas of need.
Intervention Actions for Achieving Goal	Continue conducting regular coalition meeting and provide outreach, education and resources to targeted communities. Build relationships with other community organizations that can assist in the outreach efforts.
Planned Collaboration	The Safe Kids program leads a coalition of over 30 local agencies, including hospitals, fire, police, state and county agencies devoted to preventing childhood injury and death.

Healthier Living	
Significant Health Needs Addressed	☐ Access to Behavioral Health Services ☐ Access to High Quality Health Care and Services ✓ Active Living and Healthy Eating ✓ Disease Prevention, Management, and Treatment ☐ Safe, Crime and Violence Free Communities ☐ Basic Needs
Core Principles Addressed	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	Healthier Living provides residents with chronic diseases knowledge, tools and motivation needed to become proactive with their health. Healthier Living workshops are open to anyone with any ongoing health condition, as well as those who care for persons with chronic health conditions. 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
Community Benefit Category	A1-a Community Health Education – Lectures/Workshops.
FY 2018 Report	
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 maximum target metric goal or better – 70% of all participants avoid admission post program intervention.
Measurable Objective(s) with Indicator(s)	Meet/exceed the metric goal. Develop new lay leaders and community partners to expand workshop offerings at community clinics and other agencies; increase the number of participants.
Intervention Actions for Achieving Goal	Outreach to the community clinics and other nonprofits. Build community partnerships to expand workshops and identify community lay leaders and partnerships for growth. In FY18, A Matter of Balance workshop was added that focuses on fall prevention.
Planned Collaboration	Workshops are conducted in collaboration with a variety of community organizations and are held in locations accessible to the residents, such as senior housing communities and organizations that serve a high percentage of residents that have or are caring for family members with chronic illnesses.
Program Performance / Outcome	25 Healthier Living workshops were conducted, including a reach of 299 community members and 191 participants completing the program. There are now 27 active lay leaders, 12 of which are Spanish speaking and 4 are certified master trainers in the Sacramento region.
Hospital's Contribution / Program Expense	$81,712 which is a shared expense by Dignity Health hospitals in Sacramento County.
FY 2019 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 maximum target metric goal or better – 70% of all participants avoid admission post program intervention.
Measurable Objective(s) with Indicator(s)	Continue to meet/exceed the metric goal. Develop new lay leaders and community partners to expand workshop offerings at community clinics and other agencies; increase the number of participants.
Intervention Actions for Achieving Goal	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 and Russian speaking lay leaders.
Planned Collaboration	Workshops are conducted in collaboration with a variety of community organizations and held in locations accessible to the residents, such as senior housing communities and organizations that serve a high percentage of residents that have or are caring for family members with chronic illnesses.

Housing With Dignity	
Significant Health Needs Addressed	✓ Access to Behavioral Health Services ✓ Access to High Quality Health Care and Services ✓ Active Living and Healthy Eating ✓ Disease Prevention, Management, and Treatment ✓ Safe, Crime and Violence Free Communities ✓ Basic Needs
Core Principles Addressed	✓ Focus on Disproportionate Unmet Health-Related Needs ☐ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	The program partners hospital care coordination with Lutheran Social Services to identify individuals who are chronically homeless and chronically disabled and place them in stabilization housing units. Wrap-around supportive services are provided by Lutheran Social Services to help achieve stability. Once stable, individuals are transitioned into to permanent/permanent supportive housing.
Community Benefit Category	A2-e Community Based Clinical Services - Ancillary/other clinical services
FY 2018 Report	
Program Goal / Anticipated Impact	Housing with Dignity aims to assist homeless individuals with severe chronic health and mental health issues obtain and retain housing, care and services designed to achieve stability in their lives.
Measurable Objective(s) with Indicator(s)	Address the social determinants of health by providing up to six months of transitional supportive housing for homeless individuals and provide additional services to enable participants to move toward stable and healthier lifestyles, while reducing hospital admissions.
Intervention Actions for Achieving Goal	Lutheran Social Services (LSS) works with hospital care coordinators to improve referral processes and engage additional hospital staff 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.
Planned Collaboration	Housing with Dignity is a collaborative between the Dignity Health Sacramento County hospitals, Lutheran Social Services and Health Net that assisted in expanding the program.
Program Performance / Outcome	16 patients were served during FY18. When looking hospital utilization 3 months pre and post move-in date, the following was observed: inpatient utilization decreased by 55%; total days spent in the hospital reduced by 51%; and there was an 83% decrease in ED utilization.
Hospital's Contribution / Program Expense	$150,000 which is a shared expense by Dignity Health Hospitals in Sacramento County.
FY 2019 Plan	
Program Goal / Anticipated Impact	Housing with Dignity aims to assist homeless individuals with severe chronic health and mental health issues obtain and retain housing, care and services designed to achieve stability in their lives.
Measurable Objective(s) with Indicator(s)	Continue to address the social determinants of health by providing up to six months of transitional supportive housing for homeless individuals and provide additional services to enable participants to move toward stable and healthier lifestyles, while reducing hospital admissions.
Intervention Actions for Achieving Goal	Lutheran Social Services (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.
Planned Collaboration	Housing with Dignity is a collaborative between the Dignity Health Sacramento County hospitals, Lutheran Social Services and Health Net.

Navigation to Wellness	
Significant Health Needs Addressed	✓ Access to Behavioral Health Services ✓ Access to High Quality Health Care and Services ☐ Active Living and Healthy Eating ☐ Disease Prevention, Management, and Treatment ✓ Safe, Crime and Violence Free Communities ✓ Basic Needs
Core Principles Addressed	✓ Focus on Disproportionate Unmet Health-Related Needs ☐ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	The Navigation to Wellness program utilizes a team comprised of Clinicians and a Peer Support Specialist that work closely with Dignity Health staff in identifying individuals with a self-reported behavioral health problem, who repeatedly access hospital services, and who could be more effectively served if linked to non-emergency room resources. Once a patient is referred by the hospital, the Navigation Team assesses patients to determine what outpatient behavioral health services they are eligible for or may need and links them to appropriate public and general behavioral health services.
Community Benefit Category	E2-a Grants - Program grants
FY 2018 Report	
Program Goal / Anticipated Impact	Decrease the overutilization of hospital services by individuals with behavioral health problems through the use of a team that supports the individual on discharge planning in such a way that facilitates the process and provides linkages to public and general mental health services.
Measurable Objective(s) with Indicator(s)	Individuals who were not linked previously or who were unaware of additional services available to them will be linked, decreasing any future uses of ED or inpatient services during a mental health crisis.
Intervention Actions for Achieving Goal	Build the program in collaboration with the hospital and Turning Point to link identified patients to community resources and have a peer navigator assist patients in the community setting.
Planned Collaboration	The Navigation to Wellness program is a partnership between Turning Point, Strategies for Change, Consumers Self Help Center, and NAMI through the Dignity Health Community Grants
Program Performance / Outcome	In FY18, 231 patients were linked to community resources upon emergency department and inpatient discharge and followed up with for 30 days to ensure they were connected to the resources.
Hospital's Contribution / Program Expense	$145,000 which is a shared expense by Dignity Health Hospitals in Sacramento County.
FY 2019 Plan	
Program Goal / Anticipated Impact	Continue to decrease the overutilization of hospital services by individuals with behavioral health problems through the use of a team that supports the individual on discharge planning in such a way that facilitates the process and provides linkages to public and general mental health services.
Measurable Objective(s) with Indicator(s)	Focus on linking individuals to additional outpatient resources and reconnecting individuals who were previously linked but have not received services. Decrease any future uses of hospital services during a mental health crisis and successful connect to community resources.
Intervention Actions for Achieving Goal	Continue to build the program in collaboration with the hospital and Turning Point to link identified patients in the emergency department to community resources and have a peer navigator assist patients in the community setting. Focus will be place on ensuring hospital staff continues to utilize the program and increase the number of opportunities where the Navigation to Wellness navigator can collaborate with navigators from other programs to increase the continuum of care.
Planned Collaboration	The Navigation to Wellness program is a partnership between Turning Point, Strategies for Change, Consumers Self Help Center, and NAMI.

Co-Occurring Substance Use Disorder Treatment	
Significant Health Needs Addressed	✓ Access to Behavioral Health Service ✓ Access to High Quality Health Care and Services ☐ Active Living and Healthy Eating ✓ Disease Prevention, Management, and Treatment ☐ Safe, Crime and Violence Free Communities ✓ Basic Needs
Core Principles Addressed	✓ Focus on Disproportionate Unmet Health-Related Needs ✓ Emphasize Prevention ✓ Contribute to a Seamless Continuum of Care ✓ Build Community Capacity ✓ Demonstrate Collaboration
Program Description	Through community grants, this pilot program allows for a seamless continuum of care for individuals experiencing homelessness or at-risk struggling with co-occurring substance abuse disorder and in need of mental health services. By partnering with Harm Reductions Services, Wellspace, Loaves and Fishes and TOCRE, program resources and linkages are able to be co-located with mental health service and achieve a new level of integration.
Community Benefit Category	A3-e Health Care Support Services – Information & Referral.
FY 2018 Report	
Program Goal / Anticipated Impact	Decrease the overutilization of hospital services by individuals with co-occurring substance abuse and behavioral health problems through the use of an integrated treatment specialist that understands the complexities of interactions between disorders, supports the individual on discharge planning and provides linkages to public and general mental health services, harm reduction services, and medication assisted treatment (MAT).
Measurable Objective(s) with Indicator(s)	Individuals who were not linked to services or unaware of resources will be linked, decreasing inappropriate ED utilization or inpatient services dealing with co-occurring substance abuse disorder. Improved access to outpatient mental health and substance abuse services and resources.
Intervention Actions for Achieving Goal	Build the program in collaboration with TLCS to identified patients in the hospital setting and appropriately refer, successful linkages to community resources and create training and engagement opportunities for program staff.
Planned Collaboration	The co-occurring substance abuse disorder program is a partnership between TLCS, Harm Reduction Services, Loaves and Fishes, and TCORE through the Dignity Health Community Grants
Program Performance / Outcome	35 assessments were provided at TCORE and 68 assessments were provided at Loaves & Fishes to date. 358 individuals attended groups throughout the year, including 330 individual sessions.
Hospital's Contribution / Program Expense	$100,000 which is a shared expense by Dignity Health Hospitals in Sacramento County thought the community grants program.
FY 2019 Plan	
Program Goal / Anticipated Impact	Decrease the overutilization of hospital services by individuals with co-occurring substance abuse and behavioral health problems through the use of an integrated treatment specialist that understands the complexities of interactions between disorders, supports the individual on discharge planning and provides linkages to public and general mental health services, harm reduction services, and medication assisted treatment (MAT).
Measurable Objective(s) with Indicator(s)	Individuals who were not linked to services or unaware of resources will be linked, decreasing inappropriate ED utilization or inpatient services dealing with co-occurring substance abuse disorder. Improved access to outpatient mental health and substance abuse services and resources.
Intervention Actions for Achieving Goal	Continue to strengthen the program in collaboration with TLCS to identified patients in the hospital setting and appropriately refer, successful linkages to community resources and create training and engagement opportunities for program staff.
Planned Collaboration	The co-occurring substance abuse disorder program is a partnership between TLCS, Harm Reduction Services, Loaves and Fishes, and TCORE through the Dignity Health Community Grants.

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.

	Persons Served	Net Benefit	% of Organization Expenses
Benefits for Living in Poverty			
Financial Assistance	**2,514**	**5,711,134**	**0.9**
Medicaid *	**58,453**	**6,014,603**	**0.9**
Means-Tested Programs	**5**	**10,472**	**0.0**
Community Services			
A - Community Health Improvement Services	10,899	3,508,979	0.5
C - Subsidized Health Services	33	84,050	0.0
E - Cash and In-Kind Contributions	55	3,303,100	0.5
F - Community Building Activities	1,260	1,953	0.0
G - Community Benefit Operations	0	116,783	0.0
Totals for Community Services	**12,247**	**7,014,865**	**1.0**
Totals for Living in Poverty	**73,219**	**18,751,074**	**2.8**
Benefits for Broader Community			
Community Services			
A - Community Health Improvement Services	2,178	56,009	0.0
B - Health Professions Education	1,023	700,604	0.1
E - Cash and In-Kind Contributions	9	9,591	0.0
Totals for Community Services	**3,210**	**766,204**	**0.1**
Totals for Broader Community	**3,210**	**766,204**	**0.1**
Totals - Community Benefit	**76,429**	**19,517,278**	**2.9**
Medicare	**54,377**	**50,216,366**	**7.5**
Totals with Medicare	**130,806**	**69,733,644**	**10.4**

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. If all FY17 Medicaid Provider Fee revenue had been recorded in FY17, the hospital's FY18 net benefit for Medicaid would have been $21,528,084.

APPENDIX A: COMMUNITY BOARD AND COMMITTEE ROSTERS

Dignity Health Sacramento Service Area Community Board

Marian Bell-Holmes Retired Dignity Health VP Human Resources	Sister Patricia Simpson, O.P. Religious
Glennah Trochet, MD, Vice Chair Retired Sacramento County Public Health Officer Community Representative	Dr. Ron James Chief of Staff Mercy General Hospital
Brian King, Secretary Los Rios College District Chancellor	Dr. Dave Wolf Chief of Staff Mercy San Juan Medical Center
Gil Albiani, Chair Real Estate Community Representative	Laurie Harting Sr. Vice President, Operations Dignity Health Sacramento Service Area
Darrell Teat Consultant Darrell Teat and Associates	Dr. Jeffrey Shulkin Chief of Staff Mercy Hospital of Folsom
Linda Ubaldi Former Dignity Health Director of Quality	Dr. David Pai Chief of Staff Methodist Hospital of Sacramento
Marian Bell-Holmes Retired Dignity Health VP Human Resources	Sister Patricia Simpson, O.P. Religious

Dignity Health Sacramento Service Area Community Health Committee Roster

Sister Bridget McCarthy
Vice President, Mission Integration
Dignity Health Greater Sacramento Service Area

Robin Oliver
Vice President, Marketing & Communications
Dignity Health Greater Sacramento Service Area

Sister Clare Marie Dalton
Vice President, Mission Integration
Mercy General Hospital

Sister Cornelius O'Conner
Vice President, Mission Integration
Mercy Hospital of Folsom

Michael Cox
Vice President, Mission Integration
Methodist Hospital of Sacramento and GSSA

Catherine Geraty-Hoag
Director of Clinical Partnerships
Dignity Health Greater Sacramento Service Area

Rosemary Younts
Senior Director, Behavioral Health Service Line
Dignity Health Greater Sacramento Service Area

Kevin Duggan
President, Mercy Foundation

Shirlie Marymee
Retired

Marge Ginsburg
Retired

Sister Gabrielle Marie Jones, Chair
Religious

Sister Patricia Simpson, O.P.
Religious

Ashley Brand
Director, Community Health and Outreach
Dignity Health Greater Sacramento Service Area

Liza Kirkland
Manager, Community Health and Outreach
Dignity Health Greater Sacramento Service Area

Diana Landeros
Community Health Specialist
Dignity Health Greater Sacramento Service Area

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.

- Northern California Community Loan Fund (NCCLF)
  Dignity Health has partnered with NCCLF since 1992, and was one of Dignity Health's first community investment. This CDFI has invested more than $254 million in projects throughout Northern and Central California, promoting economic justice and alleviating poverty by increasing the financial resilience and sustainability of community-based nonprofits and enterprises. In 2016 and 2017 Dignity Health approved two 7-year $1,000,000 loans respectively—the first as lending capital for NCCLF's many projects, and the second as lending capital in a "FreshWorks" Fund supporting the bringing of grocery stores and other innovative forms of healthy food retail to underserved communities ("food deserts").

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

- Transitional Housing and Lodging - When there are no available alternatives, Mercy San Juan Hospital subsidizes payments for room and board in the community for patients unable to pay when they are discharged from the hospital.

- Sacramento County Medi-Cal Managed Advisory Committee -The hospital has appointed representation on this Committee which was established by Senator Steinberg's legislation in 2010. The purpose of the Committee is to improve services and health outcomes for beneficiaries of the region's Geographic Managed Medi-Cal system. The Committee grapples with issues that include access, quality and care coordination, and reviews and provides input on quality indicators, policies and processes.

Additionally, members of the hospital's leadership and management teams volunteer significant time and expertise as board members of nonprofit health care organizations and civic and service agencies, such as the American Heart Association, Citrus Heights Chamber of Commerce, Sacramento Covered, 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.

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 telephone number listed below for your hospital.

Mercy San Juan Medical Center 6501 Coyle Ave, Carmichael, CA 95608 | Financial Counseling 916-536-3053 **Patient Financial Services** 888-488-7667 | www.dignityhealth.org/sacramento/paymenthelp