



St. Elizabeth Community Hospital Community Benefit 2018 Report and 2019 Plan



A message from

Jordan Wright, president and CEO of St. Elizabeth Community Hospital, and Jim Cross, Chair of the Dignity Health North State 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.

St. Elizabeth Community Hospital 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), St. Elizabeth Community Hospital provided \$2,120,579 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. The hospital also incurred \$10,773,753 in unreimbursed costs of caring for patients covered by Medicare.

St. Elizabeth Community Hospital'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 530.529.8015.



Jordan Wright
President/CEO



Jim Cross
Chairperson, Board of Directors

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At-a-Glance Summary

<p>Community Served</p>	<p>SECH is located off of California Interstate 5 in Red Bluff, and serves a core service area population of 86,090 residents. Tehama County is a rural county with the residents being spread out over approximately 2,962 square miles. Due to the rural nature of the county access to care is a consistent barrier for the many residents who are medically underserved and low-income and minority populations. The majority of individuals served reside in Tehama County. However, there are community health services available to bordering communities in Glenn and Shasta counties. The following zip codes make up the core service area for SECH: 95963, 96021, 96022, 96035, 96055, and 96080.</p> <p>The service area’s population remains extremely flat with growth between 2010 and 2018 being less than 1%, while California has grown 6.6% within the same timeframe. Additionally, SECH serves a very rural population with approximately 29.1 people per square mile, while California has approximately 254.8 people per square mile.</p> <p>Age and sex distribution within SECH’s service area indicates that 50.3% are female and 49.7% are male and that there are more individuals that are 65 and over (18.55%) as compared to California (14.11%) and this age segment is projected to experience an annual growth rate of 2.55%. The largest age segment within SECH’s service area are those between the ages of 18 to 44, accounting for 27,330 individuals or 31.75% of the service area population.</p>
<p>Economic Value of Community Benefit</p>	<p>\$2,120,579 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits</p> <p>\$10,773,753 in unreimbursed costs of caring for patients covered by Medicare</p>
<p>Significant Community Health Needs Being Addressed</p>	<p>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:</p> <ul style="list-style-type: none"> • Access to Care • Child Abuse/Neglect • Diabetes
<p>FY18 Actions to Address Needs</p>	<ul style="list-style-type: none"> • Charity Transportation • Diabetes education program • Mammography assistance program • Medications for Indigent Patients • Participation in local health fairs offering nutrition services consultation, glucose and cholesterol testing • Provide community grants to local non-profit organizations

	<ul style="list-style-type: none"> • Provided flu shots, glucose and cholesterol testing for the homeless and poor populations • Sports medicine program
Planned Actions for FY19	<p>The hospital plans to continue all of the above programs and add the following programs:</p> <ul style="list-style-type: none"> • Implement diabetes awareness and education program • Implement safety and violence initiatives to 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.

This document is publicly available on the hospital’s web site <https://www.dignityhealth.org/north-state/locations/stelizabethhospital/about-us/community-benefit> and a paper copy is available for inspection upon request at St. Elizabeth Community Hospital’s Community Health Office.

Written comments on this report can be submitted to the St. Elizabeth Community Hospital Community Health Office, 2550 Sister Mary Columba Dr., Red Bluff, CA 96080 or by e-mail to alexis.ross@dignityhealth.org.

MISSION, VISION AND VALUES

St. Elizabeth Community Hospital 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 St. Elizabeth Community Hospital

SECH is located in Tehama County which consists of 2,951 square miles and is approximately midway between Sacramento and the Oregon border. The county is bordered by Glenn County to the south, Trinity and Mendocino counties to the west, Shasta County to the north, and Butte and Plumas counties to the east. The county is situated in the northern portion of the Sacramento Valley and is divided in half by the Sacramento River. Red Bluff, the county seat, was established in 1856 and is located on the Interstate 5 corridor.

Description of the Community Served

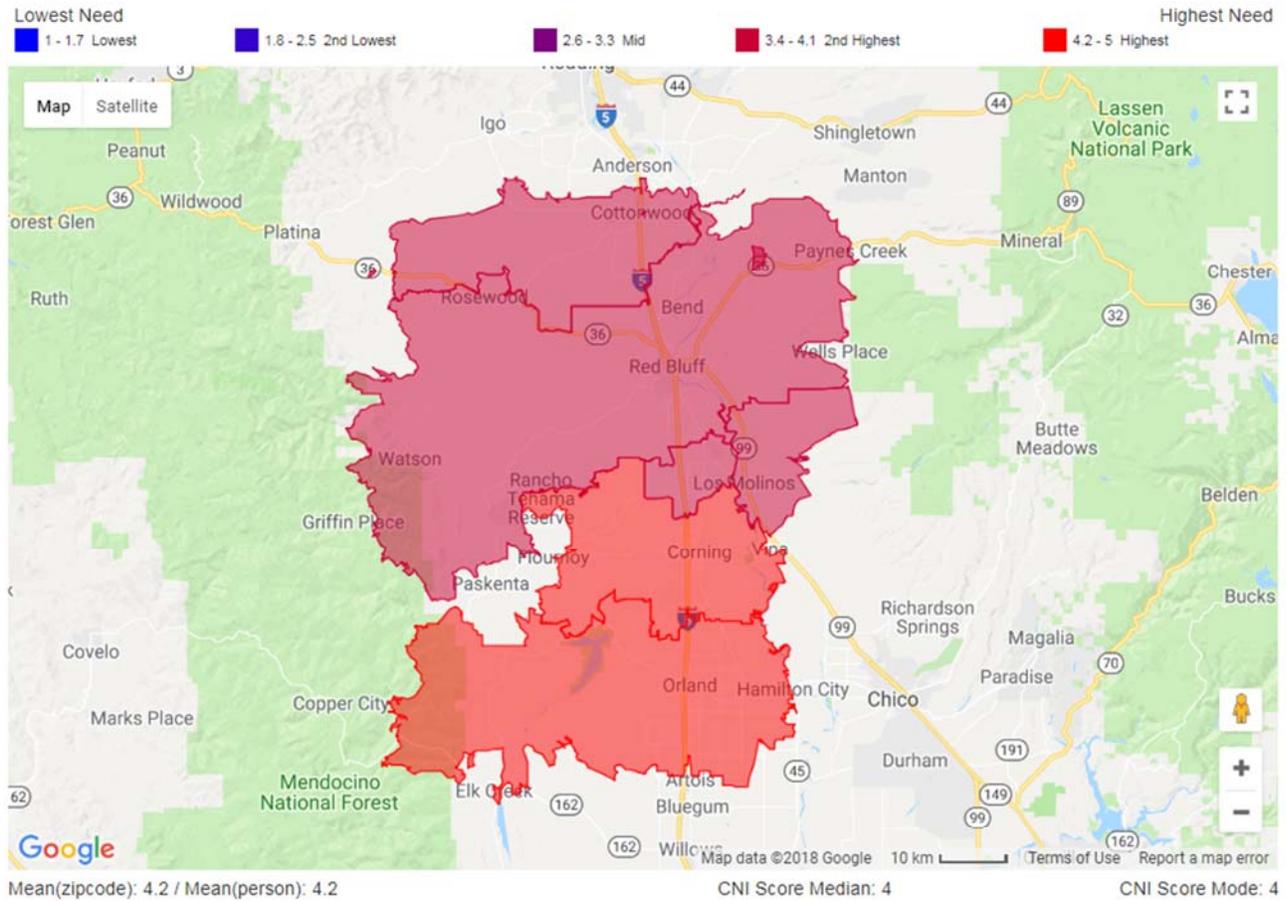
SECH serves a core service area (CSA) comprised mostly of six codes located in Tehama County. Dignity Health hospitals define service areas as the geographic area served by the hospital based on a percentage of hospital discharges and is also used in various other departments of the system and hospital, including strategy and planning. The majority of individuals SECH serves reside in Tehama County. However, there are community health services available to bordering communities in Glenn and Shasta counties. The following zip codes make up the core service area for SECH: 95963, 96021, 96022, 96035, 96055, and 96080. A summary description of the community's demographic indicators using © 2018 IBM Watson Health Analytics is listed below, and additional details can be found in the CHNA report online.

- Total Population: 86,090
- Hispanic or Latino: 27.7%
- Race: 65.2% White, 0.7% Black/African American, 1.8% Asian/Pacific Islander, 4.6% All Others
- Median Income: \$45,726
- Uninsured: 10.8%
- Unemployment: 6.9%
- No HS Diploma: 18.6%
- CNI Score Median: 4
- Medicaid Population: 36.4%
- Other Area Hospitals: 0
- 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 our primary service area is 4.0 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.



Zip Code	CNI Score	Population	City	County	State
95963	4.8	16734	Orland	Glenn	California
96021	4.8	16331	Corning	Tehama	California
96022	3.6	15993	Cottonwood	Tehama	California
96035	4	3696	Gerber	Tehama	California
96055	3.8	3812	Los Molinos	Tehama	California
96080	4	29524	Red Bluff	Tehama	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 stage Service Area Community 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 health 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
 - Tehama County is both a Health Professional Shortage Area (HPSA) and a Medically Underserved Area (MUA). The CHNA indicator reports the number of primary care physicians per 100,000 population. Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health.
- Addiction/Substance Abuse (including Tobacco Use)
 - Tehama County residents exhibit significantly higher rates of alcohol consumption than the both California and the United States. In addition, Tehama County also experiences significantly higher rates of death from drug poisoning and tobacco use by cigarette smoking than both California and the United States overall.

- Cancers
 - Tehama County residents have higher disease incidence rates than both California and the United States overall for all cancers on which data were collected. In particular, the incidence rates of lung cancer are significantly higher than that state of California and may indicate a correlation with the high rates of tobacco use in Tehama County.
- Child Abuse/Neglect
 - Since at least 2002 child abuse and neglect has been a recurring topic in the CHNA. In 2015, there were 1,606 total reports of child abuse in Tehama County. Anecdotally, a local physician and North State Community Board member have indicated that child abuse is on the rise in SECH's service area.
- Diabetes
 - The CHNA indicator report shows In Tehama County 9.4% of individuals aged 20 and over received a diabetes diagnosis as compared to 8.3% for California and 9.1% for the United States. This indicator is relevant because diabetes puts individuals at risk for further health issues and increased costs of medical care and possibly disability, and premature death.
- Elderly Population – Issues
 - Tehama County demographics indicate that 18.5% of those living in the hospital's service area are aged 65 and over. As Americans live longer, growth in the number of older adults is unprecedented. In 2014, 14.5% (46.3 million) of the US population was aged 65 or older and is projected to reach 23.5% (98 million) by 2060. Aging adults experience higher risk of chronic disease. In 2012, 60% of older adults managed 2 or more chronic conditions. Chronic conditions can lower quality of life for older adults and contribute to the leading causes of death among this population.
- Homelessness
 - Homelessness data is extremely difficult to obtain, especially for rural communities. A homeless individual is defined as “an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing.” Without definitive quantitative data regarding homelessness it is important to understand the perception of the issue from the community viewpoint. The focus groups indicated a lack of affordable housing available within the community.
- Mental Health Problems
 - The CHNA data indicates a severe lack of access to mental health services in SECH's service area due to a lack of providers and ongoing sustainable funding for services. Compared to both California and the United States as a whole, Tehama County has a significantly lower rate of providers relative to the population.

- Obesity
 - In Tehama County 27% of individuals aged 20 and over have a Body Mass Index greater than 30 and are considered obese as compared to 22.4% for California and 27.5% for the United States.

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. St. Elizabeth Community Hospital 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 the following significant health needs: addiction/substance abuse; elderly population (aging issues, Alzheimer's, dementia, etc.), cancers, homelessness, mental health, and obesity. Tehama 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. SECH 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/stelizabethhospital/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, SECH 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
- St. Elizabeth Community Hospital 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.

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

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

Health Need: Access to Care			
Strategy or Activity	Summary Description	Active FY18	Planned FY19
Provide services for vulnerable populations	Charity Care for uninsured/underinsured and low income residents. Rural Health Clinics offering sliding fee scale for patients who do not qualify for insurance	☒	☒
Increase Access to Care	Physician recruitment efforts. Rural Health Clinics eligible for federal and state student loan repayment programs for clinicians	☒	☒
Community Support	Partnership with Rolling Hills Clinic, Federally Qualified Indian Health Clinic; Greenville Rancheria; Tehama County Public Health; Tehama County Dental Health Program	☒	☒
Health Education Outreach	LIFT; Latino Multicultural Health Fair; Greenville Rancheria Wellness Fair; Senior Health Fair; Corning Olive Festival; Bi National Health Fairs participation offering nutrition services consultation, blood pressure screenings, etc.	☒	☒
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 California Health and Wellness, a Medi-Cal insurance plan, and the hospital.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Health Screening	Los Molinos Middle and High Schools – onsite health screenings for children	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
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: Diabetes			
Strategy or Activity	Summary Description	Active FY18	Planned FY19
Chronic Disease Management	Diabetes education program; Living Well With Diabetes Classes (SECH)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Chronic Disease Management	Diabetes support group program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Anticipated Impact: improvement of community awareness and detection of diabetes within the population served and increase knowledge of diabetes management through outreach and education.			

Health Need: Safety and Violence (including Child Abuse)			
Strategy or Activity	Summary Description	Active FY18	Planned FY19
Human Trafficking	The Human Trafficking (HT) initiative focuses on: <ul style="list-style-type: none"> ▪ 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 	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
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).	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Child Abuse/ Domestic Violence	<ul style="list-style-type: none"> ▪ Continue community education efforts for the community to identify and refer victims to appropriate interventions ▪ Continue to collaborate with community agencies to improve coordination of initiatives 	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Sexual Assault	<ul style="list-style-type: none"> ▪ Partnership with Tehama Sexual Assault Response Team to provide immunization and background requirements for SART staff and space for the SART exams to be performed 	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.			

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 two grants totaling \$41,504. Below is a complete listing of FY18 grant projects; some projects may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Alternatives to Violence	Housing First Tehama	\$21,504
United Way of Northern CA	2-1-1 Digital Health referral line	\$20,000

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

St. Elizabeth Community Hospital is privileged to have collaborative partnership relationships with several Tehama County agencies, all of which are working to address issues that affect the health and well-being of our community. SECH and Tehama County Mental Health designed and implemented the county's Mental Health Wellness Program. SECH is also part of an interagency stakeholder coalition to address homelessness in Tehama County and assisted with the development of a 10-year community plan. SECH administration participate on the Tehama County Health Service Agency Housing Committee. The purpose of the inter-agency committee is to find housing for patients with mental health issues, especially those that are homeless. In addition to the relationships with the County, SECH is actively involved in the Alternatives to Violence Programs and has a member seat on two Homeless Coalitions, one to address homelessness in general and the other is specific to the homeless mentally ill population. SECH is an active supporter of LIFT, a community coalition that provides health care services to the poor and disenfranchised. SECH is also a member of the Tehama County Public Health Board. SECH is also a board member of the First 5 of Tehama Commissioners Board and has worked with First 5 to promote healthy lifestyles for children 0-5, with a joint collaborative partnership with Northern California Child Development Inc. which follows children's development to the age of 18. Partnered with Tehama County to provide training to all first responders in the administration of an opioid reversal agent.

Financial Assistance for Medically Necessary Care

St. Elizabeth Community Hospital 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.

Reduction of 30-day readmissions for patients with Congestive Heart Failure, COPD, pneumonia, and those patients who are at risk for readmission after being discharged from the hospital	
Significant Health Needs Addressed	<input type="checkbox"/> Aging Problems (arthritis, hearing/vision loss, etc.) <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input checked="" type="checkbox"/> Heart Disease and/or Stroke <input type="checkbox"/> Obesity (lack of exercise and poor eating habits) <input type="checkbox"/> Substance Abuse (alcohol and drug) <input type="checkbox"/> Tobacco Use
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care

	<input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Program Description	<p>Congestive Heart Failure (CHF) is a predominant health concern and risk in Tehama County. CHF can be directly linked to lifestyle and preventable diseases including poor eating habits, obesity and diabetes, as shown by evidence based research. Research also shows that chronic disease management programs can significantly reduce the number of readmissions of patients with chronic CHF. SECH's CHF program consists of follow-up phone calls and discharge intervention to promote wellness, by a RN. Upon discharge, our CHF patients receive a self-care handbook: <i>Learning to Live with Heart Failure</i>. Materials are also printed in Spanish. Patients with limited resources are offered a scale. The scale helps the patient to monitor and report any unusual weight gain that might be cause for intervention. The program was expanded this year to include follow-up with patients who are determined to be high risk for readmission after discharge from the hospital, or with COPD and/or pneumonia.</p>
Community Benefit Category	A – Community Health Improvement Services
FY 2018 Report	
Program Goal / Anticipated Impact	SECH will continue to reduce the number of inpatient readmissions of CHF, COPD, pneumonia, and patients at risk for readmission through early intervention.
Measurable Objective(s) with Indicator(s)	SECH will continue to monitor patients participating in this program via chart review and RN assigned to the chronic disease management follow-up phone program
Intervention Actions for Achieving Goal	Decrease readmissions of participants in the hospital's chronic disease program. SECH will also explore additional models to monitor/reduce readmission rates for these individuals within 30 days post-intervention.
Planned Collaboration	Continue current process
Program Performance / Outcome	Telephone follow-up call participants=142 patients. Readmissions= 7 patients within 30 days=0.05%.
Hospital's Contribution / Program Expense	10 scales given, approximately \$200
FY 2019 Plan	
<p>Due to resource limitations, the hospital will continue the current process of monitoring patients participating in this program but will discontinue reporting this as a community benefit initiative. Remaining resources will be leveraged in order to help establish and sustain other programs that respond to a significant health need area identified in the FY18 community health needs assessment.</p>	

Increasing Diabetes Awareness and Education	
Significant Health Needs Addressed	<input type="checkbox"/> Access to Care <input checked="" type="checkbox"/> Diabetes <input type="checkbox"/> Safety & Violence
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care

	<input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Program Description	Diabetes is a growing health concern in Tehama County with, as of 2014, 9% of the population diagnosed with Type 2 Diabetes. (1) Diabetes risk factors include age, genetics in addition to lifestyle and dietary factors. Diabetes education and medical nutrition therapy has been shown to significantly improve HgA1c and can improve knowledge and skills needed to modify behaviors and assist patients in self-managing their condition. SECH Diabetes program consists of outpatient diabetes-focused medical nutrition therapy (MNT), community diabetes classes and support groups, community outreach, inpatient education and discharge follow-up phone calls to promote ongoing wellness.
Community Benefit Category	A – Community Health Improvement Services
FY 2018 Report	
Specific initiatives and measurable objectives addressing diabetes awareness and education 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 community awareness and detection of diabetes within the population served and increase knowledge of diabetes management through outreach and education.
Measurable Objective(s) with Indicator(s)	Increased knowledge and awareness of diabetes management education services among community members measured by the number of attendees at classes, support groups and MNT visits.
Intervention Actions for Achieving Goal	<ul style="list-style-type: none"> ▪ Participation in community education events to increase diabetes awareness and provide screenings. ▪ Provide community classes and support groups (Living Well with Diabetes, Diabetes: First Steps, and Diabetes Support Group). ▪ Provide medical nutrition therapy (MNT) and diabetes education services. ▪ Collaborate with community providers to improve access to diabetes education services.
Planned Collaboration	Collaboration with local community-based organizations and health care centers including but not limited to Greenville Rancheria Tribal Health Center, Corning Senior Center, and Feather River Community Health.

Safety & Violence (including Human Trafficking and Child Abuse)	
Significant Health Needs Addressed	<input type="checkbox"/> Access to Care <input type="checkbox"/> Diabetes <input checked="" type="checkbox"/> Safety & Violence
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> 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 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	<ul style="list-style-type: none"> ▪ 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)
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.

St. Elizabeth Community Hospital
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
<u>Benefits for Living in Poverty</u>			
Financial Assistance	1,480	1,407,238	1.4
Medicaid *	27,741	0	0.0
Means-Tested Programs	3	0	0.0
Community Services			
A - Community Health Improvement Services	83	16,993	0.0
C - Subsidized Health Services	2	521	0.0
E - Cash and In-Kind Contributions	2	572,298	0.6
G - Community Benefit Operations	1	69,069	0.1
Totals for Community Services	88	658,881	0.7
Totals for Living in Poverty	29,312	2,066,119	2.1
<u>Benefits for Broader Community</u>			
Community Services			
A - Community Health Improvement Services	728	8,607	0.0
E - Cash and In-Kind Contributions	16	33,494	0.0
F - Community Building Activities	12	12,359	0.0
Totals for Community Services	756	54,460	0.1
Totals for Broader Community	756	54,460	0.1
Totals - Community Benefit	30,068	2,120,579	2.2
Medicare	27,417	10,773,753	11.1
Totals with Medicare	57,485	12,894,332	13.2

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 \$2,469,697.

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

FY 2018
ST. ELIZABETH COMMUNITY HOSPITAL
LOCAL ADVISORY COUNCIL MEMBERS

Community Members

Tony Cardenas, Comcast
Gregg Cohen, District Attorney for Tehama County
C. Jerome Crow, Chair (Aide to Assemblyman Jim Nielsen)
Dave Gowen, Red Bluff Chamber
Sr. Gloria Heese, Sister of Mercy
Dave Hencraft, Tehama Sheriff's Office
Darwyn Jones, District Manager for Walmart Distribution Center
Jolene Kemen, Secretary (Community Member)
Valerie Lucero, Co-chair (Director of Tehama Public Health)
Scott Malan, MD
Maggie Michael, Alternatives to Violence
Jon Pascarella, DDS
Jessie Shields, Community Member
Mandy Staley, Tehama District Fair

St. Elizabeth Community Hospital Staff

Jordan Wright, President
Sr. Pat Manoli, Senior Director Mission Integration
Kristen Behrens, Director of Support Services
Denise Little, Director Human Resources
Maggie Redmon, President, MFN
Auxiliary Representative

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. Non-Quantifiable Benefits of the hospital include our contribution to various boards throughout the community.

SECH Administration serves on the Tehama County Health Board, Homeless Stakeholders Coalition, First Five Tehama Board and Tehama Together Community Board. Economic development is instrumental to Tehama County and surrounding areas therefore, the Clinic Supervisor has served on the Corning Chamber of Commerce Board of Directors. Additionally, the President of the Hospital serves on the Tehama County Economic Development Corporation Board. Several members of the leadership team are members are active in community service clubs such as Rotary.

SECH provides free grant writing skills trainings to non-profit Tehama County agencies to help ensure the organizations have the tools and information they need to aptly apply for the Dignity Health Community Grant Program. The Community Grants Program supports the continuum of care in the community offered by funding to local non-profit organizations who are working to improve the health status and quality of life of the communities we serve. This program is one way in which the Hospital realizes its mission and enhances the advocacy, social justice and healthier communities' efforts of our health care ministry. SECH also donates meeting space for a variety of community service groups including alcoholics anonymous, overeaters anonymous, diabetic support, childbirth education, and head trauma support.

On the ecology front, SECH continues to be a leader in waste management and reduction. SECH partners with Tehama County Waste Management to provide SHARPS containers and collection on campus. The Ecology team has created a hazardous materials business plan and continues to focus on improving our environment while cutting costs.

SECH shares the community benefit story in a variety of venues. Primarily, details of the community benefit programs are shared every other month with the Advisory Council during a designated community benefit update agenda item. Additionally, SECH provides detailed updates to the health community at large during the Tehama County Health Board meetings. Community benefit plans, projects and milestones are also shared within the region during the North State Service Area Community Board meetings. Physicians are regularly updated on the community benefit investments once a year during a general medical staff meeting and the medical executive team is updated monthly. The community at large can learn about the community benefit activities of SECH through the following items:

- Presentations to local community service groups
- Advisory Council Meetings (every other month)
- Dignity Health North State Service Area Meetings
- Health Scene Newsletter (3 times a year)
- Private Health Online Newsletter (monthly)
- Local media attention including social media venues
- Medical staff meetings (monthly)
- Updated bulletin boards throughout facility
- Director/Managers meetings (monthly)
- Facility and system websites
- Community calendar publications

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 – St. Elizabeth Community Hospital, 2250 Sister Mary Columba Drive, Red Bluff, CA 96080; **Financial Counseling** 530-529-8079; **Patient Financial Services** 888-488-7667 or by visiting www.dignityhealth.org/stelizabethhospital/paymenthelp.