



Mercy Medical Center

Community Benefit Report 2014
Community Benefit Implementation Plan 2015



Dignity Health[™]
Mercy Medical Center

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A message from David Dunham, President and CEO of Mercy Medical Center, and Cynthia Temple, Chair of the Dignity Health Mercy Medical Center Community Board.

The **Hello humankindness** campaign launched by Dignity Health is a movement ignited and based on the proven idea that human connection, be it physical, verbal, or otherwise, leads to better health. At Dignity Health the comprehensive approach to community health improvement recognizes the multi-pronged effort needed to meet immediate and pressing needs, to partner with and support others in the community, and to invest in efforts that address the social determinants of health.

At Mercy Medical Center we share a commitment to improve the health of our community and have offered programs and services to achieve that goal. The 2014 Annual Report and 2015 Plan for Community Benefit fulfills section 501 (r) of the Patient Protection and Affordable Care Act, where each hospital must complete a community health needs assessment every three years and develop a community health implementation plan to document how it will address the significant health needs of the community. We are proud to provide this report as a continuation of the work we have done to better the health of the communities we serve.

In addition, California State Senate Bill 697 requires not-for-profit hospitals to annually report its community benefit efforts and measurable objectives as well as its plans for the coming year. Encouraged and mandated by its governing body, Dignity Health hospitals comply with both mandates at each of its facilities, including those in Nevada and Arizona, and is proud of the outstanding programs and services that have been offered to improve the health of the communities we serve.

In fiscal year 2014, Mercy Medical Center provided \$42,572,157 in financial assistance, community benefit, and unreimbursed patient care. Including the unreimbursed cost of caring for patients covered by Medicare, the total expense was \$63,415,970.

Dignity Health's Mercy Medical Center Community Board has reviewed and approved the annual Community Benefit Report and Implementation Plan at their October 23, 2014 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at 209.564.5002.



President/CEO



Community Board Chair

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Executive Summary

Mercy Medical Center (MMC) is a 186-bed acute care, religious-sponsored, not-for-profit hospital located in the city of Merced, California. MMC is a member of Dignity Health, a family of over 60,000 caregivers and staff. Founded in 1986 and headquartered in San Francisco, Dignity Health is the fifth largest hospital provider in the nation and the largest hospital system in California. On May 2, 2010 MMC moved into a brand new 262,000 square foot facility on Mercy Avenue. MMC has a staff of more than 1,300 and professional relationships with more than 250 local physicians.

Major programs and services include: one licensed acute care facility with a family birthing center, intensive care unit, emergency care and four floors covering telemetry and medical/surgical nursing units. Two outpatient facilities that combined services include outpatient home care, physical and cardiac rehabilitation, ambulatory surgery, wound care, laboratory, imaging and a “Medical Assistance Program” pharmacy. There are three rural health clinics; Family Practice (32% of patients are uninsured), General Medicine Clinic (specialist clinic) and Kids Care (92% of the pediatric patients are on MediCal) that combined see over 4,000 patients a month. The clinics are highlighted in the “Program Digest” section of this report.

In response to identified unmet health-related needs in the community health needs assessment, during FY 2014 MMC focused on increasing access to health care for the broader and underserved disadvantaged members of the surrounding community. Major Community Benefit activities focused on increasing programming, Coalition Building and Health Education for those with disproportionate unmet health-related needs (DUHN).

Central California Children’s Hospital located in Madera, California, operates an eight bed Neonatal Intensive Care Unit, Level II Nursery within the Mercy Medical Center Family Birthing Center.

MMC’s Emergency Care maintains 24/7 emergency services and operates the base station for Merced County. Emergency care is provided to an average of 185 patients a day. Ambulance calls average 35 a day. Medical helicopter flights from the hospital average 25 a month, carrying patients primarily to Children’s Hospital or Doctor’s and Memorial hospitals in Modesto.

The Family Medicine Residency Program was established in 1974 as an affiliate of the University of California, Davis. It is a three year program with eight residents in each year, started because of the need for additional primary care physicians in Merced County. More than half of the active medical staff are involved in the resident training. The residents see inpatients (most do not have a medical home) and the patients at the Family Care Clinic. MMC invests more than \$3 million per year to run the residency program.

Language Interpretive Services are contracted with the United Way for a language bank of medical interpreters. The language bank provides a Spanish interpreter at the hospital and at the clinics with regularly scheduled hours. Interpreter services are also available for the following languages on an on-call basis: Hmong, Hindi, Mien, Lao, Chinese, Mandarin, Cantonese, Portuguese and Punjabi.

In addition to on site interpreters a Cyracom phone system provides interpretation for over 130 languages and is available in every patient room. Accommodation of services for the physically challenged and sight/hearing-impaired patients is on an on-call basis. MMC has also contracted with Cyracom to provide eight “Video Remote Interpretation (VRI)” telecommunication devices. These devices provide video access to sign language interpreters for immediate communication between a healthcare provider and the deaf and hard of hearing patient.

Spiritual Care Services are available 24/7 for patients, families and staff. The department presents to the community an annual program, “Spiritual Care - Visiting the Sick 101.” The 18-hour course helps individuals understand the issues of crisis in illness, care of the dying and end of life decision making and grief and bereavement support. Classes are held every September. In 2013 there were 26 community members who took the 101 class. Twelve of those who took the 101 class continued with an additional eight hours of instruction in order to become a Spiritual Care volunteer.

Mercy Health Education is a community outreach program to address prevention of disease, to empower community members to assume responsibility for their health, and to educate people about various medical conditions and the ability they have to make choices. Community education classes that are ongoing include education on diabetes, asthma, childbirth, cardiac disease and heart saver CPR/first aid.

Primary Stroke Center – in FY 2013 MMC was accredited as a *Primary Stroke Center* from the Joint Commission. A total of 191 RN’s took 38 hours of continuing education in stroke and stroke care. The Telehealth Network telemedicine robot that has video screens and Webcams has been leased and began service in the ED in May 2012. MMC works with the hospitals in the Greater Sacramento Area to provide neurology consultations. The program hubs are Mercy General and Mercy San Juan, where stroke specialists are available 24/7.

Chronic Disease Self Management classes began in FY 2013 and are part of a system with initiative of Dignity Health. Classes are offered weekly over a period of six weeks and are offered continuously throughout the year. This program has now expanded to include “Tomando Control de Su Salud” a Spanish version of CDSMP. In FY 2015 the plan is to offer the “Diabetes Self-Management Program (DSMP)” to the community. These programs provide tools to the community in order for them to manage their health and become active participants in their treatment plan.

The Community Benefit Report FY 2014 and Community Benefit Implementation Plan FY 2015 document our commitment to the health and improved quality of life in our community. The total community benefit dollars reported in FY2014 is **\$42,131,776** which excludes the unpaid costs of Medicare **\$20,846,082**. **The total community benefit net cost reported reflects 26.4 percent of the organizations expenses and 27.6 percent of the revenues.**

Mission Statement

Mission Statement (Dignity Health Mission Statement)

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.

In carrying out our healing ministry, we embody the values of dignity, collaboration, justice, stewardship and excellence.

Organizational Commitment

MMC provides a continuum of health care services ranging from preventive care to acute care, rehabilitation and health maintenance. MMC is actively engaged in promoting a holistic approach to healthful behavior, lifestyles, and well-being in mind, body and spirit. It prides itself on community involvement, building community capacity through collaborations, as well as offering programs and services that benefit the residents of Merced County.

The hospital administration along with the Community Board and the Community Advisory Committee exemplifies a strong commitment to the process of identifying priority needs, planning, implementing and evaluating the Community Benefit programs.

The Mercy Community Board and the Community Advisory Committee reviews and approves the Community Benefit reports, oversees the Dignity Health Community Grant process and selections. The community health programs are targeted to directly address the needs of the community as identified in the community needs assessment and in accordance with policies and procedures of Dignity Health and incorporate Dignity Health System wide performance measures identified by the Dignity Health Board.

The Community Board reviews health initiatives and the health needs of the medically under-served and the multicultural populations of Merced County. They provide assistance to administration in developing the strategic direction of the hospital. The Board participates in the process of establishing priorities, plans and programs for the Healthy Communities Initiatives based on an assessment of community needs and assets and monitors progress toward identified goals. They provide advice and consultation concerning the annual operating and capital budgets for the hospital as part of the budget development process and receive periodic reports from management comparing actual operations to budget.

The Community Advisory Committee members assist and advise the community benefit planning process for MMC. The Chair of the committee is a member of MMC's Community Board. The Advisory Committee meets quarterly and exists to represent or reflect medically under-served communities in Merced County and to assist the Community Benefit planning process of MMC. Special meetings may be arranged as needed. This committee oversees the Dignity Health Community Grant program selection process.

Committee Responsibility

- Support and implement Dignity Health's mission and core values related to health services
- Serve as a resource for MMC by bringing forward information relative to unmet needs of the medically under-served communities in Merced County
- Offer recommendations regarding health services needs of Merced County's medically under-served populations

- Serve as a link between MMC's Board of Directors and the Community Health Benefit planning process, coordinating and overseeing the development of the annual Health Benefit Plan
- Provide leadership for the Dignity Health Community Grant Program

For a roster of Community Board and the Community Advisory Committee members see Attachment A

Non-Quantifiable Benefits

MMC works collaboratively with community partners. The hospital provided leadership and advocacy, stewardship of resources, assisted with local capacity building, and participated in community-wide health planning.

In addition to quantifiable benefits, Mercy Medical Center also provides non-quantifiable benefits which are related to the community contribution of the hospital's organizational capacity and consulting resources. These are benefits that are difficult or impossible to measure but are important contributions to the community, such as:

- MMC staff raised funds to walk in the, Cancer Society's "Relay for Life", National Multiple Sclerosis walk, and the Hinds Hospice "Angel Babies" walk.
- In December hospital departments participate in the Spiritual Services "Christmas Sharing Project" by adopting needy families and providing non-profit agencies needed resources.
- Participated in the Samaritan's Purse, "Operation Christmas Child" project by donating 35 shoeboxes filled with items and sent to children living in poverty stricken areas around the world.
- Mercy Cancer Center was a major contributor to the Cancer Society's "Relay for Life" event.
- The St. Mary's Orthodox Church uses the hospital chapel for their weekly worship services and uses the hospital multipurpose room for weekly parish gatherings.
- Mercy has donated to local physicians many pieces of medical equipment and supplies to be taken to third world countries.
- Mercy staff represents Mercy Medical Center by being members of the Merced/Mariposa Cancer Society, Multiple Sclerosis Association, Merced Rotary, Merced Kiwanis, Merced Greater Chamber of Commerce, Tobacco Coalition, Asthma Coalition, the BiNational Committee, Central CA Health Alliance, and the Hinds Hospice "Angel Babies" committee.
- Mercy Emergency Cardiac Care Committee partners with the American Heart Association to present to the Merced/Fresno Area Task Force and Western Territory Region ECC Committee so that goals that impact health-care BLS, ACLS and PALS courses and the chain of survival initiatives are met.
- Mercy is a member of the Asthma Coalition helping to control asthma through awareness and education and flies the daily air pollution level flag.
- Mercy is part of the Merced County Health Care Consortium steering committee initiating the Children's Health Initiative to create Healthy Kids health coverage.
- The Mercy Cancer Center started a "Cancer Support Group" in FY2013. An average of 30 people attend the monthly meetings.
- A Mercy Music Program was started in FY13. It is composed of musicians who volunteer their time to visit patients and minister to them through their music.

Community

Merced County is located in the heart of the San Joaquin Valley and spans from the coastal ranges to the foothills of Yosemite National Park. The total area is approximately 2,020 square miles.

The City of Merced is the County seat and is the largest of the six incorporated cities. County and City municipalities are a major source of employment along with agricultural related industries, retailing, manufacturing, food processing and tourism.

Mercy Medical Center primary service area is comprised of the communities of Merced, Atwater, Winton and Livingston. There is only one other hospital in the county, Memorial Los Banos, a Sutter Health Affiliate, a 48-bed facility with a basic emergency services. Fulfilling the health care needs of Merced County is an extremely challenging opportunity.

Population/Race/Ethnicity

- Population: Merced County 255,793 (provided by the 2010 US Census) – Hospital Service Area 155,207
- Diversity: Caucasian 31.12%, Hispanic 52.27%, Asian 9.40%, African American 4.57%, American Indian/Alaska Native 0.49%, Other 2.15%
- Average Income: \$42,267
- Unemployment: September 2012, 14.5%
- Uninsured: 29.82%
- No HS Diploma: 30.6%
- CNI Score: 4.8
- Medicaid Patients: 30%
- Other Area Hospitals: In Merced County - Sutter Memorial Hospital, Los Banos

Educational Level - The population 25 years and older that have a college bachelor's degree or greater is one of the state's lowest at 13.8% compared to a 27.8% for the USA. Persons with some college/associate degree is 33.2%, high school degree 22.5%, some high school 13.0% and less than high school is 17.6%.

Household Income Distribution - Merced County has been identified as 49th poverty stricken counties in California. Data gathering and reporting has shown poverty to be a chronic and pervasive reality affecting all aspects of healthy living. Merced County's poverty rate is significantly higher for persons under the age of 18. It is 25.8 per 100 population under age 18 this is 49.1% higher than the rate for the State of California which is 317.3 per 100. The PSA median household income of \$40,148 is lower than the Merced County median of \$42,267 and California median of \$61,731. Household incomes under \$25K are 30.6%, \$25-\$50K is 30.8%, \$50-\$75K is 18.4%, \$75-\$100K is 9.5%, and over \$100K is 10.6%.

Economic Environment - The unemployment rate for 2014 is averaging 14.1% and is expected to decline in 2015 to 13.3%. Job growth projected to improve significantly in all sectors with real personal income expected to increase 3.3% between 2014 and 2015.

Median home prices dropped from \$253,750 in December 2007 to \$160,000 in December 2013. Housing affordability has significantly improved during the recession, but median home prices rose 33% between 2011 and 2013. As of November 2013 1 in 1,163 houses in Merced County were in foreclosure.

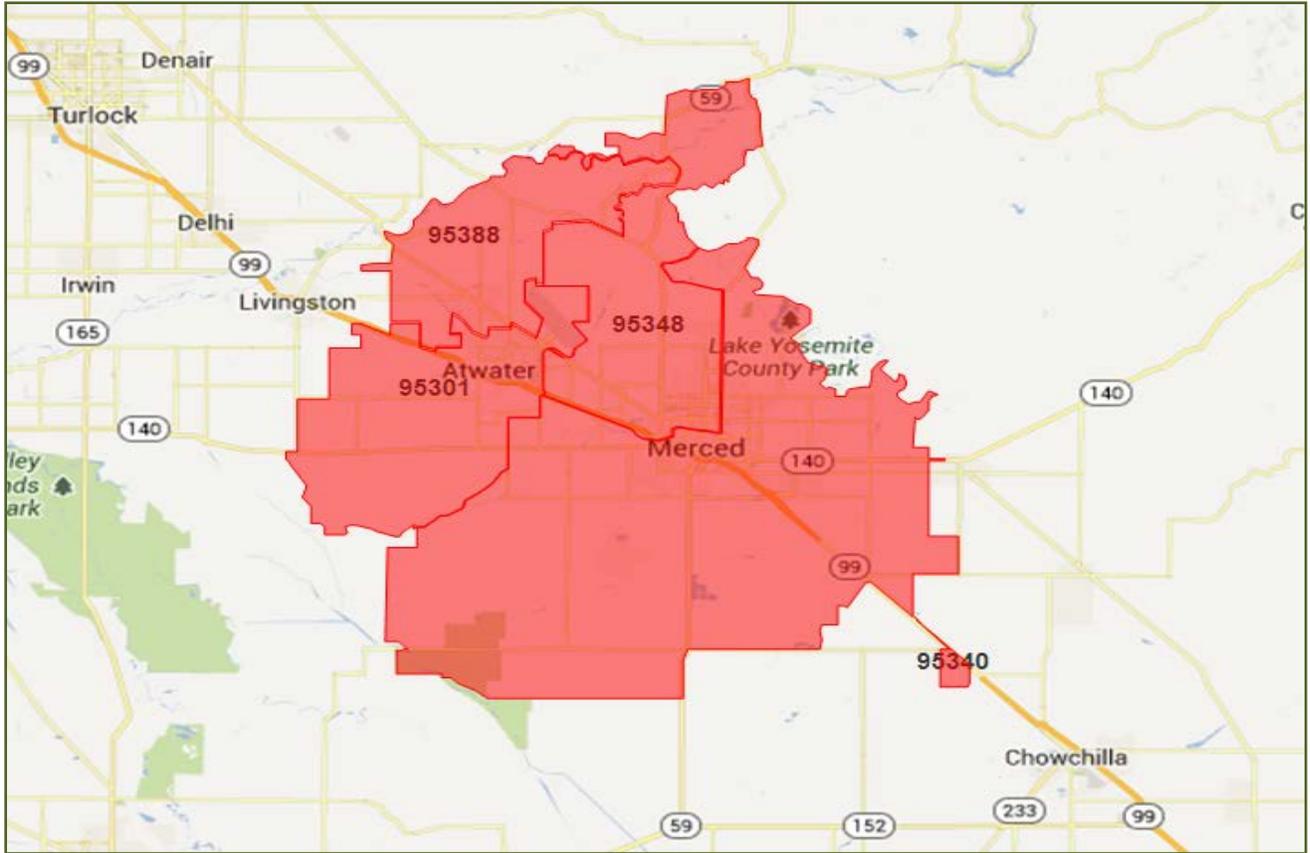
Insurance - Commercially insured residents reflect a 25%, Medi-Cal beneficiaries are at a 30%, Medicare beneficiaries are at 30% and Medicare/Medi-Cal beneficiaries 10.2% and 15% are uninsured or covered by another government program. MMC's payer mix is skewed towards public payers with an inpatient mix of Medicare and Medi-Cal of over 74%. Anthem Blue Cross is the largest commercial payers with 54% of the commercial lives (54,000 HMO and PPO lives), followed by Blue Shield with 15% of commercial lives (15,000 PPO lives, and Kaiser with 6% of commercial lives (6,000 HMO lives) in North Merced County.

Merced County is designated as a *medically underserved area*. This designation is based on an index of four variables – the ratio of primary care physicians per 1,000 populations, the infant mortality rate, the percent of the population with incomes below the poverty level and the percent of the population age 65 and over.

Merced County has moved to a *County Organized Medi-Cal Health Plan*. The program is designed to improve access to health care for Medi-Cal managed care members, as well as provide a broader scope of services to members. There have been program and funding cuts in the state Medi-Cal budget and future changes in Medi-Cal and the disproportionate share hospitals (DSH) program may continue to negatively impact revenue and available services in the hospital and clinic system.

In 2010, the California Endowment launched "*Building Healthy Communities (BHC)*," a 10-year strategic plan designed to improve health systems and the physical, social, economic and service structures that support healthy living and healthy behaviors in California. The California Endowment conducted several years of research within all of California's 58 counties to determine which counties were of the highest need. Out of the 58 counties 14 were chosen to participate in Building Healthy Community program. Merced County is one of the fourteen with three areas being identified for funding; South Merced, Beachwood/Franklin, and Planada/Le Grand. MMC is a participant in the BHC's Hub Steering Committee.

Mercy Medical Center Merced



Lowest Need Highest Need
■ 1 - 1.7 Lowest ■ 1.8 - 2.5 2nd Lowest ■ 2.6 - 3.3 Mid ■ 3.4 - 4.1 2nd Highest ■ 4.2 - 5 Highest

	Zip Code	CNI Score	Population	City	County	State
■	95340	4.8	36029	Merced	Merced	California
■	95348	4.6	29618	Merced	Merced	California
■	94301	4.8	34689	Atwater	Merced	California
■	94388	5	11287	Winton	Merced	California

CNI Median Score: 4.8

Using statistical modeling, the combination of above barriers results in a score between 1 (low need) and 5 (high need). Analysis has indicated significant correlation (96%) between the CNI and preventable hospital admissions. Communities with scores of “5” are more than twice as likely to need inpatient care for preventable conditions (ear infection, etc.) than communities with a score of “1”. The data clearly shows that Merced County with a 4.8 CNI ranking is a “high need” area.

Community Benefit Planning Process

Planning Process: Community Needs Assessment Process

The Community Health Needs Assessment was conducted on behalf of MMC by **Professional Research Consultants, Inc.** (PRC) and completed in April 2012. PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessment (CHNA) such as this in hundreds of communities across the United States since 1994. MMC's primary service areas are Merced, Atwater, and Winton zip codes. The majority of the assessment surveys were conducted in these areas.

Professional Research Consultants, Inc. has begun the process for the next CHNA. Completion will be in the spring of 2015 and results will be reported in the FY 2016 annual community benefit report.

The Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

1. **To improve residents' health status, increase their life spans, and elevate their overall quality of life.** A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
2. **To reduce the health disparities among residents.** By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors which have historically had a negative impact on residents' health.
3. **To increase accessibility to preventive services for all community residents.** More accessible preventive services will prove beneficial in accomplishing the first goal as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System, as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by PRC and Mercy Medical Center, thus to ensure the best representation of the population surveyed, a telephone interview methodology was employed.

The primary advantages of telephone interviewing are timeliness, efficiency and random-selection capabilities. Once the interviews of 400 randomly selected individuals age 18 and older in Merced County were completed, they were weighted in proportion to the actual population distribution so as to appropriately represent Merced County as a whole. To help validate the phone interview findings, two focus groups were conducted and there was the evaluation of existing health related data.

The following “health priorities” represent the top eleven recommended areas of intervention, based on the information gathered by the PRC Community Health Assessment and the guidelines set forth in Healthy People 2020.

- **Access** to health services lack of healthcare coverage, insurance instability, barriers to healthcare access and rating of local healthcare services.
- **Cancer** female breast cancer deaths.
- **Diabetes** and diabetes mellitus deaths.
- **Family planning** teen births.
- **Heart disease & stroke** heart disease deaths, stroke deaths, blood pressure screenings and blood cholesterol screenings,
- **Injury & violence prevention** unintentional injury deaths (including motor vehicle crashes), homicide rate and violent crime rate.
- **Mental health & mental disorders** fair/poor mental health and symptoms of chronic depression.
- **Nutrition, physical activity & weight status** obesity and screen time (children).
- **Oral health** recent dental care (adults) and dental insurance coverage.
- **Respiratory diseases** chronic lower respiratory disease deaths and asthma prevalence (adults).
- **Vision** blindness/trouble seeing and recent eye exams.

MMC has programs and health services to address all of the top eleven identified health priorities except for the following four priorities.

- **Family planning** – Services are being provided in the community by other entities.
- **Injury & violence prevention** – Services are being provided in the community by other entities and hospital does not have expertise in this area.
- **Oral health** – Services are being provided in the community by other entities.
- **Vision** – Services are being provided in the community by other entities.

Developing the Community Benefit Implementation Report and Plan

A series of meetings were held to develop this plan. It was a collaborative process involving the hospital community board, the community advisory committee, the administrative staff and the Dignity Health corporate staff. Representatives of the county department of public health and public schools are members of the community advisory committee. At each of the meetings the members reviewed the Community Need Index along with the community health needs assessment conducted on behalf of MMC by Professional Research Consultants, Inc. (PRC).

Based on this information, each of the identified health issues was considered. These discussions help determine the overall community benefit program and the specific community health classes offered through the Mercy Health Education department, that are related to the community need. Many of these classes were already offered but we did make some adjustments to ensure that relevant areas of the community were a focus of the outreach efforts. In addition to community classes, the Mercy Education Department offered health screenings, attended community health fairs and partnered with other health educators in the community. All the health education programs address a priority health issue identified in the community health needs assessment; diabetes, cancer, heart disease and stroke, nutrition, physical activity and weight status, respiratory diseases and prenatal care.

In the section of this report, “Description of Key Programs and Initiatives,” the Mercy Health Education department classes “Live Well with Diabetes,” “Labor of Love” along with the three rural health clinics, Dignity Health Community Grant Program, and the new “Primary Stroke Center” program have been highlighted. Each community program addresses vulnerable populations, improves the health status of the community, and supplies one or more services that are not provided by any other health care organization in Merced County.

Planning for the Uninsured/Underinsured Patient Population

In planning for the uninsured/underinsured patient population of Merced County the hospital has enacted a corporate wide Financial Assistance/Charity Care policy. This financial assistance information is given to our patients by the Financial Counselors who visit the patients before discharge and assist them through application processes of any government program they may qualify for. The policy and application is also available on the Mercy Medical Center website (mercymercedcares.org).

There is signage throughout the registration departments about the payment assistance program. The brochures are distributed through the registration department as they explain the program. Staff provides information in person to the patients at every opportunity to do so. The information is also included in the patient admission packet. A summary is included at the end of this document as “Attachment B.”

The Dignity Health “Admitting Leadership” team in Sacramento has provided “train the trainer” sessions to the Mercy Medical Center Merced management team. Sessions via WebEx provided training as it relates to the Affordable Care Act (ACA) and Covered California. MMC management is now responsible to train MMC staff on how to inform and direct patients to enroll in the Health Exchange plans.

MMC patient access areas have been provided with pamphlets that have the Dignity Health website where patients can begin enrollment in the Health Exchange plans.

Plan Report and Update including Measurable Objectives and Timeframes

Summary of Key Programs and Initiatives – FY2015

Mercy Medical Center has adopted five core principles to guide the selection and prioritization of Community Benefit program activities.

- **Disproportionate Unmet Health-Related Needs** -Seek to accommodate the needs of communities with disproportionate unmet health-related needs.
- **Primary Prevention** - Address the underlying causes of persistent health problem.
- **Seamless Continuum of Care** - Emphasize evidence-based approaches by establishing operational linkages (i.e., coordination and re-design of care modalities) between clinical services and community health improvement activities.
- **Build Community Capacity** -Target charitable resources to mobilize and build the capacity of existing community assets.
- **Collaborative Governance** - Engage diverse community stakeholders in the selection, design, implementation, and evaluation of program activities.

Below are the major initiatives and key community based programs operated or substantially supported by MMC in 2014. The key programs and initiatives that have been a major focus MMC are:

Initiative I: Improving Access to Healthcare

- Financial Assistance for uninsured/underinsured and low income residents
- Family Practice Clinic
- General Medicine Clinic
- Kids Care Clinic
- Merced County Health Care Consortium
- Healthy Communities Access Program
- Family Practice Residency Program
- Dignity Health Community Grant Program – National Alliance on Mental Illness (NAMI)

Initiative II: Improving Community Health; Education, Prevention and Treatment of Chronic Diseases

- Asthma Coalition
- Community Health Screenings
- Experience Strength and Hope (Cancer)
- Heart Saver CPR/First Aid Training
- MS Challengers (Multiple Sclerosis)
- Smoking Cessation Program
- Diabetes Community Program
- COPD Support Group
- Mercy Emergency Cardiac Care Committee
- Flu Clinic

- South East Asian Community Out Reach
- Dignity Health Community Grant Program – Central California Regional Obesity Prevention Program (CCROPP)
- Mercy Cancer Support Group
- Chronic Disease Self Management Class

Initiative III: Improving Birth Outcomes and Infant Care

- Labor of Love (prenatal care & birthing education)
- Lactation Classes
- Women Infant and Children (WIC) nutrition program
- Dignity Health Grant – JMJ Maternity Homes

Initiative IV: Improving Physical Activity and Dietary Habits

- Mercy Yoga Classes
- Mercy Zumba Classes
- Mercy Dietary Heart Healthy Meals added to menu
- Dignity Health Grant - Atwater Police Activities League, Boys & Girls Club, Love INC. of Greater Merced and Central CA Regional Obesity Prevention Program (CCROPP)

Initiative V: Improving Community Capacity (Mercy’s partnerships with)

- Building Healthy Communities – The California Endowment
- Merced County Bi-National
- Merced County Office of Education ROP/Adult Education
- United Way Of Merced County
- American Heart Association
- Merced/Mariposa Cancer Society
- Merced Lao Family Community Inc.
- Multiple Sclerosis Association
- Central CA Health Alliance
- Hinds Hospice “Angel Babies”
- Merced/Fresno Area Task Force (emergency preparedness)
- Merced County Medical Reserve Corp
- Merced College

PROGRAM DIGEST

These implementation strategies specify community health needs that the Hospital has determined to meet in whole or in part and that are consistent with its mission. The Hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During the three years ending December 31, 2015, other organizations in the community may decide to address certain needs, indicating that the Hospital then should refocus its limited resources to best serve the community.

Primary Stroke Center	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Heart Disease & Stroke X Access to Health Services <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes X Nutrition, Physical Activity & Weight Status <input type="checkbox"/> Respiratory Diseases
Program Emphasis	<ul style="list-style-type: none"> X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Health Needs Assessment	<ul style="list-style-type: none"> • Heart disease and stroke; heart disease deaths, stroke deaths, blood pressure screenings, blood cholesterol screenings. • Access to Health Services; addresses rating of healthcare services, lack of healthcare coverage and barriers to healthcare access.
Program Description	<p>“Primary Stroke Center” will ensure that patients with stroke symptoms are treated immediately upon arrival at the Emergency Department. By implementing a special code called a “Stroke Alert” the stroke team quickly gets into position for treatment. Part of the program will be to educate the community to the “Act FAST” signs of a stroke from the National Stroke Association.</p>
FY 2014	
Goal FY 2014	<ul style="list-style-type: none"> • Goal is to certify nurses through a 38 hour course in stroke and stroke care. • To continue to lease the Telehealth Network telemedicine robot and connect to the program hub at Mercy General and Mercy San Juan. • To be re-certified as a “Primary Stroke Center” by the Joint Commission. • To educate the community about stroke and the “Act FAST” signs of stroke.
2014 Objective Measure/Indicator of Success	<p>The Joint Commission certified Mercy Medical Center as a “Primary Stroke Center.” MMC sponsored a 5K “Stroke Run” along with a community health fair with the purpose of educating the community to the signs and symptoms of a stroke as well as risk factors and prevention.. Patients coming to the ED that are identified as “Stroke Alert” patients are evaluated within 10 minutes, within 25 minutes the patient has a CT of their head, within 45 minutes the CT is read to determine course of treatment – treat on-set of stroke symptoms within 3 hours. EMS alerts the hospital of possible stroke patient while in route to the hospital.</p>
Baseline	<p>Together cardiovascular disease (heart disease and stroke) and cancers accounted for more than one-half of all 2008 deaths in Merced County. Merced County</p>

	rates fail to satisfy the Healthy People 2020 objectives, Merced for heart disease 207.5 vs. Healthy People 2020 152.7. Based on 2006 – 2008 deaths per 100,000. Currently Mercy Medical Center is the only “Primary Stroke Center” in Merced County.
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> • Enroll all new RN’s in the certification program for stroke and stroke care training. • Maintain the Telehealth Network telemedicine robot with the programs network of seven partner hospitals. Stroke specialists are available 24/7. • Prepare for re-certification by Joint Commission. • Community education included a MMC annual “Family Health Festival” with a booth featuring the robot and stroke educational materials; MMC sponsored a 5K “Stroke Awareness” run (600 participants an increase of 400 runners from 2013), MMC community newsletter featured a four page article titled, “All About Stroke”, sent to 30,000 households and produced 500 stroke risk cards to be distributed at health fairs. • MMC community educators visited service clubs and community health fairs. • A stroke support group began meeting and is run by hospital staff.
Result FY 2014	Over 2,000 outpatient community members were presented stroke information by MMC. In the six month period January 2014 to June 2014 there were 210 “stroke alert” ED patients that received stroke treatment within the 3 hour minimum required time for treatment. That is an increase from 2013 of 110 patients.
Hospital’s Contribution / Program Expense	Cost for the service line = \$45,650 Price includes stroke reorientation for all of the nursing staff and rental costs of the Telemedicine Robot.
FY 2015	
Goal 2015	To receive recertification by the Joint Commission advance accreditation as a “Primary Stroke Center.” Continue training staff with annual stroke and stroke care competencies. Tracking “stroke alert” patients along with turnaround times of CT and Lab results. Continue the 5K “Stroke Awareness” run. Increase the number of attendees in the stroke support group.
2015 Objective Measure/Indicator of Success	Patient data is collected on each patient entering in as a “Stroke Alert” patient. Data collected meets the standards set by the American Stroke Association and the Brain Attack Center. Increase the awareness of the “Stroke Support Group” to the community. Plan for the 5K “Stroke Awareness” run and present stroke educational materials to the community at the annual Mercy Health Fair.
Baseline	Currently there is no other “Primary Stroke Center” in Merced County. MMC will be the only ED available for the community to receive the fastest stroke treatment within the critical 3 hour time period.
Implementation Strategy for Achieving Goal	MMC will continue with community education and prepare for the Joint Commission recertification for being a “Primary Stroke Center.” Continue with staff education and competencies for stroke intervention and for staff recertification.
Community Benefit Category	A1 Community Health Education C1 Special Services

Family Practice Clinic (FPC)	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Heart Disease & Stroke X Access to Health Services X Cancer X Diabetes X Nutrition, Physical Activity & Weight Status X Respiratory Diseases
Program Emphasis	<ul style="list-style-type: none"> X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	Poor, underinsured and working poor individuals who would not otherwise have access to health care, treatment and prevention.
Program Description	Family Care is a Rural Health Clinic. Is a training clinic for the Family Practice Residency Program in affiliation with UC Davis.
FY 2014	
Goal 2014	<ul style="list-style-type: none"> • Complete implementation of electronic medical record (EMR) • Retasure machine to check retina of diabetic patients • Add 2 Nurse Practitioners or Physician Assistants • Increase the number of Nurse Practitioners students we precept to 4
2014 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Every provider documenting electronically • Active charts abstracted into the EMR • Retasure machine installed and staff trained to take photos • 2 Nurse Practitioners (NP) or Physician Assistants (PA) hired • Precept 4 Nurse Practitioners students
Baseline	<ul style="list-style-type: none"> • 31,148 visits FY13 with an average of 2,596 patients a month (excludes lab & radiology tests) • 3,557 charity visits (sliding fee and free) which equal 12% of the revenue • 9,329 county indigent care (MAP) which equal 19% of the revenue
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> • Finish EMR implantation • Purchase Retasure and plan training strategies • Increase recruiting to hire 2 NP or PA • Work with NP to be able to add to the number of students they can precept
Result FY 2014	<ul style="list-style-type: none"> • NextGen (electronic medical record) went live January 21, 2014 • Retasure machine was purchased in June with the benefit of the foundation. ✓ The clinic has not begun implementation yet. ✓ Dr. Jeffery Lee & Dr. Matt Lee have agreed to read the retina scans. ✓ Will carry into FY 15 for full implementation • One offer has been extended to a NP. • NP students ✓ Three (3) NP students are doing their practicum at FPC ✓ Four (4) NP students are doing their introduction to hands on care at

	<p>FPC with their instructor two (2) nights a week</p> <ul style="list-style-type: none"> • The “Women’s Service Line” was not implemented. ✓ Due to provider changes in pediatrics ✓ Providers are for the implementation, but realize that we need to focus on obtaining pediatric providers (MD and NP). ✓ One FT NP was hired and the facility is in the process of making an offer to an experienced
Hospital’s Contribution / Program Expense	<ul style="list-style-type: none"> • 26,551 visits FY14 with an average of 2,213 patients a month (excludes lab & radiology tests) • The clinic continues to provide charity visits (sliding fee and free). The financials aren’t completed to provide the percentage of the visits that were charity. • Telephone survey found that 75% of our county MAP patients applied for Patient Protection and Affordable Care Act (Clinic phone survey 2.2014). ✓ The change from MAP to Managed Medical is a great improvement in the health care that can be provided. ✓ Managed Medical for Merced County is through Central California Alliance (CCA). ✓ CCA provides and promotes preventative care that is evidence based and age specific • The implementation of the Patient Protection and Affordable Care Act has provided more clients the opportunity to have managed medical, thus reducing the applicants for sliding fee scale.
FY 2015	
Goal 2015	<ul style="list-style-type: none"> • Complete implementation of the Retasure machine • Add one (1) NP or PA to the team • Residency program recruit two (2) second year residents (program is short 2) • Increase the patient visits by 10%
2015 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Retasure ✓ Every LVN trained to use the Retasure machine ✓ Contract completed with Dr. Jeffery Lee & Dr. Matt Lee ✓ Providing screening to diabetic patients and other high risk clients • Monitor the volume of pediatric visits for FPC monthly
Baseline	<ul style="list-style-type: none"> • 26,551 visits FY14 with an average of 2,213 patients a month (excludes lab & radiology tests) • No current in-house screening of patients retina’s
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> • Retasure ✓ Training to begin November for LVN’s to use the Retasure machine ✓ Contract completed with Dr. Jeffery Lee & Dr. Matt Lee ✓ Providing screening to diabetic patients and other high risk clients • Local recruiting and the use of a recruiting company for a FT NP/PA • Volume ✓ Increasing providers to full complement ✓ Implement Primary Care Medical Home techniques to increase volume ✓ Wok with Marketing to advertise the clinic and services

Community Benefit Category	C3. Subsidized Health Services: Hospital Outpatient Services
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General Medicine Clinic	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Heart Disease & Stroke X Access to Health Services X Cancer X Diabetes X Nutrition, Physical Activity & Weight Status X Respiratory Diseases
Program Emphasis	<ul style="list-style-type: none"> X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	Addressing the needs of individuals identified as poor or disenfranchised and in need of specialty health related services to treat chronic health conditions.
Program Description	<ul style="list-style-type: none"> • To provide specialty clinics to cover services that are not available to the poor, underinsured and working poor individuals in the community. • Specialty physicians rotate through the clinic to provide orthopedic, podiatry, neurology nephrology, cardiology, urology, gastroenterology, pulmonary and surgery. • Educational opportunity working with specialist for residents and medical students
FY 2014	
Goal FY 2014	<ul style="list-style-type: none"> • Increase access to Center for Diabetes • Increase access to ENT specialist
2014 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Add 1 Registered Nurse diabetic educator • Add a ENT specialist
Baseline	<ul style="list-style-type: none"> • 15,183 visits FY13 with an average of 1,265 patients a month (excludes lab & radiology tests) • 1,313 charity visits (sliding fee and free) which equal 9% of the revenue • 2,771 county indigent care (MAP) which equal 19% of the revenue
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> • Recruit a Registered Nurse to be a diabetic educator • Recruit an ENT specialist
Result FY 2014	<ul style="list-style-type: none"> • GMC had a thirteen percent (13%) decrease in volume for FY 14. ✓ Contributing factors for this was the implementation of electronic medical; record system in January. ✓ Although a full-time Center For Diabetes (CFD) educator was hired the two (2) part-time CFD educators went out on an extended medical leave. • An ENT from the Mercy Foundation was recruited but he has yet to work out a process that allows him to maximize the Foundation and GMC for visits.

Hospital's Contribution / Program Expense	<ul style="list-style-type: none"> • 13,238 visits FY14 with an average of 1,103 patients a month (excludes lab & radiology tests) • The clinic continues to provide charity visits (sliding fee and free). The financials aren't completed to provide the percentage of the visits that were charity. • The implementation of the Patient Protection and Affordable Care Act has provided more clients the opportunity to have managed medical, thus reducing the applicants for sliding fee scale.
FY 2015	
Goal FY 2015	<ul style="list-style-type: none"> • Increase patient visits to Center for Diabetes by 10% • Recruit a Nurse Practitioner (NP) • Recruit another Cardiologist
2015 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Increase CFD patient visits by 10% • Hiring a full-time (FT) NP • One (1) Cardiologist added to schedule to see patients at a minimum of once a month • Monitor the volume of pediatric visits for GMC monthly; specifically CFD and Cardiology
Baseline	<ul style="list-style-type: none"> • 13,238 visits FY14 with an average of 1,103 patients a month (excludes lab & radiology tests) • CFD visits for FY 14 were 2,761 • Cardiology visits for FY 14 were 239
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> • Local recruiting and the use of a recruiting company for a FT NP • Work with Mercy Medical Center physician Recruiter for Cardiologist
Community Benefit Category	C3. Subsidized Service, Hospital Outpatient Services

Kid's Care Clinic	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Heart Disease & Stroke X Access to Health Services <input type="checkbox"/> Cancer X Diabetes X Nutrition, Physical Activity & Weight Status X Respiratory Diseases
Program Emphasis	<ul style="list-style-type: none"> X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	Poor, underinsured and working poor individuals who would not otherwise have access to health care and treatment
Program Description	<ul style="list-style-type: none"> • Pediatric and obstetrics clinic in collaboration with Merced Faculty Associates. • Educational opportunity working with pediatricians and OB/GYN for residents and medical students
FY 2014	

Goal 2014	<ul style="list-style-type: none"> • Complete implantation of electronic medical record (EMR) • Implement “Women’s Service Line”
2014 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • “Women’s Service Line” to have 25 patients • Every provider documenting electronically • Active charts abstracted into the EMR
Baseline	<ul style="list-style-type: none"> • 13,638 visits FY13 with an average of 1,136 patients a month (excludes lab & radiology tests) • 264 charity visits (sliding fee and free) which equal 2% of the revenue
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> • Training to have begun for implementation of EMR • Team approach to accomplish “Women’s Service Line” services ✓ Protocols ✓ Appropriate billing and documentation ✓ Staff training
Result FY 2014	<ul style="list-style-type: none"> • NextGen (electronic medical record) went live January 21, 2014 • The “Women’s Service Line” was not implemented. ✓ Due to provider changes in pediatrics ✓ Providers are for the implementation, but realize that we need to focus on obtaining pediatric providers (MD and NP). ✓ One full-time (FT) Nurse Practitioners (NP) was hired and the facility is in the process of making an offer to an experienced FT NP ✓ Looking for a Locum Pediatrician
Hospital’s Contribution / Program Expense	<ul style="list-style-type: none"> • 11,324 visits FY14 with an average of 944 patients a month (excludes lab & radiology tests) • The clinic continues to provide charity visits (sliding fee and free). The financials aren’t completed to provide the percentage of the visits that were charity. • The implementation of the Patient Protection and Affordable Care Act has provided more clients the opportunity to have managed medical, thus reducing the applicants for sliding fee scale.
FY 2015	
Goal 2015	<ul style="list-style-type: none"> • Increase the business for pediatric visits by 10%
2015 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Monitor the volume of pediatric visits for Kids Care Monthly • Recruit second FT NP • Obtain a Locum or local Pediatricians to see patients at the clinic
Baseline	<ul style="list-style-type: none"> • 11,324 visits FY14 with an average of 944 patients a month (excludes lab & radiology tests)
Implementation Strategy for Achieving Goal	<ul style="list-style-type: none"> • Local recruiting and the use of a recruiting company for both a FT NP and pediatrician
Community Benefit Category	C5 Women and Children’s Services

Dignity Health Community Grants Program	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Heart Disease & Stroke X Access to Health Services X Cancer

	<p>X Diabetes</p> <p>X Nutrition, Physical Activity & Weight Status</p> <p>X Respiratory Diseases</p>
Program Emphasis	<p>X Disproportionate Unmet Health-Related Needs</p> <p>X Primary Prevention</p> <p>X Seamless Continuum of Care</p> <p>X Build Community Capacity</p> <p>X Collaborative Governance</p>
Link to Community Needs Assessment	Addressing the needs of individuals identified as poor or disenfranchised and in need of health related services to improve their quality of life.
Program Description	This is a grant program designed to give needed funds to community organizations or agencies that are a 501 (c) 3 and that are providing services to underserved populations to improve the quality of their lives. Focus of the grant is identified by the needs described in the community needs assessment.
FY 2014	
Goal FY 2014	To distribute \$124,284 in grants to organizations or agencies meeting the grant requirements and whose proposal is approved by the Community Advisory Committee (CAC) and the Dignity Health Investment Committee.
2014 Objective Measure/Indicator of Success	Community Advisory Committee members carefully reviewed letters of intent, requested funds totaled over \$500,000. Nine organizations were invited to complete a full proposal. Proposals were reviewed by the Community Advisory Committee and then recommendations were sent to Dignity Health for final approval. Programs awarded will be evaluated by Dignity Health Corporate Board.
Baseline	There are many 501 (c) 3 organizations that fulfill a community health-related need effectively and/or efficiently when partnered with the hospital. Monies awarded through the grants program helps to sustain health related programs in the community and/or provide funding for startup programs focusing on health related issues that were identified in the 2012 Community Needs Assessment.
Implementation Strategy for Achieving Goal	Once the Community Advisory Committee reviewed the 2012 Community Needs Assessment they focused on those areas for the grant, notification of the announcement to complete letters of intent were distributed throughout Merced County. PSA's ran in the local newspapers and announcements were distributed to Merced County non-profit agencies. A feature story was written for the local newspaper by the paper reporter. Agencies were invited to submit a "Letter of Intent (LOI)." A total of 22 LOI's were received, totaling over \$500,000 in requested funds. The Community Advisory Committee met, reviewed the LOI's and voted on nine of the agencies to submit a full proposal. Once the proposals were received the Community Advisory Committee met again, reviewed the proposals and voted on six agencies to receive a grant awards. Recommendations were sent to Dignity Health for final approval.
Result FY 2014	<p>\$124,284 in grant money awarded to the community for the purpose of improving the quality of life of the residents of Merced County.</p> <p>Agencies receiving grant funds were:</p> <ul style="list-style-type: none"> • Boys & Girls Clubs of Merced County - \$35,000 Seed money to begin the nationally recognized fitness and wellness program for elementary children called "Triple Play". • Central CA Regional Obesity Prevention Program (CCROPP) - \$50,000. Emphasize prevention of obesity through health education and physical activities.

	<ul style="list-style-type: none"> • Atwater Police Activities League (PAL) - \$14,284 Provides at risk youth a place to learn about health and physical activities. There is a game arena, gym and a boxing center. • Love INC. of Greater Merced - \$5,000 Provides “Love Plus Program” a 16 week education, mentoring and support services program for low income families. Tools for healthier living. • JMJ Maternity Homes - \$10,000 Provides homeless pregnant women 18 years and older with shelter, resources and support services for the mother through pregnancy and for several months thereafter. • National Alliance on Mental Illness (NAMI) - \$10,000 Outreach program for individuals with mental illness and support for family members and friends.
Hospital’s Contribution / Program Expense	Distributed grant brochures, ran an ad in the local newspapers and a massive email distributed through United Way. Provided PSA’s to local media sources. Community Advisory Committee reviewed LOI’s, reviewed full proposals and made recommendations to Dignity Health. Awarded grant money to local agencies, totaled \$124,284 + MMC’s cost for operational expenses.
FY 2015	
Goal FY 2015	Grant program awardees to submit program accountability report to Dignity Health May 2015. The Dignity Health Community Grant awards will be awarded January 2014 at the CAC meeting. Total grant money available is \$115,888.
2015 Objective Measure/Indicator of Success	Individual grantees will monitor their programs and Dignity Health/MMC will review progress and determine if proposal goals have been met.
Baseline	Continue to provide Dignity Health Community Grant money to nonprofit organizations that share our values and work to improve the health status and quality of life in our community. Focus of the grant proposals will meet the requirements of the Community Needs Assessment.
Implementation Strategy for Achieving Goal	Community Advisory Committee will meet to determine the focus for the FY 2015 grant; grant reports will be in the FY15 CB report. Continue with distribution of announcement letters and brochures and media advertisement. Community Advisory Committee members will review the proposals in September 2015.
Community Benefit Category	E1 Financial Contributions: Grants

Labor of Love	
Hospital CB Priority Areas	<input type="checkbox"/> Heart Disease & Stroke <input checked="" type="checkbox"/> Access to Health Services <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input checked="" type="checkbox"/> Nutrition, Physical Activity & Weight Status <input type="checkbox"/> Respiratory Diseases
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
Link to Community Needs Assessment	Between 2007 and 2009, 7.0% of all Merced County births received late (starting in the third trimester) or no prenatal care. This is more than twice the California

	proportion. A total of 13.2% of 2007 to 2009 Merced County births were to teenage mothers. This is higher than the California and national proportion. Low birth weight babies, weighing less than 5 pounds, 8 ounces at birth, are much more prone to illness and neonatal death than are babies of normal birth weight.
Program Description	This program prepares expectant mothers for the childbirth experience, including the stages of labor, what to expect during pregnancy and delivery, covers the importance of prenatal care, breastfeeding and infant health care.
FY 2014	
Goal FY 2014	To increase the program's capability to enroll more expectant mothers, to encourage breastfeeding and prenatal care. Outreach to more teenage mothers and women of low income and/or uninsured.
2014 Objective Measure/Indicator of Success	Increase enrollment – achieve by getting more physician referrals. Collaborate with other organizations that have lost their funding for childbirth classes. Expand the distribution of educational materials in the community. To add a new breast feeding class to the program.
Baseline	Currently there are no other, no cost, child birth classes offered in Merced County due to a lack of funding.
Implementation Strategy for Achieving Goal	Outreach measures to other organizations to provide needed information and materials. Increase the enrollment by communicating course information to Family Practice Clinic and Golden Valley Health Clinics and community OB GYN physicians. Listing of class schedules available at clinics and in the hospital community newsletter. MMC Community newsletter is sent to over 30,000 households. Information was also included in the Merced College newsletter.
Result FY 2014	Enrollment totaled 96 women and their partners. 10% were unable to complete the course usually due to a change in due date.
Hospital's Contribution / Program Expense	Hospital provided space, refreshments, educational materials and instructors. Cost \$28,322.
FY 2015	
Goal 2015	<ul style="list-style-type: none"> • Increase enrollment by more community outreach especially to pregnant teenager by contacting a local high school that enrolls the pregnant teens. • Add a Saturday class. • Encourage enrollment in the breastfeeding class. FY 14 saw an increase by 30% looking for a 50% increase in FY15. • In partnership with Sierra Vista Children's Services a new postpartum depression support group will be offered to the community, due to a very low census in FY14 the program is on hold. • A memorandum of understanding was signed with Castle Family Health Centers to add a class at the Castle facility.
2015 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Expand program's accessibility to women in the community by adding a Saturday class and a class at Castle Family Health Center. • Continue outreach to Livingston Medical Group and Golden Valley Health Centers. • Increase accessibility to non-English speaking women in the community by offering the program in Spanish • The "First Five" program "Before and After Baby" is no longer being funded therefore in order to meet the need, Mercy Education began+ offering the class "Lactating With Love". • Total enrollment will be higher than 168 attendees.
Baseline	Currently there are no other child birth classes offered at no cost in Merced County due to a lack of funding.

Implementation Strategy for Achieving Goal	Enhance current practices to improve the continuum of care with hospital departments, community clinics and collaborative community partners. Partner with Family Care and the public health indigent care program (MAP) to improve awareness and access to programs. Increase program awareness at the local high schools.
Community Benefit Category	A1 Community Health Education

Live Well With Diabetes

Hospital CB Priority Areas	<input type="checkbox"/> Heart Disease & Stroke <input checked="" type="checkbox"/> Access to Health Services <input type="checkbox"/> Cancer <input checked="" type="checkbox"/> Diabetes <input checked="" type="checkbox"/> Nutrition, Physical Activity & Weight Status <input type="checkbox"/> Respiratory Diseases
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 Collaborative Governance <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	<p>Between 2006 – 2008, there was an annual average age-adjusted diabetes mortality rate of 25.8 deaths per 100,000 populations in Merced County.</p> <ul style="list-style-type: none"> • Less Favorable than that found statewide. • Less favorable than the national rates. • Fails to satisfy the Healthy People 2020 target (19.6 or lower). Merced County diabetes mortality rate is higher among Hispanics than Whites. • Non-Hispanic White deaths per 100,000 22.4 • Hispanic deaths per 100,000 30.1 <p>Among adults with diabetes, most (81.9%) are currently taking insulin or some type of medication to manage their condition.</p>
Program Description	This is a weekly program that teaches strategies for understanding, managing and living with diabetes. It's a multi-purpose support program that features medical professional guest speakers, interactive educational experiences and develops personal actions plans. Program is offered in English and Spanish.
FY 2014	
Goal FY 2014	<ul style="list-style-type: none"> • To help prevent health complications of diabetes and help diabetic patients to manage their diabetes. • To strengthen program by offering more professional speakers in English, Spanish and Hmong. To provide a Hmong Shaman class on diabetes. • Improve the inpatient tracking of diabetic patients by establishing a Meditech link that will generate a report for patient follow up.
2014 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • A total of approximately 861 people were reached with diabetic education and or by having a free blood sugar health screening. • Current tracking of the diabetic patient is by self reporting. In the first six months of FY 2014 2% of the diabetic patients attending the “Living with Diabetes” class had a post intervention in the hospital.

	<ul style="list-style-type: none"> • An inpatient brochure in English and Spanish that has diabetic information and provides information regarding the resources that Mercy Medical Center provides. • The diabetes weekly classes were restructured to a four part series offered three times a year and was offered in Hmong, English and Spanish.
Baseline	There are no other ongoing community (free of charge) educational diabetes classes in Merced County that offer both English and Spanish instructions. This program provides a diabetes support group. Between 2006 and 2008 there was an annual average age-adjusted diabetes mortality rate of 25.8 deaths per 100,000 populations Merced County. This is less favorable than that found statewide and that of the national rate. 25.8 also fail to satisfy the Healthy People 2020 target of 19.6 or lower.
Implementation Strategy for Achieving Goal	Community health educators provide follow-up contacts with participants and track their progress.
Result FY 2014	There was an increase of 187 persons that were provided diabetic education and/or a free blood sugar health screening. An educational diabetic four hour class was offered in Hmong to the Hmong community.
Hospital's Contribution / Program Expense	Hospital's contribution increased to \$22,257 for educational materials, supplies and instructor salaries. Also added diabetes materials to 1,295 discharged patients for a cost of \$10,473.
FY 2015	
Goal 2015	<ul style="list-style-type: none"> • To help prevent health complications of diabetes and help diabetes patients to manage their diabetes. • To strengthen program by offering more professional speakers in English, Spanish and Hmong. • Continue tracking the inpatient diabetic patients with the Meditech link and establish a follow-up for the frequent readmitted diabetic patients.
2015 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Enrollment will increase in the "Living with Diabetes" Spanish and English classes. • A Hmong Shaman four hour diabetes education class will be presented. • Increase number of patients being tracked in Meditech and track the frequent readmitted diabetic patients... • Expand community awareness by having a community diabetes education moved to the "Center for Diabetes".
Baseline	There are no other ongoing community (free of charge) educational diabetes classes in Merced County that offer English, Hmong and Spanish instructions. Between 2006 and 2008 there was an annual average age-adjusted diabetes mortality rate of 25.8 deaths per 100,000 populations Merced County. This is less favorable than that found statewide and that of the national rate. 25.8 also fail to satisfy the Healthy People 2020 target of 19.6 or lower.
Implementation Strategy for Achieving Goal	Diabetic patients to be tracked in Meditech. Reach out to Merced Loa Family for Hmong referrals for the class. Current weekly diabetes class will be modeled to be more of a diabetes support group. Classes will begin to take place at the "Center for Diabetes". Collaborate

	with the Mercy rural health clinics to reach more diabetic patients.
Community Benefit Category	A1 Community Health Services

Chronic Disease Self Management Program	
Hospital CB Priority Areas	<input checked="" type="checkbox"/> Heart Disease & Stroke <input type="checkbox"/> Access to Health Services <input checked="" type="checkbox"/> Cancer <input checked="" type="checkbox"/> Diabetes <input checked="" type="checkbox"/> Nutrition, Physical Activity & Weight Status <input checked="" type="checkbox"/> Respiratory Diseases
Program Emphasis	<input type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	CDSMP meets one of the three basic goals of the Community Needs Assessment; to improve residents' health status, increase their life spans, and elevate their overall quality of life. A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
Program Description	This is a six-week comprehensive, outcomes-based program developed by Stanford University which includes education and action planning for participants living with a chronic disease. Management tools help to control symptoms such as pain and difficult emotions; improving nutrition, physical activity, health literacy and communication with physicians; managing medications and making appropriate plans that work with their lifestyle.
FY 2014	
Goal FY 2014	Expand the CDSMP by offering more workshops and increase the number of participants to reduce readmissions and improve quality of life and self-management skills. Complete a Leader Training class for community health care professionals. Expand the CDSMP to include a Spanish workshop.
2014 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Offer a Leader Training class and include MMC staff in the course. • Four CDSMP workshops to be offered in the community. • Community Partners completing the Leader Training; • Master Trainer will complete the Spanish CDSMP training.
Baseline	As reported in the Community Needs Assessment, Merced County's mortality rates are worse than national rates for diseases of the heart, stroke, CLRD (chronic lower respiratory disease), diabetes mellitus and cirrhosis/liver disease. In Merced County a total of 17.2% adults report their overall mental health as fair to poor. This is a less favorable percentage than the national 11.7%. Lung cancer death rates are higher than the state rate and female breast cancer is higher than both the California and US rates.
Implementation Strategy for Achieving Goal	Sent two staff to Stanford to become Master Trainers. Applied for funding from the Mercy Medical Center Foundation for materials and for workshop books.
Result FY 2014	<ul style="list-style-type: none"> • Two staff completed the Stanford Master Training Class in FY13 and one more Master Trainer was trained in FY14. • Three CDSMP workshops were completed with the minimum of ten participants in each workshop. Total workshop hours were 144. • A four day, 24 hour Lay Leader Training workshop was attended by 14

	<p>community members.</p> <ul style="list-style-type: none"> • Two Master Trainers were also trained in the Spanish CDSMP workshop “Tomando”. • Three Tomando workshops were presented to the community
Hospital’s Contribution / Program Expense	MMC’s contribution totaled \$11,958. Total includes Leader Trainers time, materials, room and snacks.
FY 2015	
Goal 2015	Expand the CDSMP by offering more workshops and increase the number of participants to reduce readmissions and improve quality of life and self-management skills. Complete one Leader Training class for community health care professionals and or community members. Continue the “Tomando” workshop. Staff to increase referrals of inpatients for the CDSMP workshops. We are working on including the order entry in the EMR.
2015 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Maintain the current number of workshops in English and Spanish. • Complete a Master Training workshop. • Staff will use the new referral form for inpatients. • Will increase community knowledge about workshops.
Baseline	As reported in the Community Needs Assessment, Merced County’s mortality rates are worse than national rates for diseases of the heart, stroke, CLRD (chronic lower respiratory disease), diabetes mellitus and cirrhosis/liver disease. In Merced County a total of 17.2% adults report their overall mental health as fair to poor. This is a less favorable percentage than the national 11.7%. Lung cancer death rates are higher than the state rate and female breast cancer is higher than both the California and US rates.
Implementation Strategy for Achieving Goal	Collaborate with local partners, recruit and retain leaders, secure additional funding, and expand program into other areas.
Community Benefit Category	A1 Community Health Education

Community Benefit and Economic

Mercy Medical Center uses the cost accounting methodology to determine the net benefit for Medicare, MediCal, traditional charity and means tested programs.

9/11/2014
 211 Mercy Medical Center Merced
 Complete Summary - Classified Including Non Community Benefit
 For period from 7/1/2013 through 6/30/2014

	Persons	Expense	Total Organization Revenue	Offsetting Benefit	Net Expenses	% of Revenues
<u>Benefits for Living In Poverty</u>						
Financial Assistance	21,430	6,183,362	0	6,183,362	2.6	2.7
Medicaid	91,250	81,967,678	51,788,019	30,179,659	12.7	13.3
Means-Tested Programs	10,344	4,087,879	470,458	3,617,421	1.5	1.6
Community Services						
Community Benefit Operations	20	14,768	0	14,768	0.0	0.0
Community Health Improvement Services	2	298	0	298	0.0	0.0
Financial and In-Kind Contributions	2	375,230	0	375,230	0.2	0.2
Totals for Community Services	24	390,296	0	390,296	0.2	0.2
Totals for Living In Poverty	123,048	92,629,215	52,258,477	40,370,738	17.0	17.8
<u>Benefits for Broader Community</u>						
Community Services						
Community Benefit Operations	15	419,583	0	419,583	0.2	0.2
Community Building Activities	99	4,981	910	4,071	0.0	0.0
Community Health Improvement Services	18,938	368,917	680	368,237	0.2	0.2
Financial and In-Kind Contributions	2,379	170,864	0	170,864	0.1	0.1
Health Professions Education	26	4,420,743	3,182,079	1,238,664	0.5	0.5
Totals for Community Services	21,457	5,385,088	3,183,669	2,201,419	0.9	1.0
Totals for Broader Community	21,457	5,385,088	3,183,669	2,201,419	0.9	1.0
Totals - Community Benefit	144,505	98,014,303	55,442,146	42,572,157	17.9	18.7
Medicare	30,271	93,655,640	72,811,827	20,843,813	8.8	9.2
Totals with Medicare	174,776	191,669,943	128,253,973	63,415,970	26.7	27.9

Telling the Story

MMC reports community benefit to be accountable – to our staff, physicians, donors, boards – and most of all to our community. Our mission and values guide our goals and activities. Reporting community benefit demonstrates to our community that “we walk the talk.”

Reporting community benefit is necessary to fulfill government requirements, but it also answers a number of other needs. The most important reasons to report community benefit are:

- Social accountability
- Legal requirements
- Strengthening constituent relationships
- Fostering dialogue on health care policy

We use several methods to communicate our programs and community benefit to the public.

- MMC services and educational classes are published in the two local newspapers; deliver to 30,000 homes a quarterly community newsletter which features class listings and articles about community health related issues.
- Local media – including Spanish – print feature stories and run regular press releases. Paid advertisement is used to promote our current and new classes, health services and community partnerships
- To reach the South East Asian population we have partnered with local agencies, United Way and Merced Lao Family, to disperse information.
- Mercy sponsored in FY 14 a Western medicine education class for the local Hmong Shaman.
- The hospital lobby electronic media board continuously provides information on community benefit. This information is provided in partnership with Mercy Foundation, Mission Integration and Marketing. By having this partnership/committee all of our community and internal outreach focuses on our Mission, Vision and Values.
- A MMC quarterly physician newsletter is published and distributed to over 250 physicians.
- Monthly presentations are given to various county service organizations/clubs.
- The Community Benefit Report and Implementation Plan are posted on the Dignity Health website and also on the facility website.

Attachments

Attachment A

Mercy Administration Community Board and Community Advisory Committee Rosters

Hospital Administration

A six-member senior management team operates the hospital administration.

- David Dunham, President
- Chuck Kassis, VP Operations
- Mike Strasser, CFO/VP Finance
- Gregory Rouleau, VP Nursing Services/CNE
- Robert Streeter, M.D., VP Medical Affairs
- Kathy Kohrman, VP/Strategy and Business Development

Community Board

A fourteen-member board supports the vision, mission, values, charitable and philanthropic goals of the hospital and Dignity Health. Members are regarded in their community as respected and knowledgeable in their field, are contributing citizens in their community and are knowledgeable about or willing to become educated about hospital and healthcare matters.

- Walter Adams, III – Retired Branch Manager/Crop Consultant
- John Aleman, M.D. – Family Practice
- Benjamin Duran – President, Greater Valley Center, Board Chair
- Marc Garcia – Merced Superior Court Judge
- Sr. Cornelius O’Connor, RSM, VP/Mission Integration
- Gary Tamkin, M.D. – Chief of Staff
- Paul C. Lo, Superior Court Judge, Vice Board Chair
- Barry McAuley – Auto Dealership
- Sr. Abby Newton, OP – VP/Mission Integration
- John Raggio – Retired, Municipal Government
- Atulkumar Roy, M.D. – Nephrology/Internal Medicine
- Cynthia Temple – Accounting Firm, Board Secretary
- Janet Young – Retired Associate Chancellor and COS, UC Merced
- David S. Dunham – Hospital President (Ex-Officio)

Community Advisory Committee

Members support the mission, vision, and values, of Mercy Medical Center and are knowledgeable and understand the medical needs of Merced County. They have been residents of the county for five or more years and at least seven members represent the medically underserved.

- Cora Gonzales – Livingston Medical Retired
- John Aleman, M.D. – Family Practice
- Marilyn Mochel – Community Advocate
- Kathleen Grassi – Merced County Health Department
- Lee Lor – Merced County Superintendent of Schools
- Gilbert Olquin – Central California Legal Services
- Mae Pierini – Retired
- John Raggio – Retired
- Penny Sawyer – WestMed College
- Tony Slaton – Boys & Girls Club
- Hub Walsh – Merced County Board of Supervisors
- Claudia Corchado – United Way (CROPP)
- Mary Eddings – Community Advocate

Mercy Medical Center Staff

- David Dunham – Hospital President
- Chuck Kassis – VP/Chief Operating Officer
- Greg Rouleau – VP/Chief Nursing Officer
- Dr. Robert Streeter – VP/Medical Affairs
- April Brewer – Director of Rural Health Clinics
- Janice Wilkerson – Mission Integration Director

Attachment B

Financial Assistance/Charity Care Policy

DIGNITY HEALTH
SUMMARY OF PATIENT PAYMENT ASSISTANCE POLICY
(June 2012)

Policy Overview:

Dignity Health is committed to providing payment assistance to persons who have health care needs and are uninsured or under-insured, ineligible for a government program, and otherwise unable to pay for medically necessary care based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable health care services, and to advocate for those who are poor and disenfranchised, Dignity Health strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Payment assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with Dignity Health's procedures for obtaining payment assistance, and to contribute to the cost of their care based on individual ability to pay. Individuals with financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.

Eligibility for Patient Payment Assistance:

- Eligibility for payment assistance will be considered for those individuals who are uninsured, ineligible for any government health care benefit program, and unable to pay for their care, based upon a determination of financial need in accordance with the policy.
- The granting of payment assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, or immigration status, sexual orientation or religious affiliation.

Determination of Financial Need:

- Financial need will be determined through an individual assessment that may include:
 1. An application process in which the patient or the patient's guarantor is required to cooperate and supply all documentation necessary to make the determination of financial need;
 2. The use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay;
 3. A reasonable effort by the Dignity Health facility to explore and assist patients in applying for appropriate alternative sources of payment and coverage from public and private payment programs; and will take into account the patient's assets and other financial resources.
- It is preferred but not required that a request for payment assistance and a determination of financial need occur prior to rendering of services. The need for payment assistance may be re-evaluated at each subsequent rendering of services, or at any time additional information relevant to the eligibility of the patient for payment assistance becomes known.
- Dignity Health's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of payment assistance. Requests for payment assistance shall be processed promptly, and the Dignity Health facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

Patient Payment Assistance Guidelines:

Services eligible under the policy will be made available to the patient on a sliding fee scale, in accordance with financial need as determined by the Federal Poverty Level (FPL) in effect at the time of the termination as follows:

- Patients whose income is at or below 200% of the FPL are eligible to receive free care;
- Patients whose income is above 200% but not more than 350% of the FPL are eligible to receive services at the average rates of payment the Dignity Health facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater in amount for the same services;
- Patients whose income is above 350% but not more than 500% of the FPL are eligible to receive services at 135% of the average rates the Dignity Health facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater for the same services;
- Patients whose income exceeds 500% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of the Dignity Health facility.

Dignity Health's administrative policy for Eligibility and Application for Payment Assistance shall define what qualifies as income for these purposes.

Communication of the Payment Assistance Program to Patients and the Public:

- Information about patient payment assistance available from Dignity Health, including a contact number, shall be disseminated by the Dignity Health facility by various means, including the publication of notices in patient bills and by posting notices in the Emergency and Admitting Departments, and at other public places as the Dignity Health facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the Dignity Health facility.
- Any member of the Dignity Health facility staff or medical staff may make referral of patients for payment assistance. The patient or a family member, a close friend or associate of the patient may also make a request for payment assistance.

Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient payment assistance will be included within the Social Accountability Budget of the Dignity Health facility. Dignity Health facilities will report patient payment assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.
- Patient payment assistance statistics shall be disclosed in annual financial statements but shall not include amounts that are properly considered to be bad debt or contractual discounts.

Relationship to Collection Policies:

- Dignity Health system management shall develop policies and procedures for internal and external collection practices by Dignity Health facilities that take into account the extent to which the patient qualifies for payment assistance, a patient's good faith effort to apply for a governmental program or for payment assistance from Dignity Health, and a patient's good faith effort to comply with his or her payment agreements with the Dignity Health facility.
- For patients who qualify for payment assistance and who are cooperating in good faith to resolve their hospital bills, Dignity Health facilities may offer interest-free extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences and will not send unpaid bills to outside collection agencies.

Regulatory Requirements:

In implementing this policy, Dignity Health management and Dignity Health facilities shall comply with all federal, state and local laws, rules and regulations that may apply to activities conducted pursuant to this policy.