



Mercy General Hospital



Mercy San Juan Medical Center



Methodist Hospital of Sacramento

SACRAMENTO SERVICE AREA



Mercy Hospital of Folsom



Woodland Healthcare



Sierra Nevada Memorial Hospital

Community Benefit Report 2011 Community Benefit Plan 2012

TABLE OF CONTENTS

Executive Summary	3 - 6
Overview of Hospitals	7-16
Mission Statement	17
Organizational Commitment	18-20
Community	
Definition of Community	21-32
Community Needs and Assets Assessment Process	33-35
Community Benefit Planning Process	
Developing the Hospital's Community Benefit Report and Plan	36-37
Planning for the Uninsured/Underinsured Patient Populations	38
Plan Report and Update including Measurable Objectives and Timeframes	
Summary of Priorities and Initiatives – FY 2011 and FY 2012 Plan	39-40
Program Digests (Description of Key Programs and Initiatives)	41-64
Community Benefit and Economic Value	
Classified Summaries of Un-sponsored Community Benefit Expense	65-70
Telling the Story	71
Appendix A: Community Board and Community Benefit Board Committee Rosters	72-73
Appendix B: Community Needs Index Data	74-80
Appendix C: Patient Financial Assistance Policy	81-83
Attachment 1: 2010 Community Needs Assessment Report	

EXECUTIVE SUMMARY

The **Community Benefit Report 2011 and Community Benefit Plan 2012** reflects the leadership commitment to, and investment in improving the health of the community demonstrated by Catholic Healthcare West (CHW) hospitals serving the greater Sacramento region. There are six CHW-member hospitals in the region: Mercy General Hospital; Mercy San Juan Medical Center; Methodist Hospital of Sacramento; Mercy Hospital of Folsom; Woodland Healthcare; and Sierra Nevada Memorial Hospital. Their expansive service areas encompass over 100 zip codes and span the counties of Sacramento, Yolo, El Dorado, Placer and Nevada.

Combined, the hospitals provide over 1,200 acute care beds, employ 8,114 people, and have over 1,000 affiliated physicians. All offer a full spectrum of inpatient and outpatient medical services, including: 24-hour emergency care; surgery; cardiology; women and children; neurology; oncology; orthopedics; rehabilitation; occupational health; diagnostic imaging; clinical laboratory; preventative health; and home care. Information on key service lines, areas of expertise, and new developments during 2011 for each hospital is provided in the "Overview of Hospitals" section beginning on page 7.

The hospitals share an enduring responsibility to community that continues to be inspired by the Sisters of Mercy who arrived in the region over a century ago with the sole mission to care for the sick and poor. This responsibility is carried forth daily through efforts to serve the most vulnerable, reduce health disparities, and promote positive health improvements. What differentiates the hospitals in the communities they serve is the role they play on the front lines of the safety-net, working along side and in partnership with community-based providers to ensure services are available when and where they are needed most.

Priority consideration for community benefit programming is given to initiatives that respond to health issues identified through needs assessments, focus on disadvantaged populations, involve collaboration, and deliver measurable health improvements. In an environment severely impacted by the recession and the inability of local government to fund critical health services, increasing access to care continues to take precedence - by partnering with others to build safety-net capacity, or by directly providing services that are otherwise unavailable. Increasing emphasis is also being placed on disease prevention and health education to address epidemic chronic illness and promote successful health reform.

A number of new FY 11 initiatives, and an update on the continued success of long-standing community benefit programs are highlighted in this report. They demonstrate how the hospitals are working with others at the community level to make a meaningful and often life-saving impact on the health and quality of life for thousands.

The **Community Health Referral Network** offers a promising new model of care coordination for uninsured and underinsured residents who are unable to navigate Sacramento region's weak and highly fragmented health care safety-net. Finding accessible, adequate and affordable care is a major issue identified in the recent 2010 Community Needs Assessment. It is also very evident by the alarming trend of underserved patients admitting to the hospitals for basic, non-urgent/emergent services. The new Community Health Referral Network is a region-wide collaborative initiative between the hospitals and nonprofit community clinics. It utilizes shared case management services and health information exchange technology to connect underserved patients who lack a primary care provider and admit to emergency departments with permanent health care homes in the community. It is a groundbreaking practice for the Sacramento area, which lacks a coordinated care delivery system for its low-income, vulnerable populations. Over 1,100 patients were assisted during the first 10 months of operation in FY 2011.

The hospitals expanded their partnership in the **Interim Care Program (ICP)** in FY 11 with the addition of a new five-bed skilled nursing unit to the existing 18-bed ICP facility at the Salvation Army's Center of Hope facility. The new unit addresses the shortage of beds due to the region's growing numbers of

homeless individuals. The long-standing ICP partnership between CHW hospitals, other regional health systems, Sacramento County and The Effort provides homeless individuals a safe environment for recovery when they are ready to be discharged from the hospital. Participants receive mental health care, substance abuse treatment and social services support to help make the transition to a healthier and self-sustaining lifestyle. Over 65% of all participants successfully complete the program; 100% are enrolled in a health insurance program and connected to a primary care provider; and 70% transition to permanent housing.

Through a partnership with community-based nonprofit providers, El Hogar and the El Dorado Community Health Center, a new **Intensive Outpatient Program** is available to underserved patients admitting to the emergency department with mental illness. The program offers same or next day psychological services, as well as long-term individual and group counseling five days a week if needed. It is one step toward addressing the region's dire need for increased access to mental health care. In the first four months of operation during FY 11, nearly 150 patients were referred to community partners. The Intensive Outpatient Program responds to the mental health crisis that continues to challenge the region due to local government budget cuts and mental health program and facility closures.

Thousands of the region's low-income and vulnerable residents depend on six **Mercy Community Clinics** for their primary health care needs each year. Operating under the license of the hospitals, the clinics are an integral part of the safety-net for the greater Sacramento area, responding directly to the priority issue of access to care. The clinics are situated in neighborhoods that lack community resources, and where disparities are great. Combined, the clinics provided free or low-cost primary care to over 40,500 uninsured residents in FY 2011 who otherwise would go without. This was a 30% increase over FY 10, reflecting the region's growing priority need to increase access to care for uninsured and underinsured residents.

Through the **Mercy Perinatal Recovery Network** (Mercy PRN), pregnant women and new mothers battling substance abuse learn to overcome their addictions, deliver healthier babies, prevent their children from being placed in foster care, and live a higher quality and more productive life. Mercy PRN is a drug and alcohol recovery treatment program that serves 250 vulnerable, at-risk women and their children annually in a home-like environment. Nationally, approximately 37% of individuals who begin substance abuse treatment complete 90 days, which is the benchmark for greater success in achieving long term sobriety. Over 70% of the women entering treatment at Mercy PRN complete 90 days of treatment. Statistical data for the region demonstrates the need for Mercy PRN services: An estimated 10 to 15% of women who give birth each year are abusing alcohol and other drugs; over 2,000 infants born in Sacramento County alone each year are exposed to drugs during the prenatal period; and over 12,000 children under the age of five in the county live with a parent who has a substance abuse problem.

The following Mercy PRN patient profile illustrates the complex issues faced by low-income women struggling with addiction to alcohol and other drugs, and how Mercy PRN is helping to turn their lives around:

A 36 year old African American mother of two teenage children was assessed with substance abuse, post traumatic stress disorder, depression and chronic physical pain associated with ongoing sexual abuse as a child. Homeless at the time of admission and estranged from her family, her drug of choice was methamphetamine. Through group and individual counseling at Mercy PRN, she became abstinent from alcohol and drugs and gained skills to cope with anxiety and establish appropriate relationship boundaries. She was able to address issues of victimization, domestic violence, and the effects of physical abuse on herself and her children through counseling. Since her treatment, she is now working, has her own apartment, regained custody of her children, and has reestablished a relationship with her mother. Her prognosis for long-term sobriety is excellent.

The **Congestive Heart Active Management Program (CHAMP[®])** provides the intervention those living with Congestive Heart Failure need to manage their chronic illness and live healthier, more productive lives. CHAMP[®] has been instituted at all six hospitals, and responds to a priority need identified through

community health assessments. Heart failure is a leading cause of hospitalization for residents throughout the broader Sacramento region. It is the fifth highest reason for emergency department visits, and the number one cause of death. CHAMP® is a best practice program with demonstrated results. In FY 2011, there was an 80% reduction in hospital readmissions among the nearly 1,000 participants.

Safe Kids is focused on reducing death and unintentional injury to children in auto accidents by providing proper car seat equipment, education and outreach to parents and care givers. In the greater Sacramento region motor vehicle accidents represent the fourth leading cause of death and injury for children ages 14 and under. Safe Kids specifically targets families with children living in poverty and families with children in immigrant communities, particularly Hmong, Russian and Hispanic. In FY 2011, 837 free seats were provided to families who could not afford them, 2,908 people were served at car seat fitting stations and inspections, and outreach was conducted to 5,355 people through participation in community trainings and classes, and health and safety fairs.

Growing Well with Mercy fills a gap in the Health and Wellness plan for local school districts serving the eastern suburbs of Sacramento County and neighboring foothill communities of El Dorado County. It provides hands-on education to elementary age students in collaboration with teachers, parents and school health officials. In this interactive program, students learn about the importance of good nutrition and healthy habits. School gardens were introduced as a central element of the Growing Well with Mercy's health curriculum in FY 11. The program was offered at 15 elementary schools during the year, including Title 1 schools, and reached 10,000 students.

The Caring Center continues to experience growth year over year as an increasing number of participants benefit from information, education, and different options for therapeutic techniques that reduce the physical and emotional affects of chronic illness, reduce stress, and provide coping skills when dealing with an acute health crisis. The center engages multiple community partners and volunteer professionals who provide services that include massage, reflexology, Healing Touch, and Therapeutic Touch. The center was established as a result of a focused assessment that identified lack of access in the community for these specific types of services. Nearly 1,000 clients received care in FY 11, an increase of over 11% from FY 10.

The "Your Life, Take Care" Chronic Disease Self Management Program continued to offer free, six-week courses taught in Spanish and English in Yolo County to help residents cope with ongoing health issues and chronic diseases that have been identified as priority issues for this region. Program participants learn to better manage such illnesses as cancer, diabetes, arthritis, obesity, and depression. The program, taught by four Master Trainers who have been Stanford University certified, focuses on goal setting and problem solving, nutrition, communication skills, relaxation techniques, medication usage, community resources, and partnering with care providers. In FY 11, 120 people benefited from the six- week classes. Promotora Lay Leader training for community health educators that support the program was held for 20 people. FY 12 will see increases in the demand for these classes.

The Healthy Lives Program responds to the prevalence of diabetes among the region's underserved Hispanic population in Yolo County, offering intervention, education and skills needed to better manage this chronic disease. Collaborative efforts with other community agencies complement the program with healthy cooking and exercise components. Healthy Lives continues to expand its outreach each year, demonstrating a meaningful impact on the health and well-being of participants. In FY 11, the number of program participants increased by 68%. Hospital admissions for participants were reduced by 100%.

A new **Diabetes – Take Control** initiative was implemented in FY 2011, as a component of the Wellness Program offerings for residents living in Nevada County. Diabetes is a growing chronic disease concern in Nevada County, attributable to factors that include a more susceptible aging population, and increasing numbers of higher-risk minority groups. The program combines knowledge about, and tools for managing diabetes and provides nutrition consultation to help participants control this disease and lead healthier and more productive lives. In the first six months of the program, no participants admitted to the hospital.

Details on these and other programs are provided beginning on page 41 in the Program Digest portion of the "Plan Report and Update including Measurable Objectives and Timeframes" section.

Proactive community benefit contribution in FY 2011 (July 1 through June 30) for all six hospitals was \$28,494,455, which marked a 47% increase over FY 10. Total quantifiable community benefit in FY 11 was \$158,187,064, including charity care, and the unpaid cost of Medi-Cal and other government funded programs, but excluding \$56,646,023 in unpaid Medicare costs. A complete financial review of community benefit for the poor and broader public is shown in the "Community Benefit and Economic Value" section of this report starting on page 65.

OVERVIEW OF HOSPITALS

Mercy General Hospital

4001 J Street
Sacramento, CA 95819
(916) 453-4545

Mercy General Hospital's history in Sacramento dates back to the opening of the first hospital by the Sisters of Mercy – Mater Misericordiae – in the downtown area. The Sisters broke ground for Mercy General in 1925.

Fiscal Year 2011 Facts

Number of Employees: 2,221
Number of Licensed Acute Care Beds: 342
Number of Intensive Care Unit Beds: 20
Number of Cardiac and Surgical Telemetry Beds: 71
Number of Emergency Department Beds: 16
Number of Emergency Department Visits: 38,052

Highlight of Services

Alex G. Spanos Heart & Vascular Center

Construction progress continued in FY 11 on Mercy General Hospital's new \$170 million Alex G. Spanos Heart & Vascular Center facilities. The center is scheduled to open in late 2012, and will house state-of-the-art technology, including new cardiac operating rooms and a hybrid operating suite. Collaboration with surrounding neighbors and the City of Sacramento resulted in a design for the center that blends the established East Sacramento community with the new construction.

Mercy Heart & Vascular Institute

Nationally recognized for its full range of cardiac programs, the Mercy Heart & Vascular Institute provides a full range of services, from prevention to intervention and surgery, to rehabilitation, wellness and education. The Institute is the largest surgical program in California, and remains at the forefront of care through leading-edge cardiovascular research. Mercy General Hospital received the designation of an accredited Chest Pain Center by the Society of Chest Pain Centers, and is the first hospital in the region to hold the distinction.

Screening

Mercy Heart & Vascular Institute, (MHVI), also provides pro-active screening programs for participants to understand their individual risk factors and make lifestyle changes. The Vascular & Heart HealthScreens are provided throughout the year. In addition, the MHVI launched the Women's Heart and Health Center to address the growing need for women's awareness, prevention and treatment for heart disease.

Hybrid Surgical/Cath Lab Suite

In November 2010, Mercy General Hospital opened the Hybrid Surgical Suite in a remodeled Cath Lab. These state-of-the-art hybrid suites combine the hi-tech sterile environment of the operating room with exceptional imaging capabilities of the Cath Lab. These hi-tech suites are critical for performing many of the new procedures for advanced conditions and will be required for future technologically advanced procedures.

da Vinci Si HD Robotic Surgical Assist Technology for Minimally Invasive Surgery Services

Mercy General Hospital offers da Vinci for minimally invasive OB/GYN, Urology and Cardiac procedures. The da Vinci Si HD Surgical System integrates 3D High Definition endoscopy and state-of-the-art robotic technology to virtually extend the surgeon's eyes and hands into the surgical field. This latest version of the da Vinci technology allows for improved clarity and detail of tissue planes required for

cardiac surgeries. Mercy General Hospital is the only hospital in Northern California performing da Vinci heart valve repairs and replacements.

TandemHeart® Capabilities Added to Cardiovascular Services

Mercy General Hospital's cardiovascular services have been enhanced through TandemHeart® expertise. The TandemHeart®, which is threaded into position through blood vessels to temporarily assist the heart's pumping function, helps deliver oxygenated blood to the body's vital organs to prevent further tissue damage on heart attack patients.

Mercy Neurological Institute of Northern California

Mercy General Hospital is one of few California hospitals to have earned the Gold Seal of Approval™ by the Joint Commission for the diagnosis, treatment and rehabilitation of stroke patients. The hospital is the first principal provider of national stroke research in Northern California, and specializes in the care of epilepsy, multiple sclerosis, brain tumors, headache, spine, brain trauma and other brain disorders. Coiling of brain aneurysms are treated using biplane suite.

Comprehensive neurology services were fully integrated into Mercy General Hospital's CARF Accredited Acute Rehabilitation unit in the past year, and the hospital continues to expand services through telemedicine, placing robots at Methodist Hospital of Sacramento, North Bay Medical Center, North Bay Vaca Valley Hospital, and St. Joseph's Medical Center in Stockton in FY 11 to support stroke diagnosis and treatment.

Mercy General Hospital Outpatient Surgery

An Outpatient Surgery Center on the hospital campus offers a variety of surgical services in a convenient outpatient basis. The facility has reported the highest volume of outpatient surgeries in the region for several consecutive years.

Orthopedic Center of Excellence

Mercy General Hospital offers a broad scope of orthopedic services, from minimally-invasive arthroscopy to total joint replacement surgery, to patient exercise, education and treatment solutions to restore strength, flexibility and function.

Spine Center of Excellence

Mercy General Hospital offers highly specialized comprehensive spine services provided by multi-disciplined specialists from Orthopedics, Neurology and Physical Therapy and Rehabilitation. National quality ratings recognize the hospital for providing exceptional quality in spine surgery in. The hospital also received a "five-star" rating for spine surgery and was recognized as "Best Rated in the Region."

CARF Accredited Acute Rehabilitation Program

Mercy General Hospital was the first hospital in the region of California north of San Francisco to be accredited by the Commission of Accreditation of Rehabilitation Facilities (CARF) for acute rehabilitation. In June 2011, CARF also accredited the hospital's Stroke Specialty Program within the Acute Rehabilitation center.

MRI Upgrade at MGH

The most recent GE Signa 1.5T HDx Magnetic Resonance Imaging (MRI) technology provides advanced diagnostic tools to assist various service lines, including Cardiology, Neurology and Orthopedics.

Mercy San Juan Medical Center

6501 Coyle Avenue
Carmichael, CA 95608
(916) 537-5000

Mercy San Juan Medical Center was established in 1967 and continues the mission that began 150 years ago when the Sisters of Mercy arrived in Northern California to devote their lives to care for the poor and sick.

Fiscal Year 2011 Facts

Number of Employees: 2,100
Number of Licensed Acute Care Beds: 370
Emergency Department Beds: 31
Number of Emergency Department Visits: 68,000

Highlight of Services

New Wing Expansion

A new six-story wing at the hospital brings 110 additional private patient care beds to the community, featuring the latest technology and a soothing healing environment. A new parking structure, space for 30 more beds in the future, and a new chapel are key components of the project.

Level II Trauma Center

For over 10 years, the Mercy San Juan Trauma Center has been recognized nationally as a leader in trauma care. The Trauma Center combines excellent care from nurses and specialty physicians with advanced diagnostic imaging equipment, monitoring technology and lab services. Verified by the American College of Surgeons (ACS) as the gold standard for trauma centers, Mercy San Juan Medical Center's program is a model and blueprint for other hospitals to follow.

Lung & Esophageal Program

The hospital's Lung & Esophageal Program offers a comprehensive approach for evaluating, diagnosing and treating individuals with known or suspected diseases of the lungs, chest or esophagus. The specialized level of care represents one of the largest and most advanced programs of its kind in Northern California. Mercy San Juan Medical Center was the first Sacramento area hospital to use new life-saving technology to reach previously inaccessible lesions deep in the lungs for the early detection of lung disease. The superDimension™ lung navigation system is a revolutionary technology that enables surgeons to locate and biopsy remote lesions, which can then be analyzed and treated immediately. Survival rates for lung cancer increase dramatically with early detection.

Bariatric Surgery

Mercy San Juan Medical Center's bariatric surgery program provides comprehensive, state-of-the-art surgical care for patients suffering from severe obesity and helps patients manage the associated damaging health effects of diabetes, high blood pressure and infertility. The American Society of Bariatric Surgeons recognizes the hospital as a Center of Excellence.

Family Birth Center and Neonatal Intensive Care Unit (NICU)

At Mercy San Juan Medical Center, 3,000 babies are born each year in the Family Birth Center. Premature or seriously ill newborns receive excellent care in the Neonatal Intensive Care Unit (NICU). The hospital's 26-bed NICU is ranked among the world's elite for survival rates of premature infants.

Cardiac Services

Mercy San Juan's complete cardiac program includes cardiac surgery, cardiac catheterization and cardiac rehabilitation. A new, third catheterization lab offers the latest technology, with a focus on peripheral vascular disease. The cardiac team ranks among the nation's best in getting patients from the emergency room to the procedure they need in the fastest time. Blue Cross/Blue Shield named Mercy San Juan Medical Center a Blue Distinction Center for Cardiac Care.

da Vinci Surgical System

A comprehensive robotic surgery program offers multiple specialties, including colorectal surgery, gynecology, gynecologic oncology, thoracic surgery and urology. This minimally-invasive alternative to both traditional surgery and laparoscopy provides patients with smaller incisions, less bleeding and quicker recoveries. Mercy San Juan Medical Center physicians are the first to use a single-port option for robotic gynecologic surgeries, reducing invasiveness and enhancing recovery even further.

MAKO Orthopedic Robotic Surgery

Mercy San Juan Medical Center was the first hospital in the greater Sacramento area to perform MAKO robotic surgery for partial knee resurfacing, rather than total knee replacement. MAKOplasty is an innovative treatment option for adults with early to mid-stage osteoarthritis, offering pain relief, improved mobility and a faster recovery time compared to traditional knee surgery. The MAKO System has garnered widespread community interest and is available only at Mercy.

Mercy Cancer Center

The Mercy Cancer Center provides high-quality comprehensive cancer services in one centralized location. Each year, the medical center sees nearly 2,000 patients in its Oncology Unit and provides core services such as preventative and early detection, inpatient and outpatient treatment, specialized surgery, research, rehabilitation, home health and hospice.

Mercy Neurological Institute of Northern California

Mercy San Juan brain specialists work collaboratively with specialists at Mercy General Hospital to provide care for complex neurological diseases that affect the brain, including stroke, epilepsy, multiple sclerosis, brain tumors, advanced neurovascular therapy, spine and brain trauma. Mercy San Juan Medical Center has achieved the Gold Seal of Approval™ and designation as a Primary Stroke Center from The Joint Commission.

Hyperbaric Oxygen

Mercy San Juan Medical Center is the only hospital in the Sacramento area to provide hyperbaric oxygen therapy to treat patients with tissue damage from radiation therapy, carbon monoxide poisoning and slow-healing wounds.

Mercy Sleep Center

Accredited by the American Academy of Sleep Medicine, the Mercy Sleep Center offers the latest digital technology and doctors who are board certified in sleep medicine to help treat sleep disorders including sleep apnea, narcolepsy, periodic limb movements and insomnia.

Methodist Hospital of Sacramento

7500 Hospital Drive
Sacramento, CA 95823
(916) 423-3000

Methodist Hospital of Sacramento opened in 1973 after a decade-long effort to expand health care services for a rural community in need. After signing an affiliate agreement in 1993, Methodist continues its commitment to provide care to a growing community today under the CHW umbrella.

Fiscal Year 2011 Facts

Number of Employees: 1,300
Number of Licensed Acute Care Beds: 162
Emergency Department Beds: 29
Number of Emergency Department Visits: 56,340

Highlight of Services

Emergency Department Expansion

An expanded state-of-the-art emergency department prepares Methodist Hospital for the future with the capacity to treat 75,000 patients a year. The projected utilization is 65,000 patients a year by 2020. The expansion increases the number of beds from 15 to 29 including six fast-track beds. Each room is private and has the capacity to treat critical patients. The facility nearly tripled in size from 8,100 to 21,876 square feet. Other enhancements include a four bay ambulance entrance, three critical resuscitation rooms and a decontamination room. The project also involved the remodeling of existing emergency department space for a new patient waiting room, registration and other support services.

Family Birth Center NICU

The Family Birth Center at Methodist Hospital, where over 1,300 babies are born each year, features state-of-the-art equipment and special amenities, with labor, delivery and recovery taking place in private and spacious rooms. New mothers are provided with lactation support, couplet care and a wide-range of classes to help them prepare for their new role as a parent. As part of Methodist Hospital's Women's and Children's services, the Level II NICU is one of two specialized Mercy units equipped with the latest technologically advanced equipment and around-the-clock care.

Orthopedic Center

Methodist Hospital's Orthopedic Center delivers leading-edge inpatient and outpatient orthopedic services with innovative technology and high quality patient care. The orthopedic team consists of surgeons, nurses, rehabilitation staff and educators. From pre-admission testing to registration, surgery, recovery and rehab, the team works together toward the best possible result for the patient. Progressive renovation has taken place to provide patients with private rooms and a peaceful healing environment. The hospital is exploring, and committed to incorporating new orthopedic technologies such as MAKOplasty and others in the future.

Blue Distinction Center for Hip & Knee Replacement

Blue Shield of California has designated Methodist Hospital as a Blue Distinction Center for Knee and Hip Replacement. Methodist Hospital is one of only two hospitals in Sacramento to receive such an honor and is among the 37 hospitals throughout California that hold this distinction. Comprehensive knee and hip replacement services are offered, including custom-fit, minimally invasive surgical techniques, extensive pre-operative education and progressive rehabilitation protocols including ambulation on day of surgery and group therapy.

Blue Distinction Centers for Knee and Hip Replacement demonstrate a commitment to quality care, resulting in better overall outcomes for knee and hip replacement care. The hospital meets evidence-based clinical criteria, developed in collaboration with a panel of expert physicians and medical organizations, including the American Academy of Orthopedic Surgeons and American Association of Hip and Knee Surgeons and is subject to periodic re-evaluation as criteria continue to evolve.

Primary Stroke Center

Methodist Hospital has been certified as a Primary Stroke Center by the Joint Commission. The certification is based on a rigorous on-site review, as well as an examination of months of patient information. To be a Joint Commission-certified primary stroke center means the hospital has demonstrated the ability to provide a continuum of care, including prevention education, time-sensitive treatment, and follow-up care for stroke patients.

Bariatric Surgery Center of Excellence

Methodist Hospital has been named an American Society for Metabolic and Bariatric Surgery (ASMBS) Bariatric Surgery Center of Excellence®. This designation recognizes surgical programs with a demonstrated track record of success in bariatric surgery.

According to a report released in 2007 by the Agency for Healthcare Research and Quality, the number of bariatric surgeries has grown from 16,000 procedures performed in 1992 to 170,000 performed in 2005. Faced with clinical evidence that the most experienced and best-run bariatric surgery programs have by far the lowest rates of complications, the ASMBS Bariatric Surgery Centers of Excellence program was created to recognize bariatric surgery centers that perform well and to help surgeons and hospitals continue to improve the quality and safety of patient care. To earn a Bariatric Surgery Center of Excellence designation, the hospital underwent a site inspection that closely examined all aspects of the program's surgical processes and collected data on patient outcomes.

Hand Therapy Program

The Hand Therapy Program addresses hand, wrist and elbow injuries caused by carpal tunnel syndrome, rheumatoid arthritis and sports or work related injuries. Patients work directly with a certified hand therapist.

Occupational & Physical Therapy Center

A full-service Occupational & Physical Therapy Center is one of only two facilities in Sacramento that features an indoor, heated, therapeutic swimming pool and health and wellness programs geared toward rehabilitating athletes and injured workers.

Family Practice Residency Program

Established in 1995, this accredited and nationally recognized three-year program provides resident physicians with specialty training in primary care family practice. Methodist Hospital's Family Practice Residency Program has received the highest level of residency accreditation and is nationally recognized for excellence in training, quality of residents and patient care. The program features an ethnically and culturally diverse faculty, resident and patient population. A priority of the program is caring for the underserved at the Mercy Family Health Center.

Digestive Services Department

Millions of Americans suffer from the painful acid reflux disease, with symptoms of heartburn, difficulty swallowing, and chronic sore throat or cough. Methodist Hospital provides expertise in treating this disease and associated causes including ulcers, cancer of the esophagus, hiatal hernias, polyps and colorectal cancer. An outpatient treatment that destroys pre-cancerous tissue in the lining of the esophagus, known as ablation therapy, is performed at the hospital to mitigate the risk of developing esophageal cancer.

Bruceville Terrace

Licensed under Methodist Hospital, this fully accredited 171-bed skilled nursing facility provides 24-hour sub-acute long term nursing care for the elderly, or short term care for patients recovering from a hospital procedure. Bruceville Terrace admits approximately 800 patients each year; nearly 60% return home or to a lower level of care. Rehabilitation, nutrition, education and recreation are among the key services provided.

Mercy Hospital of Folsom

1650 Creekside Drive
Folsom, CA 95630
(916) 983-7400

Mercy Hospital of Folsom is a growing community hospital committed to partnering with its community in health. The hospital is an integral part of Folsom, El Dorado Hills and neighboring foothill communities, providing all levels of healthcare from preventive to emergency. Its history in the community dates back nearly 30 years when the Sisters of Mercy acquired the struggling 30-bed Twin Lakes Hospital in order to maintain the health care safety-net for what was then a small, rural community. In 1989, the Sisters opened the new 85-bed Mercy Hospital of Folsom on a 26-acre parcel of property donated by the Cummings and Tsakopoulos families.

As the sole acute care provider in Folsom, the hospital has experienced a major increase in demand for services, responding to population growth by expanding its Surgery unit, Family Birth Center, Emergency Department, Rehabilitation and Occupational Medicine programs. FY 11 marked another year of growth, renovation and continued expansion. The hospital celebrated the opening of its new Progressive Care Unit, adding 21 beds. A remodeling of the Family Birth Center was also completed in spring, which led to an 8% increase in volume in just three months.

Fiscal Year 2011 Facts

Number of Employees: 668
Number of Licensed Acute Care Beds: 106
Emergency Department Beds: 25
Number of Emergency Department Visits: 29,786

Highlight of Services

Progressive Care Unit

A 21-bed all private room Progressive Care Unit opened in May 2011, expanding the hospital's footprint by 25 percent to better meet the growing healthcare needs of the community. The new unit provides immediate relief to Emergency Department and Intensive Care Unit overcrowding. Volume has increased within all services.

Cummings Emergency Pavilion

The Cummings Emergency Pavilion opened in June 2008, after the hospital witnessed a 51% increase in emergency patient volume. The pavilion features a dedicated and highly-trained staff and 25 private rooms for patient comfort and confidentiality, and state-of-the-art diagnostic imaging technology. Patients and family members enjoy privacy during registration and triage. The pavilion is 22,410 square feet in size; a near five-fold expansion from the previous 4,620 square foot Emergency Department. It provides much needed space to meet growing patient demand.

Advanced Stroke Telemedicine

Working with the Mercy Neurological Institute of Northern California, Mercy Hospital of Folsom was the first hospital in the network to incorporate and effectively demonstrate advanced telemedicine capability for stroke patients. The use of a remote presence robot allows the hospital's Emergency Department medical staff to connect stroke patients immediately with neurologists at Mercy's nationally certified stroke centers. The purpose of this remote system is to enable stroke experts to respond rapidly to urgent emergency cases at outlying hospitals that lack full-time neurological services. It eliminates the need to wait for an on-call neurologist to reach the point-of-care location, saves precious minutes by not having to transport a patient to a tertiary care facility for evaluation and diagnosis, and allows stroke patients to remain in their own community close to family. The generosity of the Elliott Family Foundation made this effective new technology possible.

Woodland Healthcare

1325 Cottonwood St
Woodland, CA 95695
(530) 662-3961

Woodland Healthcare's history in Yolo County dates back to the opening of the Woodland Sanitarium in 1905. The Woodland Sanitarium grew to become the Woodland Clinic Hospital in the 1920s. In 1967, a new Woodland Memorial Hospital and Woodland Clinic were completed with the help of the community. In 1992, Woodland Clinic and Woodland Memorial Hospital formed an affiliation to create Woodland Healthcare. The hospital joined CHW in 1996.

Fiscal Year 2011 Facts

Number of Employees: 1,000
Active Medical Staff: 100
Number of Licensed Acute Care Beds: 108
Emergency Department Beds: 20
Number of Emergency Department Visits: 20,860
Inpatient mental health beds: 20

Highlight of Services

Chest Pain Center Accreditation

As the only Yolo County healthcare provider recognized by the Society of Chest Pain Centers, Woodland Healthcare has achieved the highest level of expertise in dealing with patients who arrive with symptoms of a heart attack. Emphasize is on the importance of standardized diagnostic and treatment programs that provide more efficient and effective evaluation as well as more appropriate and rapid treatment of patients with chest pain and other heart attack symptoms.

Cardiology Services

Woodland Healthcare has invested in advanced diagnostic equipment and a new cardiac catheterization lab that offers a full spectrum of diagnostic and therapeutic procedures, including pacemaker and defibrillator implants, stress testing, and a Women's Cardiology Clinic.

Cardiac Wellness Program

Woodland Healthcare offers a supervised personal exercise program to all cardiac patients with predisposing risk factors who have been referred by their general practitioner. The goal is to help patients perform activities of daily living, increase their fitness level, and educate them about reducing risk factors that lead to heart disease.

Primary Stroke Center

Recognized by the Joint Commission on Accreditation of Healthcare Organizations, Woodland Healthcare is at the cutting edge of stroke diagnosis and treatment. In addition, the hospital has continually been recognized by the American Heart Association/American Stroke Association's Get With The Guidelines[®] program as a Gold Plus Award recipient. The stroke center is unique in Yolo County, and offers patients an extensive continuum of care, from exceptional Emergency Department care to rehabilitation after discharge from the hospital.

Family Birth Center

Woodland Healthcare's state-of-the-art family birth center's suites provide a home-like setting for delivering a healthy baby in a safe, caring environment. A Skin-to-Skin Program encourages early bonding, helps to regulate the baby's temperature and improve infant brain development. As the 97th hospital in the United States to be named a Baby-Friendly[®] facility by the World Health Organization and UNICEF, the hospital is committed to giving all babies the healthiest, most natural care, right from the start. In addition, the center also includes a Level II intermediate care unit for special care infants in Yolo County. Through affiliations and consulting agreements, physicians have access to medical specialists in neonatology, cardiology and genetics.

Cancer & Neurosciences Center

At the Cancer and Neurosciences Center (the Lorie Haarberg Building), the latest in radiological and nuclear technology necessary is available for screening and early detection, including current advances in PET scan technology, with radiologists, laboratory and complementary care services on-site to ensure patients receive the best care possible. On-site Infusion Services offers patients the ability to receive the treatment they need, in a comfortable state-of-the-art 10 station facility.

Inpatient Mental Health Facilities

Since 1969, Woodland Healthcare has offered a wide variety of services to those suffering from emotional or psychological disorders. In a newly remodeled state-of-the-art facility, patients receive individualized care focused on their special needs. The facility routinely draws patients from counties throughout Northern California to the Oregon border.

Outpatient Diagnostic Imaging

Woodland Healthcare offers the most comprehensive diagnostic imaging services in Yolo County, including CT scans, magnetic resonance imaging (MRI), angiography, vascular studies, mammography, ultrasound and X-ray.

Yolo Adult Day Health Center

The Yolo Adult Day Health Center offers a diverse program of health, social and rehabilitation services, promoting the well-being, dignity and self-esteem of the individual. Programs are designed to meet the needs of the participant and those they love, taking into consideration physical and cognitive limitations.

Home Health Services

The hospital's Home Health Services offers patients an alternative by providing skilled nursing visits at home. With comfort and independence in mind, a team of professionals works with physicians and families to establish treatment and care plans. The hospital has been recognized as a Top 25 Home Health Agency by HomeCare Elite for the past four years, and is licensed, Joint Commission accredited and Medicare/Medi-Cal certified.

Sleep Disorders Center

Accredited by the American Academy of Sleep Medicine, the center offers full diagnostic evaluation, testing and treatment of all major sleep disorders, including Obstructive Sleep Apnea Syndrome; Primary Snoring; Restless Leg Syndrome and Periodic Limb Movements of Sleep; Insomnia; Narcolepsy; and Parasomnia.

Sierra Nevada Memorial Hospital

155 Glasson Way
Grass Valley, CA 95945
(530) 274-6000

Sierra Nevada Memorial Hospital has been a part of western Nevada County since 1958. The hospital has experienced significant growth that has led to additions of a 68,000 square foot Outpatient Center; a Transitional Care Unit; a Cancer Center; a Wound Clinic and the Sierra Nevada Diagnostic Center.

Fiscal Year 2011 Facts

Number of Employees: 825
Number of Licensed Acute Care Beds: 120
Number of Skilled Nursing Beds: 17
Emergency Department Beds: 10
Number of Emergency Department Visits: 32,000

Highlight of Services

Ambulatory Treatment Center

The Ambulatory Treatment Center was created especially for patients with chronic illnesses and non-emergency outpatient care needs. Services include: maintenance of specialized IV lines (Hickmans, Portacaths, Broviacs, PICCS); transfusions; blood component therapy; IV therapy/antibiotics; wound care for post-operative and traumatic/puncture wounds; and pressure ulcer care.

Cancer Center

The Center is nationally accredited as a Comprehensive Community Cancer Program by the Commission on Cancer of the American College of Surgeons. Services combine expertise by staff and physicians, state-of-the-art technology and a healing environment with a range of diagnostic options, including a 64-slice CT scanner. Chemotherapeutic and radiologic treatments are available, and the hospital also participates in many of the latest clinical trials.

Primary Stroke Center

New stroke response protocol has standardized and improved quality of care at Sierra Nevada Memorial Hospital. The hospital has earned the Gold Seal of Approval from The Joint Commission for Primary Stroke Centers.

Sierra Nevada Home Care

The hospital's skilled nursing care center offers comprehensive services that include:

- IV therapy.
- Enterostomal therapy.
- Maternal child care.
- Phototherapy.
- Psychiatric nursing.
- Home health aide and home medical equipment.
- Speech and physical therapy.
- Occupational therapy.
- Medical social services.
- Lifeline.
- Nutrition.

MISSION STATEMENT

The six hospitals share the mission of Catholic Healthcare West and its Sponsoring Congregations:

Catholic Healthcare West and its Sponsoring Congregations 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.

ORGANIZATIONAL COMMITMENT

Strategic Planning

A commitment to community benefit is embedded in the structure, governance, operations and culture of each of the hospitals, and demonstrated at multiple levels by hundreds of employees throughout the organization.

A common policy integrates community benefit into the ongoing process of planning, budgeting, evaluating and reporting. Community benefit is also incorporated into the strategic plans for each hospital. Strategic initiatives in FY 11 were aligned with objectives of the hospitals and needs within the community to address the growing number of underserved, and were focused on:

- Increasing access to primary, mental and specialty care (medical home model) through strategic partnerships for patient referrals and care coordination with nonprofit providers at the community level. Both the Community Health Referral Network and the Intensive Outpatient Program were new FY 11 initiatives implemented as a direct outcome of this objective.
- Coalition building to strengthen and add capacity within the region's safety-net, including:
 - A leadership role on the Health Reform Coalition convened by Congresswoman Doris Matsui and the Sierra Health Foundation to work with the region's weak and fragmented Federally Qualified Health Centers (FQHC) to develop a collaborative FQHC Network and long-term strategic plan.
 - A leadership role with Sacramento County and other health systems on the Medi-Cal Managed Care Stakeholders Advisory Committee to develop recommendation to the Department of Healthcare Services for improved access and quality and coordination of care.
 - A leadership role with Yolo County on the Future of the Safety Net Committee to plan and manage the problem of caring for residents who do not have health insurance and may not qualify for government programs.
 - A leadership role with Yolo County Low Income Health Plan (LHIP) Advisory Committee to develop plans to help the uninsured until Federal Healthcare Reform is implemented in 2014.
- Aligning the CHW Community Grants Program priorities with strategic objectives - nearly \$600,000 in funding was awarded to community-based nonprofit organizations in FY 11 to support programs providing direct access to care and/or services that lend to a continuum of care in the community.
- Funding through the CHW Community Investment Program and additional grant and in-kind leadership support to enable the nonprofit Midtown Medical Center for Children and Families to successfully achieve FQHC status.

The planning process for these and other community benefit initiatives is a joint effort that engages Hospital Presidents, Executive Management Teams, Hospital Community Boards and Community Health Committee members, the Community Benefit Department, and others from various clinical and administrative departments throughout the organization. A number of forums provide regular opportunities to discuss strategies, prioritize and evaluate initiatives, and make resource allocations, including board and committee meetings, service area leadership meetings, executive management and operational team meetings and special project group meetings.

Governance

The hospitals have a well-defined governance infrastructure that includes Community Boards to provide oversight for accountability and quality of community benefit efforts. There are also two designated Community Health Committees that serve as advisory bodies to ensure the hospitals develop and support programs and services that:

- Align with the CHW System-wide five core principles:
 - Focus on disproportionate unmet health-related needs.
 - Emphasize prevention.
 - Contribute to a seamless continuum of care.
 - Build community capacity.
 - Demonstrate collaborative governance.
- Address the health and health-related issues identified through community needs assessments.
- Meet the objectives of hospital strategic plans.
- Maximize community health assets and resources through collaboration.
- Conform to uniform methods of accounting for community benefit.

The Committee is also responsible for:

- Evaluating the effectiveness of existing community benefit programs and collaborative partnerships on an ongoing basis, and recommending continuation or termination of support, based on program progress toward identified objectives, utilization of funds and fiscal responsibility, and alignment with community benefit priorities.
- Reviewing and approving the annual Community Benefit Plan and Report.
- Reviewing and approving the Sacramento Service Area Community Benefit Budget, and providing direction for budgeting decisions related to major programs and region-wide collaborative efforts.
- Ensuring that the Board is regularly briefed on activities and developments.
- Overseeing the annual CHW Community Grants Program, including determining priorities for grant funding that are aligned with community needs assessments and needs identified by Hospital Leadership.

In board and committee recruiting, the hospitals seek members from the community and from the organization who possess competencies related to core principles and have a direct stake in the success of programs. A dedicated Community Benefit Department works with the board, committee, hospital leadership, operations, strategic planning and clinical staff to identify, plan, budget and monitor initiatives (See **Appendix A** for a roster of Board and Committee members).

Non-Quantifiable Community Benefit

Advocacy and volunteer service by hospital leadership is an important aspect of community benefit. The hospitals are helping drive engagement in the community by reaching out and bringing diverse stakeholders from public, private and nonprofit sectors together to redesign current practices, develop new models of care, and move toward an agreed-upon vision for an improved health delivery system. In FY 11, the hospitals worked to foster collaboration across a broad range of stakeholders to address critical health-related challenges facing the region. Efforts involved instrumental leadership roles with the:

- Sierra Health Foundation Safety-Net Reform Coalition.

- Sacramento County Medi-Cal Managed Care Stakeholder Advisory Board.
- Sacramento Region Mental Health Workgroup.
- Sacramento Steps Forward homeless task force.
- California Endowment's Building Healthy Communities initiative (Health Access Work Group).
- Sacramento County Public Health Advisory Board.
- Capital Community Health Network.
- Yolo County LIHP Advisory Committee.
- Yolo County Future of the Safety Net Committee.
- Yolo County Health Council.

Employees at many levels of the organization – from leadership on down – actively participate as members or directors on the boards of community-service organizations focused on health and health related improvements, as well as on neighborhood revitalization, economic development, and job and career development. Service to the community through volunteerism is encouraged as part of the mission, philosophy and responsibility of the hospitals to positively impact health and social factors that affect the well-being of the region. Some of the organizations that benefit from the expertise hospital employees lend include:

American Heart/Stroke Association	Kiwanis Club
American Lung Association	Midtown Medical Center Board
American Red Cross	Minors Western Sierra Clinic Board
Capitol Community Health Network	Partnership Healthcare of California
CARES	Rancho Cordova Rotary Club
Center for Community Health and Well-Being	Sacramento Allied Agency Area Work Group
Child Abuse Prevention Center	Sacramento Hispanic Chamber of Commerce
Citrus Heights Chamber of Commerce	Sacramento Metropolitan Chamber of Commerce
Citrus Heights Rotary Club	SPIRIT
Cosumnes River Community College	Woodland Chamber of Commerce
Cover the Kids	Woodland Hispanic Chamber of Commerce
Davis Chamber of Commerce	Woodland Kiwanis Club
Davis Rotary Club	Woodland Rotary Club
Dixon Chamber of Commerce	Woodland United Way
East Sacramento Chamber of Commerce	YMCA
Economic Resource Council	Yolo County Breast Feeding Coalition
Elk Grove Economic Development Corporation	Yolo County Health Council
Food Bank of Yolo County	Yolo County Emergency Medical Care Committee
Folsom Chamber of Commerce	Yolo County Workforce Investment Board
Grass Valley Chamber of Commerce	Yolo Family Resource Center
Healthcare Linked to Housing	Yolo Wayfarer's Center
Hospital Council of Northern California	
Interim Care Oversight Committee	

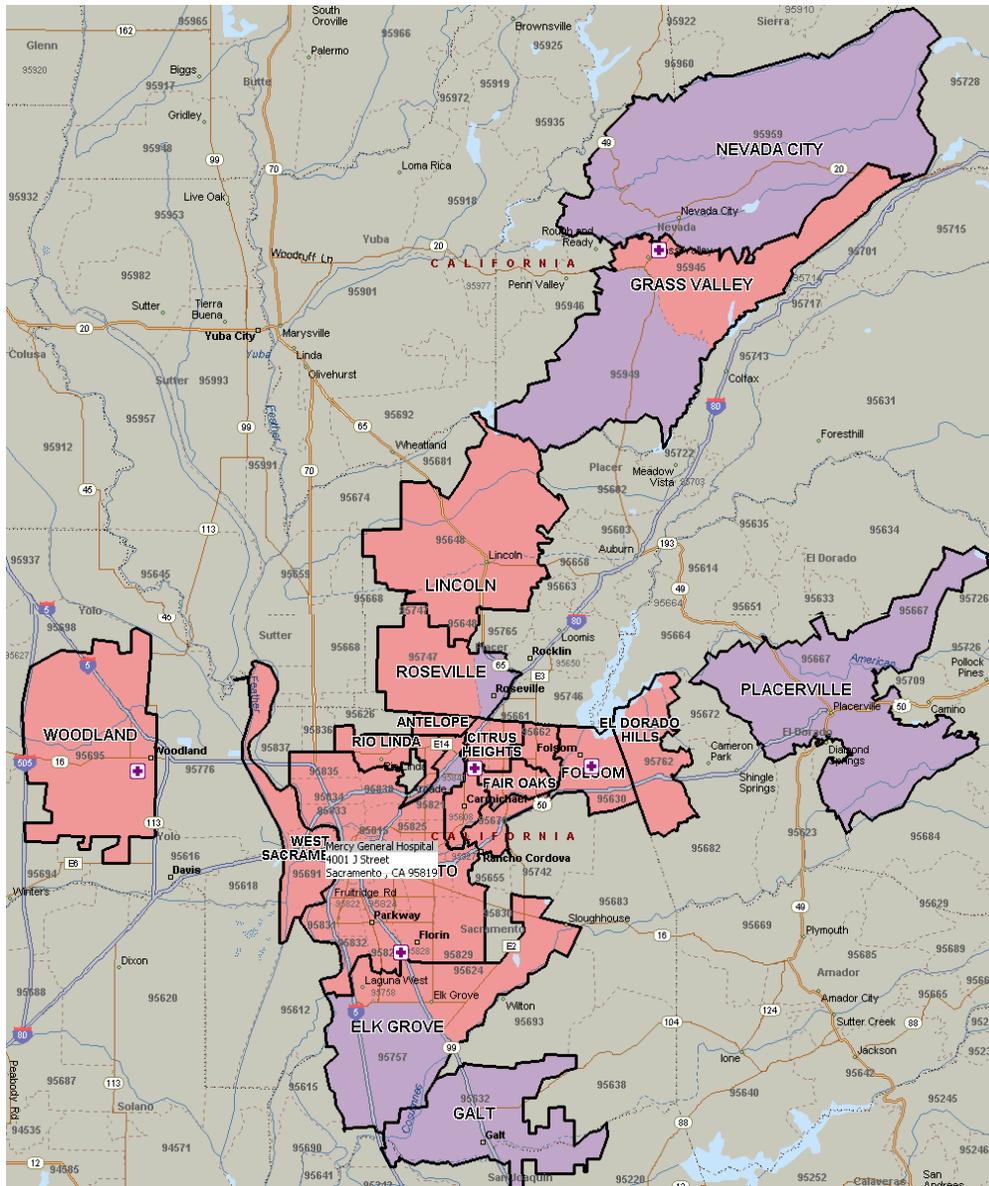
COMMUNITY

Definition of Community

Many sources of information are utilized to define the communities served by the hospitals, both geographic and demographic in nature, including:

- Community Needs Assessments.
- Service areas as prescribed by the Office of Statewide Health Planning and Development (OSHPD).
- Demographic information provided by regional and local government agencies; reimbursement agencies; the United States Census Bureau; and research organizations, such as Claritas, Inc., and Thomson Healthcare.
- Types of patient populations served and types of insurance coverage.

Mercy General Hospital

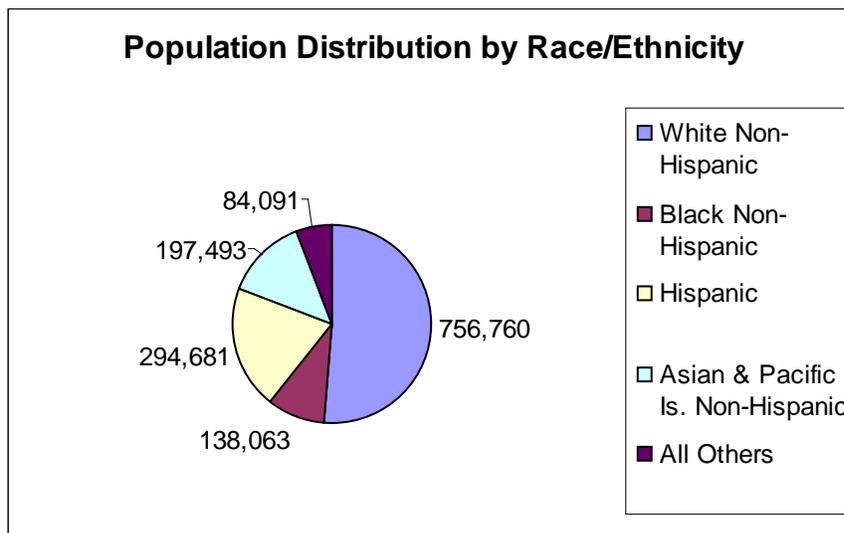


Population

Population within Mercy General Hospital's primary service area is 1,471,088, and is projected to grow to 1,703,519 by 2015. The hospital serves a fairly young population with 26% under the age of 18, and 38% between the ages of 18 to 44. Over 24% of the population is between the ages of 45 to 64, and 11% is 65 years or older. Significant growth in population is expected to occur in the 45 to 64 and 65 and older age groups, estimated at as much as 17% for each age group by 2015. More than half of the population is female.

Ethnicity

Ethnicity within Mercy General Hospital's primary service area is depicted in the chart below. More than half of the population is Caucasian. The Hispanic population is expected to have the highest rate of growth, increasing to an estimated 22% by 2015. The African American population is also expected to grow to nearly 10% by 2015.



Household Income

Of the 536,939 households within Mercy General Hospital's primary service area, nearly 10% exist on an annual income of under \$15,000. Nearly 9% of families have annual incomes of \$15,000 to \$25,000; over 23% have annual incomes that range from \$25,000 to \$50,000; 20% have annual incomes that range from \$50,000 to \$75,000; 14.4% have annual incomes between \$75,000 and \$100,000; and nearly 24% have annual incomes of over \$100,000.

Education

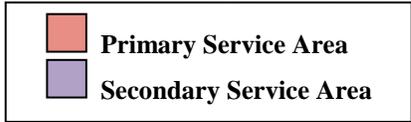
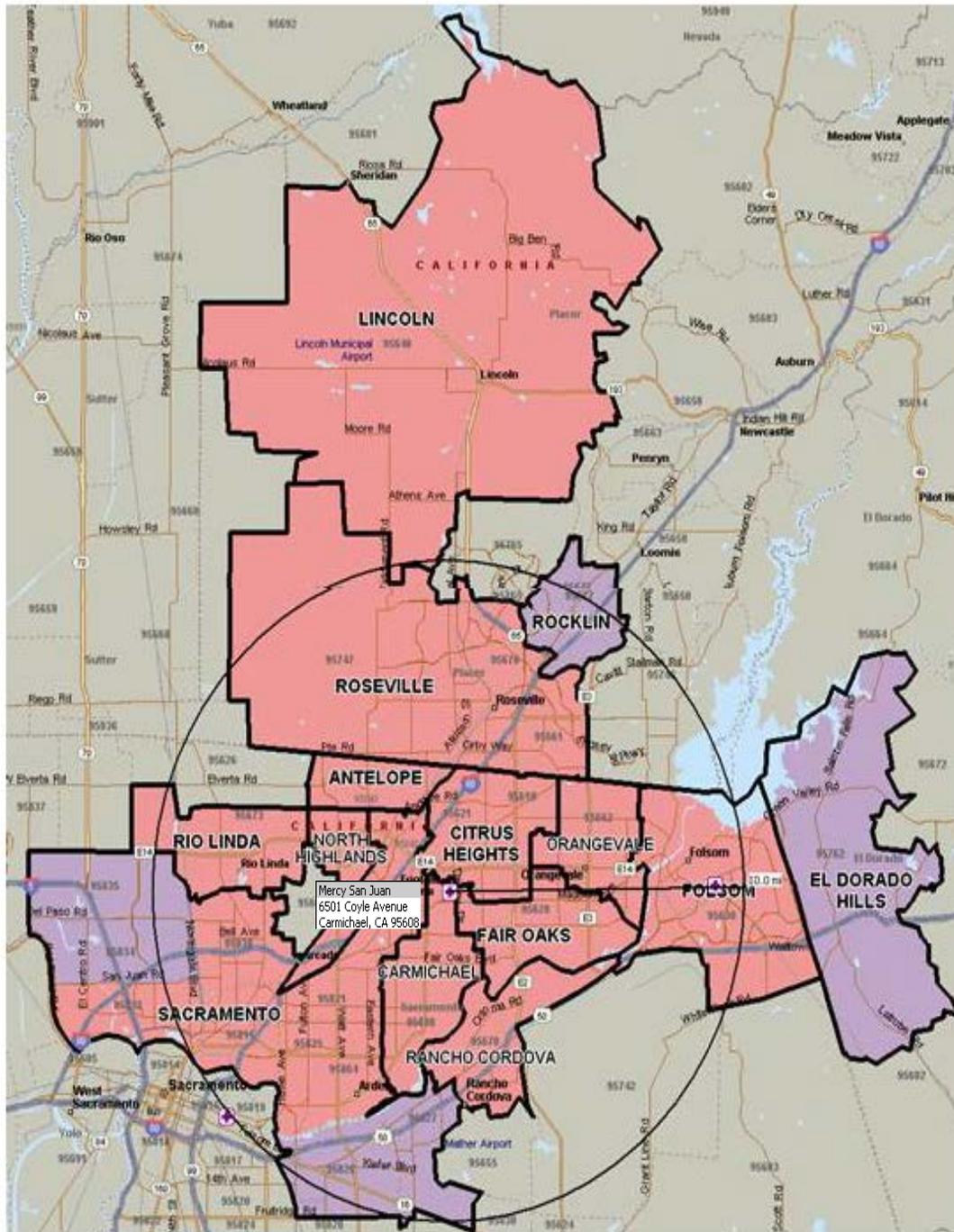
Over 14% of the adults living in Mercy General Hospital's primary service area do not have a high school diploma. 35% have some college education, and 28.3% hold a bachelor's degree or higher.

Insurance Coverage

Over 41% of the patient population treated and discharged by the hospital is insured by Medicare; 25.3% of the patient population has Medi-Cal; 26% has HMO or PPO coverage; and nearly 6% is without insurance.

*Specific neighborhoods within Mercy General Hospital's primary service area with disproportionate unmet health-related needs are shown in Community Needs Index data in **Appendix B**.*

Mercy San Juan Medical Center



Primary Service Area

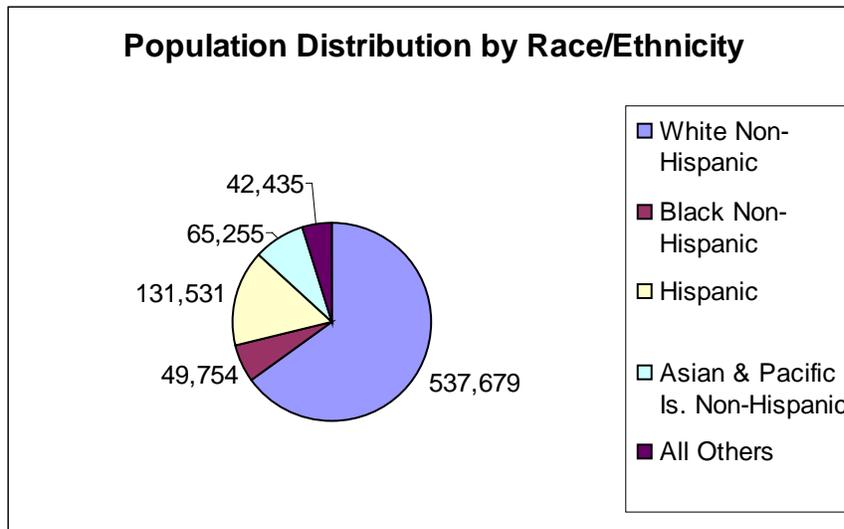
Mercy San Juan Medical Center is located in the northern Sacramento County suburbs, serving major communities that include Citrus Heights, Fair Oaks, North Highlands, Carmichael, Antelope, Roseville, and other neighboring cities that comprise 22 zip codes.

Population

Population within Mercy San Juan Medical Center's primary service area is 826,654, and is projected to grow to 901,885 by 2015. A large percentage of the hospital's primary service area population is made up of families and children. Children, ages 17 and under represent 25% of the population; over 62% of the population is between the ages of 18 and 64. About 13% of the population is 65 years of age or older. Population age distribution is expected to remain fairly stable over the next several years. Over half of the population is female.

Ethnicity

Ethnicity within Mercy San Juan Medical Center's primary service area is depicted in the chart below. The largest percent of the population is Caucasian (65%).



Household Income

Of the 311,039 households within Mercy San Juan Medical Center's primary service area, nearly 9% exist on annual incomes of under \$15,000. Over 8% of families have annual incomes of \$15,000 to \$25,000, and 23.6% have annual incomes that range from \$25,000 to \$50,000. Over 20% of households have annual incomes that range from \$50,000 to \$75,000; 14.6% have annual incomes between \$75,000 and \$100,000; and just over 24% have annual incomes over \$100,000.

Education

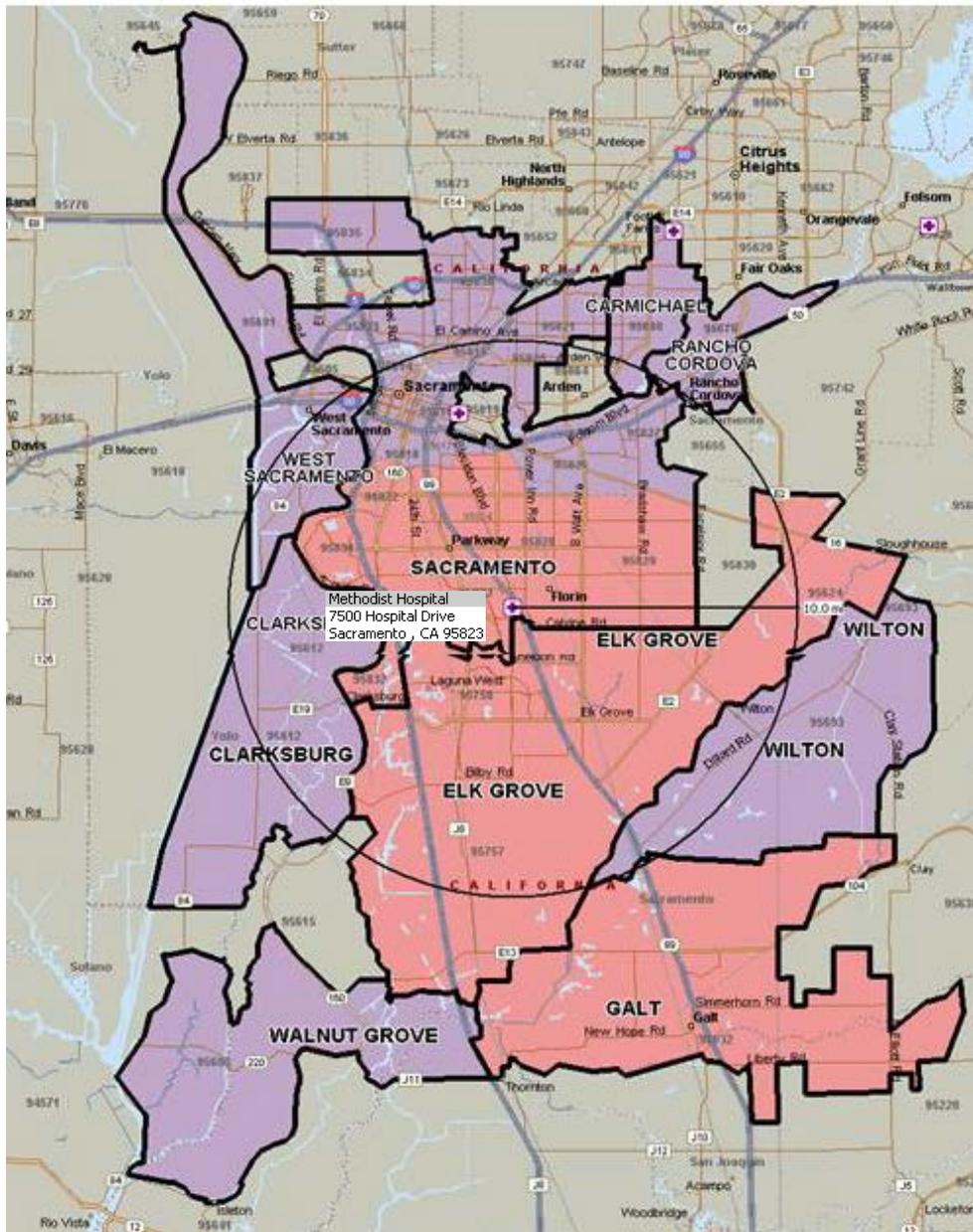
Of the adults living in Mercy San Juan Medical Center's primary service area, over 11% do not have a high school diploma. Just nearly 37% have some college education, and 28.5% hold a bachelor's degree or higher.

Insurance Coverage

Nearly 44% of the patient population treated and discharged by the hospital has Medicare insurance, and 26.4% of patients are insured by Medi-Cal. 19% of the patient population has HMO or PPO coverage, and over 9% have no insurance coverage.

*Specific neighborhoods within Mercy San Juan Medical Center's primary service area with disproportionate unmet health-related needs are shown in Community Needs Index data in **Appendix B**.*

Methodist Hospital of Sacramento



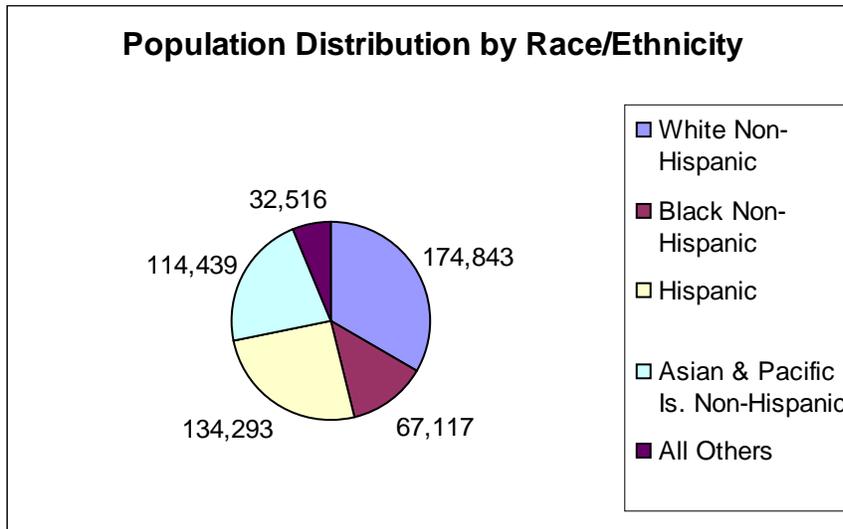
Primary Service Area
 Methodist Hospital's primary service area encompasses a major portion of south Sacramento County. The hospital's primary service area is comprised of 12 zip codes, and includes the suburban communities of Elk Grove, Laguna, Wilton and Galt. A portion of the hospital's primary service area known as the Fruitridge area is designated a federal Medically Underserved Area (MUA).

Population

Population within Methodist Hospital's primary service area is 523,208, and is projected to grow to 575,615 by 2015. A large percentage of the population within the hospital's primary service area is made up of families and children. Children under the age of 18 represent 29% of the population; over 51% of the population is between the ages of 18 and 54; and nearly 10% between the ages of 45 and 64. Over 10% of the population is 65 years of age or older. Age distribution is not expected to change significantly over the next several years. Over half of the population is female.

Ethnicity

Methodist Hospital serves an ethnically diverse population within its primary service area, depicted in the chart below. Caucasians represent the largest number of residents (34%).



Household Income

Of the 169,622 households within Methodist Hospital's primary service area, nearly 10% exist on annual incomes of less than \$15,000. An estimated 8% of families have annual incomes of \$15,000 to \$25,000, and 22.4% have annual incomes that range from \$25,000 to \$50,000. 20% of households have annual incomes that range from \$50,000 to \$75,000; 15.3% have annual incomes between \$75,000 and \$100,000; and nearly 25% have annual incomes over \$100,000.

Education

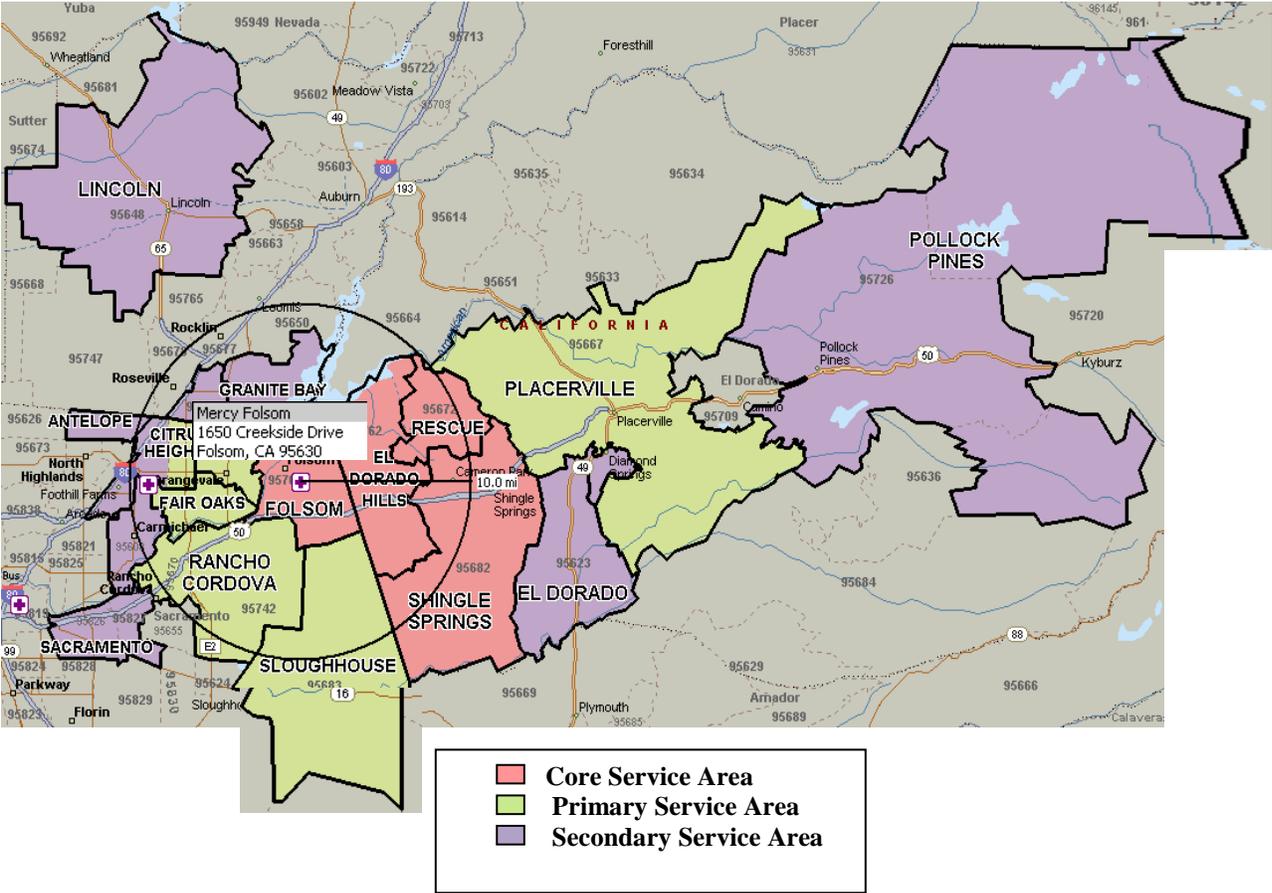
Of the adults living in Methodist Hospital's primary service area, over 18.4% do not have a high school diploma. 34% have some college education, and 25.3% hold a bachelor's degree or higher.

Insurance Coverage

Nearly 42% of the patient population treated and discharged by the hospital has Medicare insurance, and more than 28% of patients are insured by Medi-Cal. 19.8% have HMO or PPO coverage, and over 8% have no insurance coverage.

*Specific neighborhoods within Methodist Hospital's primary service area with disproportionate unmet health-related needs are indicated on Community Needs Index data in **Appendix B**.*

Mercy Hospital of Folsom



Primary Service Area

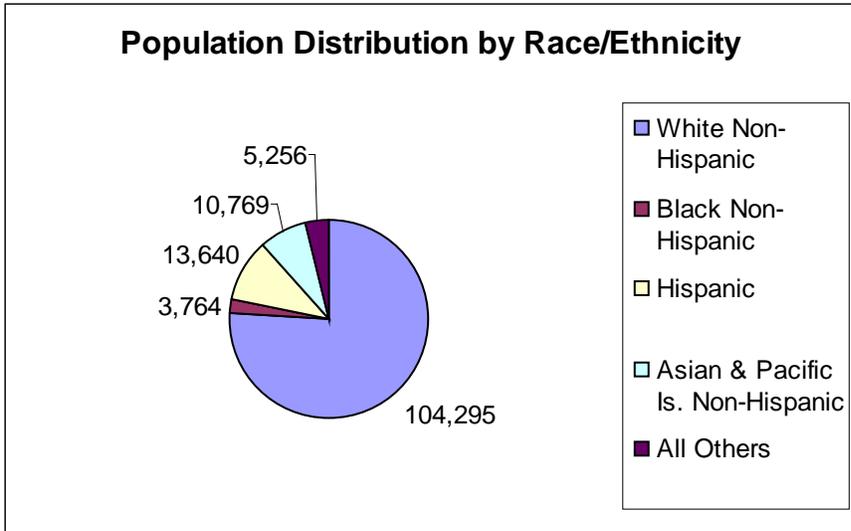
Mercy Hospital of Folsom is located within the City of Folsom in the eastern suburbs of Sacramento County. The hospital’s core service area includes Folsom, El Dorado Hills, Cameron Park, Shingle Springs and Rescue. Its primary service area extends to portions of Rancho Cordova, Sloughhouse and Placerville, and includes 12 zip codes.

Population

Population within Mercy Hospital of Folsom’s core and primary service areas is 137,724, and is projected to grow to 152,806 by 2015. Within the hospital’s core service area, a large percentage of the population is currently between the ages of 18 and 54 (53.7%). Children under the age of 18 make up 25% of the population; and 21.6% of the population is above the age of 55 years of age. Shifts in age distribution are projected by 2015, with the numbers of people ages 45 to 64, and 65 and older expected to increase significantly. Just over half of the population is female.

Ethnicity

Ethnic make up within Mercy Hospital of Folsom’s core and primary service areas is predominately Caucasian (75.7%). Ethnic break out is depicted in the chart on page 27. Growth is expected in the Hispanic community in coming years.



Household Income

Of the 47,485 households within Mercy Hospital of Folsom’s core and primary service areas, nearly 3.5% have annual incomes of under \$15,000. 4% of families have annual incomes of \$15,000 to \$25,000, and 12% of households have annual incomes that range from \$25,000 to \$50,000. Just under 15% of households have annual incomes that range from \$50,000 to \$75,000; over 17% have annual incomes between \$75,000 and \$100,000; and 48% have annual incomes over \$100,000.

Education

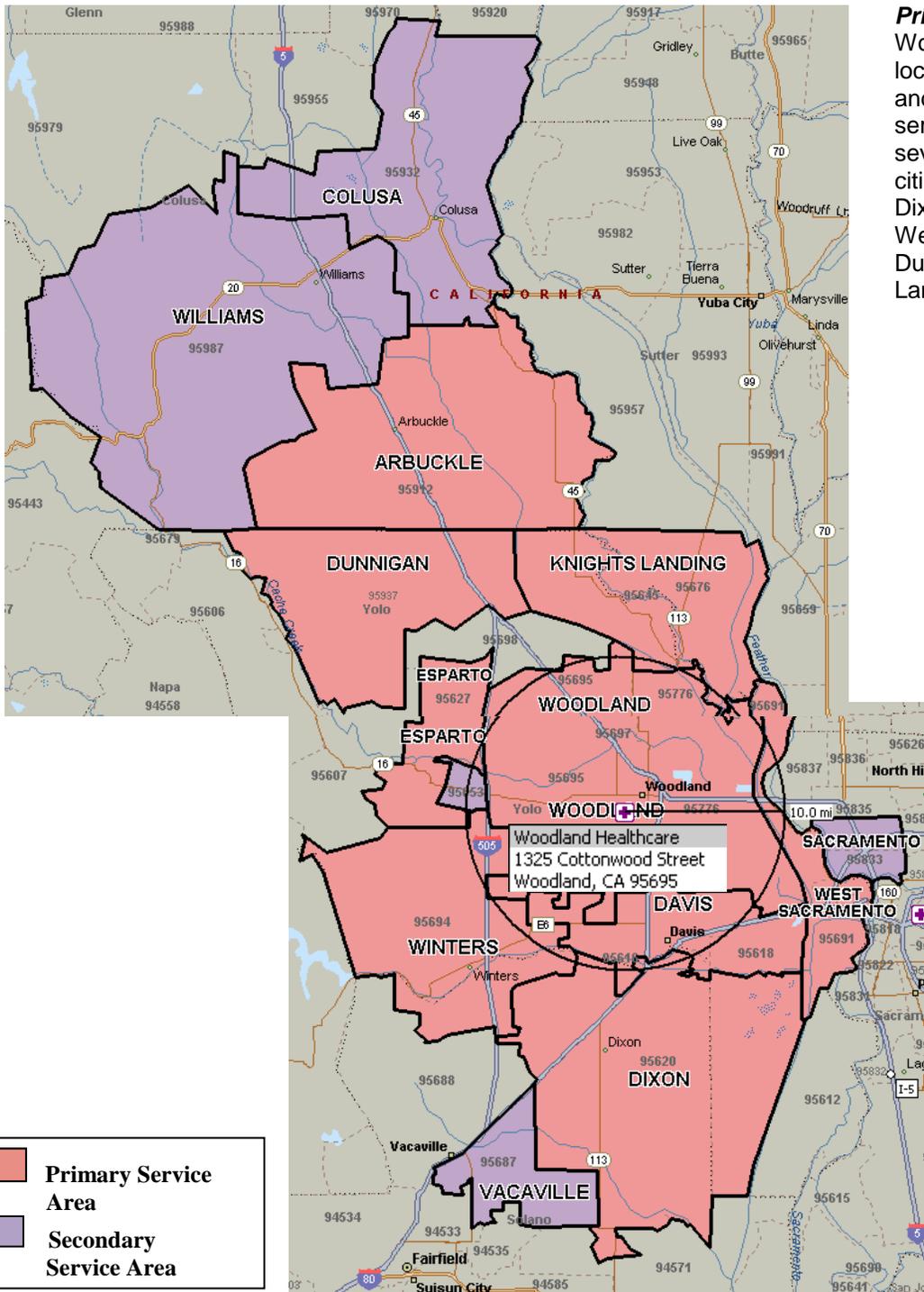
Of the adults living in Mercy Hospital of Folsom’s core and primary service areas, 6.5% do not have a high school diploma; 34% have some college education and nearly 42% hold a bachelor’s degree or higher.

Insurance Coverage

Over 42% of the patient population treated and discharged by the hospital has Medicare insurance, and nearly 4% of patients are insured by Medi-Cal. 45.5% have HMO or PPO coverage, and nearly 4% have no insurance coverage.

*Specific neighborhoods within the hospital’s core and primary service areas with disproportionate unmet health-related needs are indicated on Community Needs Index data in **Appendix B**.*

Woodland Healthcare

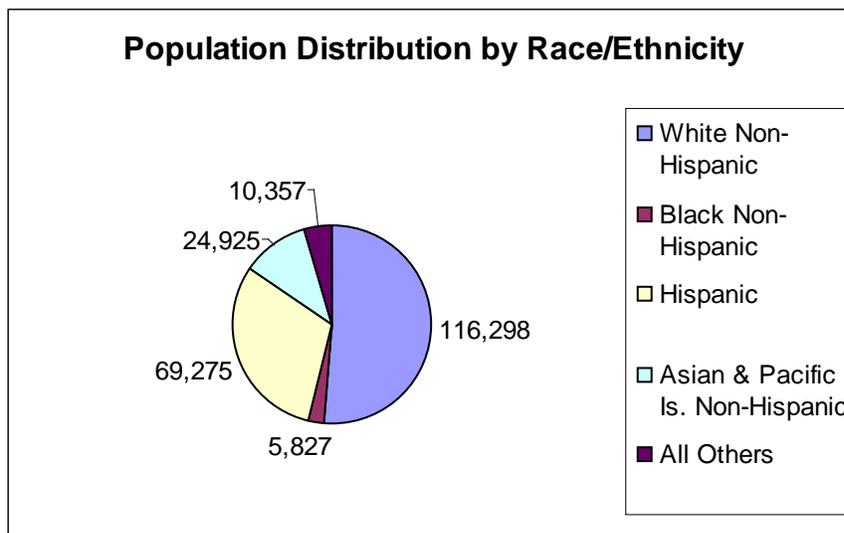


Population

Population within Woodland Healthcare's primary service area is 226,682, and is projected to grow to 246,795 by 2015. Within the hospital's primary service area, the largest population age group is 18 to 54 years of age, representing nearly 57%. Children age 17 and under make up 23.6% of the population. Over 19% of the population is between the ages of 54 and 64, and 10% is 65 years of age and older. The population is expected to age over the next five years, with an 18% increase in the 65 and older age group. Over half of the population is female.

Ethnicity

Over 51% of the population in Woodland Healthcare's primary service area is Caucasian. The Hispanic community makes up nearly 31% of the population and is expected to grow in future years. Ethnic break out is depicted in the chart below.



Household Income

Of the 77,555 households within Woodland Healthcare's primary service area, nearly 12% exist on annual incomes of less than \$15,000. Over 9% of households have annual incomes of \$15,000 to \$25,000. 22% of households have annual incomes of \$25,000 to \$50,000; 18% have annual incomes that range from \$50,000 to \$75,000; 13% have annual incomes between \$75,000 and \$100,000; and 25.7% have annual incomes in excess of \$100,000.

Education

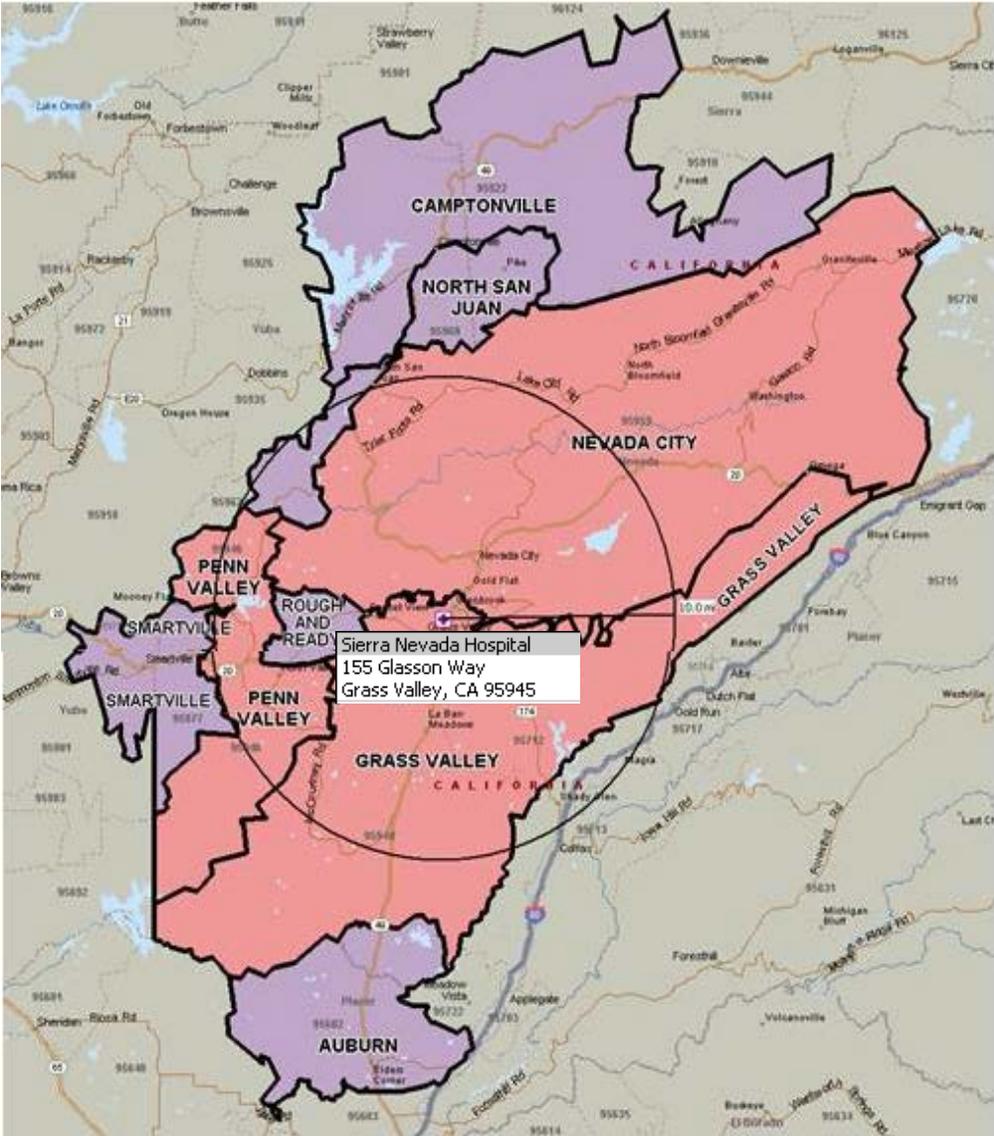
Of the adults living in Woodland Healthcare's primary service areas, 17% do not have a high school diploma. Nearly 26% have some college education, and 37.6% hold a bachelor's degree or higher.

Insurance Coverage

Nearly 40% of the patient population treated and discharged by the hospital has Medicare insurance, and 23.8% of patients are insured by Medi-Cal. Nearly 27% have HMO or PPO coverage, and 6% have no insurance coverage.

*Specific neighborhoods within the hospital's core and primary service areas with disproportionate unmet health-related needs are indicated on Community Needs Index data in **Appendix B**.*

Sierra Nevada Memorial Hospital



Primary Service Area

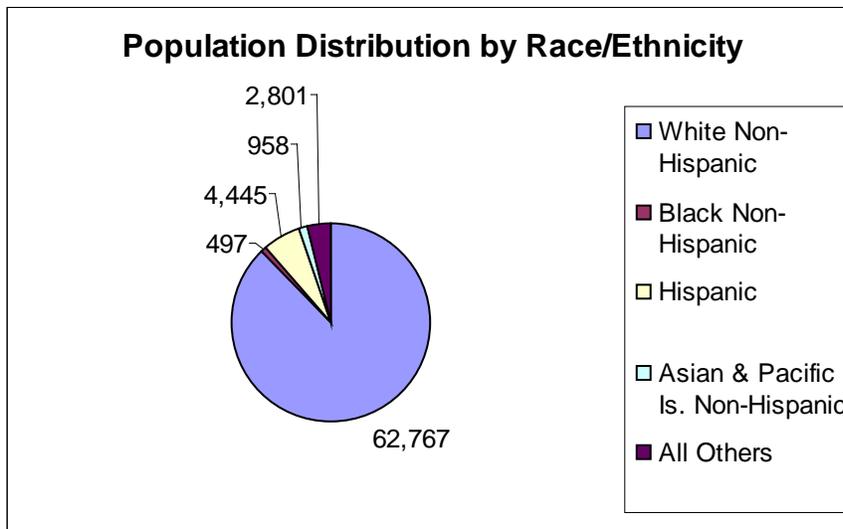
Sierra Nevada Memorial Hospital is in Nevada County encompassing four zip codes in the communities of Grass Valley, Penn Valley and Nevada City.

Population

Population within Sierra Nevada Memorial Hospital’s primary service area is 71,468, and is projected to grow to 73,769 by 2015. Within the hospital’s primary service area, people between the ages of 35 and 64 make up the largest percentage of the population (40%). Over 25.6% of the population is between 18 and 34 years of age. Children age 17 and younger make up 17% of the population, and seniors 65 years and older account for nearly 21% of the population. Growth in the senior population is anticipated in the future. Over half of the population is female.

Ethnicity

The majority of the population in Sierra Nevada Memorial Hospital's primary service area is Caucasian (88%). Ethnic break out is depicted in the chart on page 31. Growth is expected in the Hispanic community.



Household Income

Of the 29,700 households within Sierra Nevada Memorial Hospital's primary service area, 10% exist on annual incomes of less than \$15,000. Over 9% of households have annual incomes of \$15,000 to \$25,000. 26.2% of households have annual incomes of \$25,000 to \$50,000; 20% have annual incomes that range from \$50,000 to \$75,000; 13.3% have annual incomes between \$75,000 and \$100,000; and 21% have annual incomes in excess of \$100,000.

Education

Of the adults living in Sierra Nevada Memorial Hospital's primary service areas, 6% do not have a high school diploma. 39% have some college education, and 30.3% hold a bachelor's degree or higher.

Insurance Coverage

Nearly 56% of the patient population treated and discharged by the hospital has Medicare insurance, and 12% of patients are insured by Medi-Cal. Nearly 11% have HMO coverage; 14% are fee-for-service; and 3% have no insurance coverage.

*Specific neighborhoods within the hospital's core and primary service areas with disproportionate unmet health-related needs are indicated on Community Needs Index data in **Appendix B**.*

COMMUNITY

Community Needs and Assets Assessment Process

The community benefit planning process is driven in large part by community needs assessments, which enable the hospitals to more strategically and effectively plan for initiatives that focus on priority health and health-related issues in areas of the region with disproportionate unmet health needs (DUHN). The current Community Needs Assessment (CNA), completed in 2010, was a collaborative undertaking in partnership with Kaiser Permanente, Sutter Health Sacramento Sierra Region, and the University of California Davis Health Care System.

Many other partners within the four counties assessed - Sacramento, Yolo, El Dorado and Placer - added valuable insight and perspective to this important community project:

- Input was received from county public health officers serving each of the four counties.
- Numerous healthcare professionals and experts served as key informants, including those that manage or work in area community clinics; medical practitioners that work within various segments of underserved areas; homeless; immigrant and other target populations; and healthcare consultants.
- Information was sought from a wide-range of community-based organizations within segments of the target population that deliver specialty services such as prenatal and infant care, family counseling, and mental health.
- Members of the target populations themselves – recent immigrants new to the US and region – and members of the many diverse ethnic communities that call this region home (Hmong, Eastern Europe and Hispanic) were engaged to provide their first-hand experiences, concerns and needs.

Consultants in the assessment process included public health expert Dr. Heather Diaz, and vulnerable populations' specialist Dr. Mathew Schmidlein, both professors at the California State University at Sacramento, as well as the research and community development team at Valley Vision, Inc.

Study Objectives

The objectives of the CNA were to: 1) identify the unmet health needs of under-represented residents in the Greater Sacramento area, 2) understand the challenges these populations face when trying to maintain and/or improve their health, 3) understand where underserved populations turn for services needed to maintain and/or improve their health, and 4) understand what is needed to help these populations maintain and/or improve their health.

Website and Assets Mapping

Another important component of the project included the redesign of the assessment website, www.healthlivingmap.com. The site now contains health indicators in much greater detail and is easier for anyone in the community to interpret and utilize. The website also provides an expanded inventory of health assets in the region. CNA partners are now working with Sierra Health Foundation to go beyond assets mapping and conduct a gap analysis to determine the current capacity that exists within the region's safety-net, and the capacity the region actually needs to adequately provide appropriate levels of care.

Study Area

The CNA study area included the counties of El Dorado, Placer, Sacramento, and Yolo; home to over two million residents. To provide details of different health needs across the region, data were collected and analyzed at the ZIP code level across the region. In all, 106 total ZIP codes were included in the study.

Data Collection and Analysis

A key informant sample consisted of both community members and service providers. Fifteen focus groups with 134 community members were conducted in various settings throughout the region. Another 12 community members were individually interviewed. All focus groups with community members were recorded and transcribed, and those conducted in languages other than English were translated. All

transcriptions were analyzed for common themes and results which addressed the study objectives. A total of 20 service providers were interviewed. They included public health experts; county public health officers; health care and social service practitioners; physicians serving the poor and uninsured; and other members of community-based organizations serving the underserved. Additionally, the most recent secondary data, which included years 2006, 2007, and 2008, were collected. All data was collected by ZIP code, and included:

- Rates of emergency department visits and hospitalization by cause.
- Birth and mortality data.
- Demographic data (socio-economic indicators).
- Age stratified population data.
- Low birth weight rates.
- Infant mortality rates.
- Age adjusted mortality rates.
- Life expectancy at birth.

Additional variables not available at the ZIP code level were collected and examined at the county level. All secondary data were analyzed with the study objectives in mind, and findings were statistically validated.

Study Findings – Top Five Causes of Hospitalization, Emergency Department Visits, and Mortality

Findings included the identification of the top five causes of emergency department visits, hospitalization, and death for the region for 2008. These are displayed in Table 1 below. An up arrow (↑) indicates that the respective rate is above the state-wide rate for the same condition; a down arrow (↓) indicates the rate is below the state-wide rate:

Table 1: Top Five Causes of Hospitalization, Emergency Department Visits, and Mortality, 2008

Rank	Hospitalization	Emergency Department Visits	Mortality
1	Injury (unintentional) ↓	Injury (unintentional) ↓	Heart Disease ↑
2	Heart Disease ↓	Mental Health ↓	Cancer ↑
3	Mental Health ↓	Asthma ↓	Stroke ↑
4	Cancer ↓	Homicide ↓	Chronic Lower Respiratory Disease ↑
5	Stroke ↓	Diabetes ↓	Injury (unintentional) ↑

While all hospitalization and emergency department visits rates are below the state rate, all mortality rates are above. Further, trend analysis revealed year-over-year (2006-2008) increases in emergency department visits due to 1) unintentional injury, 2) mental health, 3) asthma, and 4) diabetes (rates due to homicide increased from 2006 to 2007, however, these were not available for 2008). Rates decreased year-over-year for hospitalization due to heart disease. Rates decreased for deaths due to 1) heart disease, 2) stroke, and 3) unintentional injury. No other trends were noted.

Study Findings – The Unmet Health Needs of Underserved Populations

To identify the unmet health needs of underserved populations, a variety of measures were taken. A vulnerability index was created—the *Community Health Vulnerability Index* (CHVI). The CHVI index drew on validated research used by Catholic Healthcare West in its Community Needs Index (CNI), which identified nine socio-demographic population characteristics known to contribute to poor health outcomes. These predictor variables were combined to create a CHVI score for each ZIP code in the study area. The highest ranked ZIP codes were compared to the lowest, and health conditions with statistically significant differences identified. Second, qualitative data (key informant interviews) were conducted across the region to help identify unmet health needs. Third, trend analysis was conducted on all secondary data to identify conditions that have increased consistently over the three year period for which data were collected. When taken together, these three measures revealed four conditions experienced at greater rates among underserved populations, and these are identified as the predominant unmet health needs of these residents, which include: 1) asthma, 2) diabetes, 3) mental health, and 4) hypertension.

In general, populations living in high vulnerable areas have lower life expectancies, higher mortality rates, higher infant mortality rates, and higher rates of low birth-weight infants.

Study Findings – Challenges of Underserved Populations Trying to Maintain/Improve Health

Analysis of the qualitative results produced six predominant obstacles that hindered or prevented access to health care by underserved populations. These included:

1. Affordability—of health care and specifically health insurance.
2. Locating physicians, specialists, dentists, mental/behavioral health, and other providers that take Medi-Cal and/or work at reduced rates.
3. Navigating a complex and inefficient safety net and related social services system.
4. Poor diet—resulting from the affordability and accessibility of healthy foods.
5. Cultural barriers—including language and social customs.
6. The stress of being poor.

Study Findings – Understanding Where Underserved Populations Turn When Needing Health Care

The analysis of qualitative data revealed a recurring pattern of action undertaken by under and uninsured populations when faced with a health care issue. This pattern of reaction was set into a model labeled “Avoidance of Care/Escalation Model.” The model shows that underserved populations, when faced with a health care issue, first **avoid** treatment of any type in the hopes that the condition will cure itself, due to costs. If the health care condition worsens, the next step in the model is to turn to **family, friends**, and sometimes **internet resources**, in the hopes of self-treatment, again, to avoid incurring costs. Data revealed that these populations often share prescription medications among family and friends. Finally, if self-treatment fails, the individual will turn to low-cost care at a free or reduced price clinic. The avoidance of care also results in a worsening condition requiring **emergency level** treatment.

Study Findings – What is Needed to Help Underserved Populations Maintain/Improve Health

When qualitative data were analyzed to understand what uninsured and underinsured populations felt they needed to maintain and improve their health, three strategies emerged. These were:

1. Increase **access to affordable health care and insurance**
2. Improve **quality of health care delivered in low or no-cost settings**
3. Provide more **health care information and education**

Conclusion

The 2010 CNA provided a thorough study of health outcomes between the most vulnerable and least vulnerable communities, coupled with information gathered from speaking directly with the community. It is assisting the hospitals in focusing and refining community benefit planning and programming efforts to address the greatest needs in the communities they serve. Results of the assessment have also been widely disseminated. Forums to examine the findings were conducted within all of the hospitals for management teams and employees who perform community service. Forums were also extended to local government officials and over 100 nonprofit community-based organizations. Tutorials for maneuvering the www.healthylivingmap.com website were also provided

*The full CNA report has been included in this report as **Attachment 1**, and provides findings in much greater detail. It can also be downloaded from the website.*

COMMUNITY BENEFIT PLANNING PROCESS

Developing the Hospital's Community Benefit Report and Plan

The 2010 CNA provides a comprehensive, large-scale view of the health of the region that helps steer hospital community benefit planning. However, it must be recognized that the greater Sacramento region is highly challenged by instability. Health and social challenges of the community are largely products of the region's economy, which has been stunned by the recession. Recovery forecasts show that the area is lagging well behind most of the nation. The recession, compounded by government budget cuts to public health, and a weak and fragmented FQHC system that has been unsuccessful to date in obtaining new federal monies to add capacity and efficiency, have a significantly negative affect on the health of the community. The hospitals continued to fill a monumental gap in needed safety-net services in FY 11, seeing alarmingly high utilization rates for uninsured and underinsured residents who admit to emergency departments in need of primary, mental, and specialty care they cannot find in community or county public health settings.

The region's health environment is also at a critical stage where cooperative and coordinated efforts between health care providers, nonprofit community-based organizations, county, city and state governments, business, and other sectors must materialize if the region intends to adequately care for its underserved residents, and improve the health status of the community.

The above factors have an important bearing on community benefit planning by the hospitals, and were the impetus for new initiatives in FY 11 to increase access to care, including the **Community Health Referral Network**, the **Intensive Outpatient Program**, the **Resource Connection**, and the expansion of the **Interim Care Program**. All of these initiatives are conducted in partnership with multiple community organizations. Program details and outcomes for these new FY 11 initiatives have been in the "Program Digest," beginning on page 41.

The hospitals also placed increasing emphasis on chronic disease education, prevention, and management in FY 11. The **CHAMP**[®] team significantly expanded its community outreach to underserved populations, offering health screenings and education, as well as referrals into the program if needed to residents of low-income housing developments across the region. The number of participants in both the **Diabetes - Take Control** and **Healthy Lives Program** is steadily increasing through enhanced community outreach. The **Your Life, Take Care** Chronic Disease Self Management Program continues to increase classes and trainers, targeting underserved populations in both English and Spanish. More on these programs can also be found in the "Program Digest."

FY 12 Program Planning

Emphasis on Chronic Disease

Heightened attention to chronic disease prevention, education and management is at the core of strategic community benefit planning and programming efforts in FY 12. Efforts will specifically target underserved populations where chronic disease is more prevalent and often goes unattended until urgent/emergent care is required. The 2010 CNA, and an increasing trend of higher hospital utilization rates for chronic disease conditions point clearly to the growing prevalence of not only diabetes, but heart disease, asthma, and hypertension as well among the region's poorest and most vulnerable populations; indicators that more than access to primary care is needed for residents to maintain good health. The CNA also determined there are limited resources at the community level to offer chronic disease education and intervention services. Counties have reduced or eliminated their offerings and nonprofit community-based clinic providers lack budget and staff.

A new region-wide Chronic Disease Self-Management Program will be introduced by the hospitals in Sacramento County in FY 12 in partnership with community clinics, Mercy Housing, and other partners. Providing this program at the community level will allow a natural pathway for reaching underserved populations. The program will incorporate two evidence-based educational workshop models developed by the Stanford University School of Medicine: 1) the Chronic Disease Self-Management Program; and 2) the Diabetes Self-Management Program. Both programs will be conducted in workshop settings within the

community and will be offered on a consecutive basis. They will complement the existing chronic disease programs in Yolo and Nevada counties.

Two other new initiatives are being launched by Methodist Hospital in FY 12; both aligned with strategy to build capacity in the community. While not addressed in the 2010 CNA, domestic violence is a growing concern for underserved women and children particularly in certain pockets of the region. This was revealed in a separate assessment undertaken by The California Endowment as part of the Building Healthy Communities initiative. The assessment identified domestic violence as one of the priority issues for underserved women and children living in several neighboring communities in the south Sacramento area served by Methodist Hospital; a part of the region that lacks domestic violence services.

WEAVE Wellness Center

To address the need, Methodist Hospital in collaboration with WEAVE, the primary nonprofit community-based provider of crisis intervention services for survivors of domestic violence and sexual assault, will establish a new WEAVE Wellness Center adjacent to the campus hospital. The project will leverage assets, areas of expertise and experience to provide an innovative model of comprehensive care that integrates the many special health needs of this target population at one location in the heart of a community where the need is great. Anticipated to open in fall 2011, The WEAVE Wellness Center will provide triage, intake, mental health and counseling services, education, case management and other support services. Training of clinical and other key staff within the hospital is already underway to enhance quality health care interventions for domestic violence victims that admit to the Emergency Department during crisis. The hospital-based domestic violence program will complement, collaborate with and support efforts at the WEAVE Wellness Center. Additionally, ongoing primary and preventative health care at the hospital's onsite Mercy Family Health Center will be provided for victims who are uninsured, underinsured, or undocumented and lack a medical home. Community outreach efforts are also underway to build domestic violence awareness, increase knowledge about resources available, and build upon the collaboration.

The project provides the full continuum of care that is essential for improved health and quality of life for women and children suffering from domestic violence. It marks a major departure from the conventional medical model. It builds capacity and increases access in a way that redefines current practice in the region.

New Beginnings Birth and Wellness Center

Methodist Hospital is also collaborating with the Center for Community Health and Well-Being to establish a New Beginnings Birth and Wellness Center satellite clinic offering prenatal and postnatal care to low-income and at-risk women in south Sacramento. The clinic will be housed in the same office complex as the WEAVE Wellness Center and responds to the health issues related to high infant mortality rates identified in the 2010 CNA.

According to 2006-2008 data, Sacramento County had an average infant mortality rate of 5.8 deaths per 1,000 live births; higher than the state rate at 5.3/1,000. Examination of mortality rates at the community level shows stark differences among area subgroups- both geographically and ethnically. Infant mortality in ZIP code 95820 served by Methodist Hospital is 8.29 deaths per 1,000 live births. This community has the highest infant mortality rate in all of urban California according to CNA data obtained from the California Department of Public Health. Reasons for such disparate conditions include a lack of prenatal care, low birth weight, and race as a contributing factor. Infant mortality rates for African Americans are greatest at 11.3 per 1,000; the rate for Caucasians is 5.4 per 1,000; and for Hispanics, 4.4 per 1,000.

Methodist Hospital is experiencing an increase in the number of underserved at-risk pregnant women with complications admitting to the Emergency Department. New Beginnings Birth and Wellness Center will also open in the fall of 2012. The New Beginnings Birth and Wellness Center will work closely with Methodist Hospital physicians to coordinate prenatal care and delivery. The center plans a fall 2012 opening.

Planning for the Uninsured/Underinsured Patient Population

Meeting the health care needs of the underserved is an integral part of the CHW Sacramento Service Area mission. No one should go without health care and the hospitals are committed to treating patients who have financial needs with the same dignity, compassion and respect that is extended to all patients. The hospitals consider each patient's ability to pay for his or her medical care, and follow the Patient Financial Assistance Policy established by CHW, which makes free or discounted care available to uninsured individuals with incomes up to 500% of the federal poverty level. The Patient Financial Assistance Policy is provided in **Appendix C**.

Continued education is provided on the assistance policy to hospital leadership and employees at all levels of the organization. Employees working in Admitting and Patient Financial Services are fully versed in the policy and dedicated to assisting patients that are in need of assistance. Any employee or member of the medical staff can refer patients for financial assistance. Family members, friends or associates of a patient may also make a request for financial assistance.

To ensure all patients are aware of the policy, financial assistance information is distributed in a number of ways. Notices in the primary languages spoken by the populations each hospital serves are posted in all emergency departments, in admitting and registration areas, and in business and financial services offices. Notices are also placed in all patient bills and include a toll-free contact number.

In addition to financial assistance, the hospitals support the specific needs of uninsured and underinsured patient populations by assisting them with government health program enrollment, providing free mental health consultations, and offering transportation.

Enrollment Assistance

Following medical treatment, the hospitals provide assistance to help uninsured patients enroll in government sponsored health insurance programs. In FY 11, over 18,000 uninsured patients received this free assistance, and an estimated 3,000 patients were successfully enrolled. Hospital-sponsored expenses for this assistance were over \$3 million.

Mental Health Consultations

In response to a priority need, the hospitals provide psychiatric consultations to uninsured patients who admit to the emergency departments because there are limited mental health services elsewhere in the community due to steep government budget cuts and closure of facilities. There were 2,190 patients that received mental health evaluations in FY 11. Hospital-sponsored community benefit to provide this service approached \$900,000.

Transportation

Taxi transportation is available for patients who do not have, or cannot afford their own transportation home upon discharge from the hospital. Nearly 3,000 patients received this service in FY 11. Hospital-sponsored community benefit to provide this service was over \$128,000.

PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

Summary of Key Priorities and Initiatives

Community benefit programs and initiatives in FY 11, and programs planned for FY 12, including those previously highlighted in this report, fall under five overarching priorities that are based on health issues and needs identified through community assessment, hospital strategic planning, and system-wide core principles. They include:

Priority 1: Increasing Access to Care

- Charity care
- Community Health Referral Network (new in FY 11).
- Mercy community clinics:
 - MercyClinic Norwood
 - MercyClinic Loaves & Fishes
 - MercyClinic White Rock
 - MercyClinic Folsom
 - MercyClinic North Highlands
 - Mercy Family Health Center
- Intensive Outpatient Program (new in FY 11).
- Resource Connection at Woodland Healthcare (new in FY 11).
- Cover the Kids (Mayor's initiative to enroll all children in health insurance).
- SPIRIT (referral program to provide specialty care for indigent residents).
- CHW Community Grants Program.
- CHW Community Investment Program.
- Immunization and health screening programs.
- Enrollment assistance Program.
- School Health Nurse Program.
- Emergency mental health counseling services.
- Prescription Medication Program.
- Transportation.

Priority 2: Chronic Disease Prevention, Education and Management

- CHAMP[®] (Congestive Heart Active Management Program).
- Cardiac conditioning and rehabilitation.
- Healthy Heart Education Series
- Healthy Lives Program.
- Diabetes – Take Control! (new in FY 11)
- The Caring Center.
- Community Health Education Program.
- Wellness Education Program (chronic disease self-management, smoking cessation, aging, healthy cooking, and prenatal care).
- Pulmonary Rehabilitation, Education and Support Program.
- Community Health Screenings:
 - Vascular
 - Blood Pressure
 - Cholesterol
 - AICD
- Master Training for Chronic Disease Leaders (implemented in FY 11, and planned for FY 12).
- Sacramento Community Chronic Disease Self-Management Program (planned in FY 12)

Priority 3: Continuum of Care to End Homelessness

- Interim Care Program (ICP) and ICP+ Mercy 5-bed skilled nursing unit (new in FY 11).
- Generous Helping Program.
- Friendship Park Program.
- Lodging and transitional housing subsidy.

Priority 4: Women's and Children's Health and Safety

- Mercy Perinatal Recovery Network
- Safe Kids
- Maternity Health Screening Program
- WEAVE Wellness Center (planned in FY 12)
- New Beginnings Birth and Wellness Center (planned in FY 12)

Priority 5: Community Health and Well-Being

- Growing Well With Mercy
- Alzheimer's Outreach Program
- Nutrition Consultation
- Yolo Adult Day Care
- Support Groups:
 - Cancer
 - Living with Loss
 - Traumatic Brain Injury
 - Stroke
- Lifeline
- Health fairs
- Farmers Markets
- Mercy Faith and Health Partnership Program
- CPR Training
- Professional and Medical Education:
 - Health Careers Academy
 - Cristo Rey Work Study Program
 - Student RN Orientation Program
 - Regional Occupational Program
 - Web-based Nursing Education Program
 - Respiratory Therapy Preceptor Program
 - Dietetic Internship Program

Programs within these priority areas are tracked and evaluated, with an increasing emphasis on outcomes measurement. Reports are provided to the Community Health Committee, Community Board, hospital presidents and executive management teams on an ongoing basis. A number of these programs are highlighted in greater detail in the following "Program Digest."

PROGRAM DIGEST

Priority 1: Increasing Access to Care

COMMUNITY HEALTH REFERRAL NETWORK – REGIONAL INITIATIVE	
Hospital CB Priority Areas	<ul style="list-style-type: none"> ✓ Access to Care <input type="checkbox"/> Chronic Disease Prevention, Education and Management <input type="checkbox"/> Continuum of Care to End Homelessness <input type="checkbox"/> Women's and Children's Health and Safety <input type="checkbox"/> Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention <input type="checkbox"/> Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment	Access to primary care and the difficulty in navigating the community clinic system were identified in CNA as top priorities for uninsured and underinsured populations. Need also evidenced by high rate of utilization for non-urgent/emergent care by target population in Emergency Departments
Program Description	Network provides a model of care coordination to improve access to care for the underserved. The project is a collaborative effort between the hospitals and 18 nonprofit FQHC/community clinics in the region, including Mercy Clinics. It uses health information technology (MobileMD) and shared case management support to assist patients who rely on EDs for non-acute needs because they are unable to navigate a fragmented safety-net by finding them a medical home in an appropriate community clinic setting.
FY 2011	
Goal FY 2011	Assist 500 uninsured and underinsured patients in finding a medical home with one of the Network clinic partners; seek grant funding and consider expanding project.
2011 Objective Measure/Indicator of Success	Number of successful community referrals made; appointments kept by patients assisted; reduction in ED readmits by 75% for patients assisted; patient satisfaction in community clinic setting.
Baseline	The region has a weak and fragmented safety-net that was further devastated by severe cuts to public health services and the recession. Access to care for underserved is a crisis. Unprecedented numbers are turning to EDs for basic care because they lack a primary care provider and are unable to navigate the system. Over 30% of emergency department admissions could be avoided if patients had access to affordable care.
Intervention Strategy for Achieving Goal	Daily/weekly check-ins with referral specialist; continued interface with clinic partners, ED Patient Registration, Case Management and clinical staff; ongoing follow up with those patients assisted; constant outcome monitoring and program evaluation.
Result FY 2011	1,125 patients assisted; 64% kept their clinic appointment; 88% were satisfied with care in a clinic setting; 85% did not readmit to the Emergency Department. Added Sacramento County Primary Care Center as a partner to support county insured patients.
Hospital's Contribution / Program Expense	\$78,234.
FY 2012	
Goal 2012	Assist 1,500 patients in finding medical homes in the FQHC/community clinic system. Continue to assess capacity in the region to determine if expansion is feasible. Priority for CHW Community Grants will be focused on clinic partners to help offset sliding scale fees, lab and other testing costs, in order to assist and place additional patients.
2012 Objective Measure/Indicator of Success	Number of successful community referrals made; appointments kept; reduction in readmits by 75% for patients assisted; patient satisfaction in community clinic setting.
Baseline	Conditions in the Sacramento region have not changed from FY 11; access to care and care coordination remains a priority.
Intervention Strategy for Achieving Goal	Daily/weekly progress check-ins with referral specialist; continued interface with clinic partners, Emergency Department Patient Registration, Case Management and clinical staff; ongoing follow up with those patients assisted; constant outcome monitoring and program evaluation.
Community Benefit Category	A3-e Health Care Support Services – Information & Referral.

MERCYCLINIC NORWOOD – MERCY GENERAL HOSPITAL	
Hospital CB Priority Areas	<ul style="list-style-type: none"> ✓ Access to Care <input type="checkbox"/> Chronic Disease Prevention, Education and Management <input type="checkbox"/> Continuum of Care to End Homelessness <input type="checkbox"/> Women's and Children's Health and Safety <input type="checkbox"/> Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment	Access to primary care for uninsured and low-income populations identified as a top CNA priority. Need also evident in increased ED admissions for non-urgent care by target population.
Program Description	MercyClinic Norwood provides medical care to the underserved populations living in an economically depressed part of the region. Those who do not have insurance are treated free of charge. Services include primary and preventative care, including adult and child physicals, immunizations, chronic disease management, and lab services.
FY 2011	
Goal FY 2011	Provide a health care safety net for uninsured and underinsured residents, increasing access to care in an area of the region that has been identified as having high-need.
2011 Objective Measure/Indicator of Success	Capacity utilization; numbers of patients served. Maintain hospital support. Increased efficiency through strategic community partnerships.
Baseline	MercyClinic Norwood fills a gap in the safety-net, where there are not enough providers to serve populations in need; provides care to undocumented populations, which is critical since Sacramento County eliminated all services this population; and operates in a DUHN area where services are not available.
Intervention Strategy for Achieving Goal	Hospital increased financial support, enabling the clinic to add a new provider and expand capacity. Work closely with Community Benefit Department and the Community Health Referral Network to develop partnership strategies.
Result FY 2011	11,921 patients served, nearly 500 more than FY 10 as a result of adding new physician provider. The clinic significantly expanded its ability to accept new patients assisted by the Community Health Referral network.
Hospital's Contribution / Program Expense	\$2,007,967.
FY 2012	
Goal 2012	Provide a health care safety net for uninsured and underinsured residents, increasing access to primary care in an area of the region that has been identified as having high-need. Enhance focus on education and intervention to enable patients to manage chronic disease.
2012 Objective Measure/Indicator of Success	Capacity utilization – number of patients served. Linkage to Community Health Referral Network. Patient referrals to chronic disease programs.
Baseline	Access to care and need for stronger safety-net continue to be a priority.
Intervention Strategy for Achieving Goal	Develop partnership strategies to improve structure and efficiency and level of service. Continued evaluation of clinic operations by Clinic Director and Hospital leadership. Link patients referred by the Community Health Referral Network with CHAMP [®] and other chronic disease offerings.
Community Benefit Category	C3 – Hospital Outpatient Services.

MERCYCLINIC LOAVES & FISHES – MERCY GENERAL HOSPITAL	
Hospital CB Priority Areas	<ul style="list-style-type: none"> ✓ Access to Care <input type="checkbox"/> Chronic Disease Prevention, Education and Management <input type="checkbox"/> Continuum of Care to End Homelessness <input type="checkbox"/> Women's and Children's Health and Safety <input type="checkbox"/> Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment	Access to primary care for the uninsured populations is identified as a top CNA priority. The numbers of homeless have also grown in the region with the recession, which is evidenced in increased admissions to the hospitals.
Program Description	MercyClinic Loaves & Fishes provides free episodic and urgent health care to homeless people in collaboration with Sacramento County. Mercy General Hospital provides nursing; clerical staff; medical and business supplies; equipment; telephone; housekeeping; security; and EKGs.
FY 2011	
Goal FY 2011	Provide a health care safety net for the homeless and immediate access to free urgent care.
2011 Objective Measure/Indicator of Success	Continued support and collaboration with Sacramento County to maintain current levels of service.
Baseline	The numbers of homeless are estimated to have more than doubled over the past three years due to the recession. The clinic is one of very few points of health care access available.
Intervention Strategy for Achieving Goal	Maintaining relationship with Sacramento County during a period of severe county budget cuts to ensure program continues is a priority.
Result FY 2011	3,686 patients served.
Hospital's Contribution / Program Expense	\$259,071.
FY 2012	
Goal 2012	Provide a health care safety net for the homeless and immediate access to free urgent care.
2012 Objective Measure/Indicator of Success	Continued support and collaboration with Sacramento County to maintain current levels of service.
Baseline	The numbers of homeless are estimated to have more than doubled over the past three years due to the recession. The clinic is one of very few points of health care access available.
Intervention Strategy for Achieving Goal	Maintaining relationship with Sacramento County during a period of severe county budget cuts to ensure program continues is a priority.
Community Benefit Category	C3 – Hospital Outpatient Services.

MERCYCLINIC WHITE ROCK – MERCY HOSPITAL OF FOLSOM	
Hospital CB Priority Areas	<ul style="list-style-type: none"> ✓ Access to Care <input type="checkbox"/> Chronic Disease Prevention, Education and Management <input type="checkbox"/> Continuum of Care to End Homelessness <input type="checkbox"/> Women's and Children's Health and Safety <input type="checkbox"/> Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment	Access to primary care for uninsured and low-income populations identified as a top CNA priority. Need also evident in increased ED admissions for non-urgent care by target population.
Program Description	Located in an underserved area of Rancho Cordova, the clinic provides free or low-cost primary health care for the working poor and uninsured. Imaging and other diagnostic procedures are donated by Mercy Hospital of Folsom. A social services program that includes individual and family counseling, case management and resource/referral expertise is provided in addition to primary care.
FY 2011	
Goal FY 2011	Provide a health care safety net for uninsured and underinsured residents, increasing access to care in an area of the region that has been identified as having high-need.
2011 Objective Measure/Indicator of Success	Capacity utilization; numbers of patients served. Increased efficiencies through strategic community partnership.
Baseline	The clinic fills a gap in the region's safety-net, which has been devastated by local government budget cuts and the recession; provides care to undocumented immigrants, which is critical since Sacramento County eliminated all services to this populations; and operates in an area where services are not available.
Intervention Strategy for Achieving Goal	Capacity utilization; numbers of patients served. Maintain hospital support. Work closely with Community Health Referral Network.
Result FY 2011	1,786 patients served. Hospital financial support increased however, the clinic lost a provider for a period of time in FY 11, which decreased numbers served and ability to accept new patients. A new provider was added late in the year, which should re-open capacity in FY 12.
Hospital's Contribution / Program Expense	\$589,554.
FY 2012	
Goal 2012	Provide a health care safety net for uninsured and underinsured residents, increasing access to primary care in an area of the region that has been identified as having high-need. Enhance focus on education and intervention to enable patients to manage chronic disease.
2012 Objective Measure/Indicator of Success	Increase numbers of patients served to capacity levels of FY 10. Maintain level of hospital support. Linkage to Community Health Referral Network. Patient referrals to chronic disease programs.
Baseline	Access to care and need for stronger safety-net continue to be a priority.
Intervention Strategy for Achieving Goal	Added new provider to return to full capacity. Clinic director incorporating new standardized procedures for increased efficiency. Work closely with Community Health Referral Network. Link patients to chronic disease offerings in the community. Develop partnership strategies to improve structure and efficiency and level of service.
Community Benefit Category	C3 – Hospital Outpatient Services.

MERCYCLINIC FOLSOM – MERCY HOSPITAL OF FOLSOM	
Hospital CB Priority Areas	<ul style="list-style-type: none"> ✓ Access to Care <input type="checkbox"/> Chronic Disease Prevention, Education and Management <input type="checkbox"/> Continuum of Care to End Homelessness <input type="checkbox"/> Women's and Children's Health and Safety <input type="checkbox"/> Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment	Access to primary care for uninsured and low-income populations identified as a top CNA priority. Need also evident in increased ED admissions for non-urgent care by target population.
Program Description	MercyClinic Folsom provides free or low-cost primary care services including well child exams, immunizations, physicals, and health education to uninsured patients.
FY 2011	
Goal FY 2011	Provide a health care safety net for uninsured and underinsured residents, increasing access to care in an area of the region that has been identified as having high-need.
2011 Objective Measure/Indicator of Success	Capacity utilization; numbers of patients served. Maintain hospital support. Increased efficiency and level of service through strategic community partnerships.
Baseline	The clinic fills a gap in the region's safety-net, that has been devastated by local government budget cuts and the recession; provides care to undocumented immigrants, which is critical since Sacramento County eliminated all services to this populations; and operates in an area where services are not available.
Intervention Strategy for Achieving Goal	Maintain hospital support. Work closely with Community Health Referral Network. Develop partnership strategies.
Result FY 2011	2,503 patients served, 532 more than in FY 10.
Hospital's Contribution / Program Expense	\$358,879.
FY 2012	
Goal 2012	Provide a health care safety net for uninsured and underinsured residents, increasing access to primary care in an area of the region that has been identified as having high-need. Enhance focus on education and intervention to enable patients to manage chronic disease.
2012 Objective Measure/Indicator of Success	Maintain increased levels of patient volume. Linkage to Community Health Referral Network. Patient referrals to chronic disease programs.
Baseline	Access to care and need for stronger safety-net continue to be a priority.
Intervention Strategy for Achieving Goal	Clinic director incorporating new standardized procedures for increased efficiency. Work closely with Community Health Referral Network and new Chronic Disease Self Management Program. Develop partnership strategies to improve structure and efficiency and level of service.
Community Benefit Category	C3 – Hospital Outpatient Services.

MERCYCLINIC NORTH HIGHLANDS – MERCY SAN JUAN MEDICAL CENTER	
Hospital CB Priority Areas	<ul style="list-style-type: none"> ✓ Access to Care <input type="checkbox"/> Chronic Disease Prevention, Education and Management <input type="checkbox"/> Continuum of Care to End Homelessness <input type="checkbox"/> Women’s and Children’s Health and Safety <input type="checkbox"/> Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment	Access to primary care for uninsured and low-income populations identified as a top CNA priority. Need also evident in increased ED admissions for non-urgent care by target population.
Program Description	The North Highlands community lacks adequate access to medical services for the uninsured and low-income population. Mercy San Juan Medical Center has partnered with the Twin Rivers Unified School District and the County of Sacramento to provide free primary health care to those in the community who otherwise would not be able to afford it. The clinic serves as part of the region’s safety-net.
FY 2011	
Goal FY 2011	Provide a health care safety net for uninsured and underinsured residents, increasing access to care in an area of the region that has been identified as having high-need.
2011 Objective Measure/Indicator of Success	Capacity utilization; numbers of patients served. Maintain hospital support.
Baseline	The clinic fills a gap in the region’s safety-net, which has been devastated by local government budget cuts and the recession; provides care to undocumented immigrants, which is critical since Sacramento County eliminated all services to this populations; and operates in an are where services are not available.
Intervention Strategy for Achieving Goal	No intervention strategy.
Result FY 2011	2,347 patients served; clinic at capacity.
Hospital’s Contribution / Program Expense	\$1,021,833.
FY 2012	
Goal 2012	Provide a health care safety net for uninsured and underinsured residents, increasing access to care in an area of the region that has been identified as having high-need. Enhance focus on education and intervention to enable patients to manage chronic disease.
2012 Objective Measure/Indicator of Success	Capacity utilization – numbers of patients served. Maintain hospital support.
Baseline	Access to care and need for stronger safety-net continue to be a priority.
Intervention Strategy for Achieving Goal	Clinic director incorporating new standardized procedures for increased efficiency. Work closely with new Chronic Disease Self Management Program. . Develop partnership strategies to improve structure, efficiency and level of service.
Community Benefit Category	C3 – Hospital Outpatient Services.

MERCY FAMILY HEALTH CENTER – METHODIST HOSPITAL OF SACRAMENTO	
Hospital CB Priority Areas	<input checked="" type="checkbox"/> Access to Care <input type="checkbox"/> Chronic Disease Prevention, Education and Management <input type="checkbox"/> Continuum of Care to End Homelessness <input type="checkbox"/> Women’s and Children’s Health and Safety <input type="checkbox"/> Community Health and Well-Being
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
Link to Community Needs Assessment	Access to primary care for uninsured and low-income populations identified as a top CNA priority. Need also evident in increased ED admissions for non-urgent care by target population. Mercy Family Health Center fills a gap in the region’s safety-net, by providing care to uninsured and underinsured in south Sacramento, a part of the region that has been identified as a DUHN area that has been devastated by local government budget cuts and the recession; and operates in an area where services are not available.
Program Description	Mercy Family Health Center fills a gap in the region’s safety-net, by providing care to uninsured and underinsured in south Sacramento, a part of the region that has been identified as a DUHN area.
FY 2011	
Goal FY 2011	Increase access to primary health care for uninsured and low-income ethnically diverse populations as part of the region’s safety-net.
2011 Objective Measure/Indicator of Success	Capacity utilization – number of patients served. Manage and support center operations. Community outreach by Residency Physicians who provide care in the Center.
Baseline	The center fills a gap in the region’s safety-net, which has been devastated by local government budget cuts and the recession, and operates in an area where services are not available.
Intervention Strategy for Achieving Goal	No intervention strategy.
Result FY 2011	23,256 patients served; nearly 10,000 more than FY 10.
Hospital’s Contribution / Program Expense	\$3,867,360.
FY 2012	
Goal 2012	Increase access to primary health care for uninsured and low-income ethnically diverse populations as part of the region’s safety-net.
2012 Objective Measure/Indicator of Success	Capacity utilization – number of patients served. Manage and support center operations. Continued outreach to community by Resident Physicians.
Baseline	Access to care and need for stronger safety-net continue to be a priority.
Intervention Strategy for Achieving Goal	Hospital leadership focused on enhanced operational efficiencies.
Community Benefit Category	C3 – Hospital Outpatient Services.

INTENSIVE OUTPATIENT PROGRAM – REGIONAL INITIATIVE	
Hospital CB Priority Areas	<ul style="list-style-type: none"> ✓ Access to Care <input type="checkbox"/> Chronic Disease Prevention, Education and Management <input type="checkbox"/> Continuum of Care to End Homelessness <input type="checkbox"/> Women’s and Children’s Health and Safety <input type="checkbox"/> Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment	Mental health and the lack of services to treat this illness are identified as top priorities in the 2010 CNA. The hospitals have seen a major and alarming increase in patients admitting to the EDs with crisis mental health conditions.
Program Description	Two nonprofit community based organizations, El Dorado County Community Health Center and El Hogar Community Services, Inc, each provide one full-time LCSW dedicated to receiving referrals from Mercy General Hospital, Mercy San Juan Medical Center, Mercy Hospital of Folsom, and Methodist Hospital for patients in need of immediate outpatient mental health care residing in Sacramento and El Dorado counties. El Hogar also takes referrals for patients needing substance abuse treatment. Both agencies provide same or next business day psychological services for mentally ill patients that are able to be discharged and treated on an outpatient basis. Agencies offer ongoing individual and group outpatient mental health treatment five days a week.
FY 2011	
Goal FY 2011	Increase access to mental health care for those that suffer from this illness.
2011 Objective Measure/Indicator of Success	Hospital leadership increased budget to implement partnership. Initial goal established to serve 75 patients.
Baseline	Budget cuts by local government have severely impacted mental health services, and the need has reached a level of crisis.
Intervention Strategy for Achieving Goal	Education about the partnership in the hospital EDs, and engagement of hospital Case Management and Discharge Planners
Result FY 2011	146 patients referred in initial six months of program operation.
Hospital’s Contribution / Program Expense	\$50,000 CHW Community Grant to each partner; additional \$24,000 per hospital in community benefit funding; Total - \$196,000.
FY 2012	
Goal 2012	Increase access to mental health care for those that suffer from this illness.
2012 Objective Measure/Indicator of Success	Double number of patients referred.
Baseline	Budget cuts by local government have severely impacted mental health services, and the need has reached a level of crisis.
Intervention Strategy for Achieving Goal	Maintain increased level of CB funding. Ongoing tracking and evaluation of partnership.
Community Benefit Category	E1-a Cash Donations – Contributions to Nonprofit orgs/Community groups.

THE RESOURCE CONNECTION – WOODLAND HEALTHCARE	
Hospital CB Priority Areas	<ul style="list-style-type: none"> ✓ Access to Care <input type="checkbox"/> Chronic Disease Prevention, Education and Management <input type="checkbox"/> Continuum of Care to End Homelessness <input type="checkbox"/> Women's and Children's Health and Safety <input type="checkbox"/> Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment	Access to primary and specialty care for uninsured and low-income populations identified as a top CNA priority. Need also evident in increased ED admissions for non-urgent care by target population and lack of financial resources to pay for services. The Resource Connection fills a gap in the region's safety-net, by providing health education information and insurance enrollment assistance to uninsured and underinsured in Yolo County, a part of the region that has been identified as a DUHN area that has been devastated by local government budget cuts and the recession; and operates in an area where services are not available.
Program Description	The Resource Connection (A Program of the Yolo Family Resource Center) is located in the Woodland Healthcare Clinic and serves as a community service hub by providing a one stop access point for community services and health education in both Spanish and English. Services provided: health insurance enrollment assistance for children and adults, health education, case management, referrals to local community organizations/resources, homelessness prevention & intervention services.
FY 2011	
Goal FY 2011	Improve and Increase access to healthcare services and other community services.
2011 Objective Measure/Indicator of Success	To offer an additional service hub site in Woodland with varied day/evening hours to address the needs of 150 families (600 individuals) a year with 700 resource connections.
Baseline	Budget cuts by local government have severely impacted health insurance enrollment services and resource programs for our neediest families.
Intervention Strategy for Achieving Goal	Education and outreach about the partnership and services of the service hub in the WHC Clinic.
Result FY 2011	Served 720 individuals with 825 resource connections
Hospital's Contribution / Program Expense	\$20,000 cash and \$73,344 in in-kind space in clinic
FY 2012	
Goal 2012	Improve and Increase access to healthcare services and other community services.
2012 Objective Measure/Indicator of Success	To offer an additional service hub site in the Woodland with varied day/evening hours to address the needs of 200 families (800 individuals) a year with 1,500 resource connections.
Baseline	Budget cuts by local government have severely impacted health insurance enrollment services and resource programs for our neediest families.
Intervention Strategy for Achieving Goal	Education and outreach about the partnership and services of the service hub in the WHC Clinic.
Community Benefit Category	E1-a Cash Donations – Contributions to Nonprofit orgs/Community groups.

Priority 2: Chronic Disease Prevention, Education and Management

CONGESTIVE HEART ACTIVE MANAGEMENT PROGRAM (CHAMP®) – REGION-WIDE FOR SACRAMENTO COUNTY	
Hospital CB Priority Areas	<ul style="list-style-type: none"> ✓ Access to Care ✓ Chronic Disease Prevention, Education and Management Continuum of Care to End Homelessness Women's and Children's Health and Safety Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment	Responds to a priority need identified through community health assessments. Heart failure is a leading cause of hospitalization for residents throughout the broader Sacramento region. It is the fifth highest reason for emergency department visits, and the number one cause of death.
Program Description	CHAMP® establishes a care relationship with patients that have heart disease after discharge from the hospital through: <ul style="list-style-type: none"> - Regular phone interaction; support and education to help manage this disease - Monitoring of symptoms or complications and recommendations for diet changes, medicine modifications or physician visits
FY 2011	
Goal FY 2011	Improve the health and quality of life of those that suffer from heart disease, enabling them to better manage their disease and reducing their need to be admitted or readmitted to the hospital.
2011 Objective Measure/Indicator of Success	Increase enrollment of underserved through outreach; collaborate with community; continue to maintain reduction in number of hospitals admissions and readmissions for enrolled participants. Collaborate with FQHC to identify new program participants.
Baseline	Heart failure is a priority health issue for the region, identified in past and current CNAs. The program continues to demonstrate improvements in the health of participants suffering from this chronic disease.
Intervention Strategy for Achieving Goal	Education and screenings events scheduled at 9 low-income housing projects. Orientation and training of Emergency Department physicians at Methodist Hospital, including linkage to a community physician serving low-income residents. Gap analysis conducted by a clinical nurse liaison at Mercy San Juan Medical Center to identify heart failure inpatients and facilitate referrals and enrollment. Incorporation of CHAMP® auto referral functions within Cerner by Mercy Hospital of Folsom Case Management.
Result FY 2011	1,811 participants enrolled in program; 81% reduction in heart failure admissions. (916 participants enrolled in program in FY 10, and 81% reduction in hospital readmits by program participants.)
Hospital's Contribution / Program Expense	\$212,507
FY 2012	
Goal 2012	Improve the health and quality of life of those that suffer from heart disease, enabling them to better manage their disease and reducing their need to be admitted or readmitted to the hospital.
2012 Objective Measure/Indicator of Success	Increase enrollment of underserved through outreach; collaborate with community; continue to maintain reduction in number of hospitals admissions and readmissions for enrolled participants.
Baseline	1,811 participants enrolled in program and 81% reduction in hospital readmits by program participants in FY 2011 provides baseline for FY 2012.
Intervention Strategy for Achieving Goal	Regular meetings with CHAMP® Teams at hospitals; Strategy meeting with FQHC; program outcome monitoring and evaluation.
Community Benefit Category	A2-e Community Based Clinical Services – Ancillary/Other Clinical Services

CONGESTIVE HEART ACTIVE MANAGEMENT PROGRAM (CHAMP[®]) – WOODLAND HEALTHCARE (YOLO COUNTY)	
Hospital CB Priority Areas	<ul style="list-style-type: none"> Access to Care ✓ Chronic Disease Prevention, Education and Management Continuum of Care to End Homelessness Women's and Children's Health and Safety Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment	Responds to a priority need identified through community health assessments. Heart failure is a leading cause of hospitalization for residents throughout the broader Sacramento region. It is the fifth highest reason for emergency department visits, and the number one cause of death.
Program Description	The Congestive Heart Active Management Program (CHAMP [®]) provides patients with a vital link after they leave the hospital through regular phone intervention, educational classes and better disease management skills. This program targets patients diagnosed with Congestive Heart Failure (CHF), post heart attack high cholesterol and/or high blood pressure. Regular phone calls are made regarding weight and blood pressure changes, pain, medication side effects, or any other complications. Staff members make recommendations for diet, medicine modification, or physician visits. Follow up is conducted with physicians.
FY 2011	
Goal FY 2011	Assist patients with ongoing intensive management of heart disease to improve health and reduce hospital readmissions.
2011 Objective Measure/Indicator of Success	Objectives for FY 11 were to enroll 30 people annually and decrease readmissions by 5% for CHF.
Baseline	Heart failure is a priority health issue for the region, identified in past and current assessments of the community and hospital utilization rates. The program continues to demonstrate improvements in the health of participants suffering from this chronic disease. Heart Disease is # 5 in top causes in Yolo County for ES visits; #3 in top causes for hospitalization and #2 in top causes of mortality. It is identified in the 2010 CNA as a priority health issue.
Intervention Strategy for Achieving Goal	Continue education from staff and physicians to patients on the importance of healthy choices; additional outreach to increase enrollment.
Result FY 2011	18 patients were enrolled. At year end 100% of the patients were on ACEI, surpassing the goal of 82%. At year end 80% of the patients were on Beta Blockers, narrowly missing the goal of 82%. There were 2 re-admissions by CHAMP patients, therefore reducing re-admissions by 94.5%. During the 4 th quarter of FY 11, patient satisfaction surveys were distributed and results will be reported in the first quarter of FY 12. A six question Physician Satisfaction Survey was sent out in March, 2011, with a target of 4.5. Overall satisfaction score was 3.125. Communication was sited as an area of improvement. Physician follow up will be conducted.
Hospital's Contribution / Program Expense	\$7,620.
FY 2012	
Goal 2012	Assist patients with ongoing intensive management of heart disease to improve health and reduce hospital readmissions.
2012 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Enroll 30 people annually. • Avoid hospital or emergency department admissions among 60% of participants.
Baseline	Need in community; number of participants and successful rate of reduction in hospital admits/readmits determined basis for FY 12.
Intervention Strategy for Achieving Goal	Continue education from staff and physicians to patients of importance of healthy choices; additional active outreach to increase enrollment.
Community Benefit Category	A2-e Community Based Clinical Services – Ancillary/Other Clinical Services.

CONGESTIVE HEART ACTIVE MANAGEMENT PROGRAM (CHAMP®) – SIERRA NEVADA MEMORIAL HOSPITAL (NEVADA COUNTY)	
Hospital CB Priority Areas	<ul style="list-style-type: none"> Access to Care ✓ Chronic Disease Prevention, Education and Management Continuum of Care to End Homelessness Women's and Children's Health and Safety Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment	Congestive Heart Failure (CHF) has been identified through assessment and hospital utilization as a priority health issue for Nevada County, where there is a large and growing elderly population.
Program Description	CHAMP® is open to all eligible with a diagnosis of CHF at no-cost. The program improves the health status of heart failure patients by providing patients with a vital link to the medical world after they leave the hospital through regular phone interaction and educational discussion. The goal is to improve patient understanding and management of CHF to reduce hospital admissions/readmissions. The program monitors patient symptoms or complications; and provides recommendations on diet changes, medicine modifications, daily weights and physician visits. Some participate engage in Cardiac Rehabilitation concurrently, where they receive appropriate exercise therapy which complements this CHF management program.
FY 2011	
Goal FY 2011	Improve the health and quality of life for those that suffer from heart disease, helping them better manage this chronic disease and reducing their need to be admitted or readmitted to the hospital.
2011 Objective Measure/Indicator of Success	Objectives were to decrease heart failure admission/readmission rates by 5% for enrolled participants and increase program enrollment by 5%. There were 102 participants enrolled FY 10.
Baseline	Need in the community and the success the program is achieving in health improvements of participants dictate the importance of offering CHAMP®.
Intervention Strategy for Achieving Goal	Regular meetings with CHAMP® Team; outreach to increase enrollment; improvements in methodology for program outcome measurement.
Result FY 2011	57 new participants enrolled in CHAMP®. Reduction of readmissions over FY 2010 by 12%.
Hospital's Contribution / Program Expense	CHAMP® - \$23,900. Cardiac Rehabilitation - \$21,568.
FY 2012	
Goal 2012	Improve the health and quality of life for those that suffer from heart disease, helping them better manage this chronic disease and reducing their need to be admitted or readmitted to the hospital.
2012 Objective Measure/Indicator of Success	Avoid hospital or emergency department admissions among 60% of participants.
Baseline	Evidence shows there is a growing need in the community for this intervention. Increases in enrollment and decreases in hospitalizations in FY 11 will serve as a baseline for measurement in FY 12. Number of participants and rate of reduction in hospital admits/readmits in FY 2010.
Intervention Strategy for Achieving Goal	Regular meetings with CHAMP® Team; more outreach to increase enrollment; improvements in program outcome evaluation.
Community Benefit Category	A2-e Community Based Clinical Services – Ancillary/Other Clinical Services.

HEALTHY LIVES – WOODLAND HEALTHCARE	
Hospital CB Priority Areas	<p>Access to Care</p> <ul style="list-style-type: none"> ✓ Chronic Disease Prevention, Education and Management Continuum of Care to End Homelessness Women's and Children's Health and Safety Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment	Diabetes is among the top chronic diseases identified as priority health issues in the 2010 CNA. The program specifically targets uninsured and underserved Hispanic residents in Yolo county who are at greater risk for this disease.
Program Description	Healthy Lives is a free 6-week diabetes education program taught in Spanish at 2 locations in Yolo County, focusing on signs and symptoms of diabetes, nutrition, medications, etc. Collaborations with other community agencies offer an optional healthy cooking class and an exercise component. A physician assists with medication questions.
FY 2011	
Goal FY 2011	Improve the health of the target population in the community by providing education to enable them to manage diabetes and improve overall well-being.
2011 Objective Measure/Indicator of Success	<p>Enroll 350 people in sessions.</p> <p>Incorporate participants into Tomando de Salud, the Spanish version of Chronic Disease Self Management classes.</p> <p>Measure success by attendance in classes and maintenance of healthy diabetic living.</p>
Baseline	Yolo County is home to the largest Hispanic population of all 4 surrounding counties. Diabetes within this community is the second highest cause for ED admissions.
Intervention Strategy for Achieving Goal	Outreach to the Hispanic community to promote free classes; identify new participants at health screening fairs; referrals from community physicians
Result FY 2011	<p>526 served.</p> <p>All participants had reductions in their Blood Sugars, 197 participants had reductions in their weight of at least 3-5 pounds and 100 participants saw decreases in their Body Mass Index (BMI) by 2%. 225 participants have continued a regular exercise program. Achieved a 100% reduction in ED admissions by participants.</p> <p>75 participants went on to the Tomando Control De Su Salud workshops (Chronic Disease Management Program-CDSMP) which are also well attended.</p> <p>The workshop was featured in the quarterly Choose Health newsletter, which is distributed to members within Yolo County.</p> <p>The hospital's Spanish Diabetic group is the only one of its kind in the Sacramento Valley.</p>
Hospital's Contribution / Program Expense	\$6,566.
FY 2012	
Goal 2012	Improve the health of the target population in the community by providing education to enable them to manage diabetes and improve overall well-being.
2012 Objective Measure/Indicator of Success	<p>Hold classes supporting 550 Spanish speaking participants.</p> <p>Include a behavioral component as almost half of the participants reported symptoms of anxiety and depression with no available resources in the community.</p>
Baseline	Yolo County is home to the largest Hispanic population of all 4 surrounding counties. Diabetes within this community is the second highest cause for ED admissions. The number of participants of the Healthy Lives classes in FY 2011 provides the basis for improvement FY 2012.
Intervention Strategy for Achieving Goal	Ongoing collaboration with Yolo County community agencies; encouraging participation and education for those living with diabetes and other chronic diseases; continue to train lay leaders so more classes can be offered.
Community Benefit Category	A1-a Community Health Education – Lectures/Workshops.

DIABETES: TAKE CONTROL! PROGRAM – SIERRA NEVADA MEMORIAL HOSPITAL	
Hospital CB Priority Areas	<ul style="list-style-type: none"> Access to Care ✓ Chronic Disease Prevention, Education and Management Continuum of Care to End Homelessness Women's and Children's Health and Safety Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment	Diabetes has been identified as a growing health issue in Nevada County, due to an aging population and rates of obesity.
Program Description	Diabetes Take Control focuses on a number of components - Diabetes Facts and Nutrition, Diabetes Self Management, Health Living-Chronic Disease Self Management and Nutritional counseling. This program is offered to all patients regardless of their ability to pay. These participants will be tracked 6 months post intervention to make sure they have not been readmitted to the hospital for a diabetes related condition.
FY 2011	
Goal FY 2011	Improve the health and quality of life for those that suffer from Diabetes, helping them better manage this chronic disease and reducing their need to be admitted or readmitted to the hospital.
2011 Objective Measure/Indicator of Success	Continue support for program. Increase awareness of Diabetes: Take Control Program throughout the community. Reductions in hospital admissions by participants 6 months post intervention (60%).
Baseline	This new program was implemented to respond to the growing numbers of residents with this chronic illness within the hospital's primary service area.
Intervention Strategy for Achieving Goal	Outreach to increase enrollment; improvements in methodology for program outcome measurement; feedback from group participants.
Result FY 2011	69 new participants enrolled in Diabetes: Take Control. Since this was a new program introduced in FY 11, reporting on the rate of reduction in hospital admissions will begin in FY 12.
Hospital's Contribution / Program Expense	\$5,300.
FY 2012	
Goal 2012	Improve the health and quality of life for those that suffer from Diabetes, helping them better manage this chronic disease and reducing their need to be admitted or readmitted to the hospital.
2012 Objective Measure/Indicator of Success	Continue support for program. Increase awareness of Diabetes: Take Control Program throughout the community. Track and evaluate hospital admissions six months post intervention. Avoid hospital or emergency department admissions among 60% of participants.
Baseline	The program addresses a priority need in the community. The number of persons served (69), and reduction in hospital admissions will provide basis for measurement FY 12.
Intervention Strategy for Achieving Goal	Regular evaluation of Diabetes: Take Control programs to align with needs of community; hospital admissions avoided and feedback from group participants.
Community Benefit Category	A1-e Community Health Education – Self-help.

THE CARING CENTER – MERCY HOSPITAL OF FOLSOM	
Hospital CB Priority Areas	<ul style="list-style-type: none"> Access to Care ✓ Chronic Disease Prevention, Education and Management Continuum of Care to End Homelessness Women's and Children's Health and Safety Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment	An assessment by the hospital of its primary service area indicates that there are very few options for care for residents who suffer from chronic illnesses, stress, or acute health issues such as cancer. The Caring Center responds to this identified need.
Program Description	The Caring Center provides information, education and additional treatment techniques such as massage, healing touch, and therapeutic touch to enhance wellness and reduce stress. The center serves teenagers to elderly and is open to all, with special attention on low-income underserved populations referred by MercyClinic Folsom. The Center provides an experience of deep relaxation and stress reduction and encourages learning, exploration, and safe use of complementary modalities to enhance traditional medical treatment for those dealing with physical and emotional stresses, chronic illnesses such as heart disease, diabetes, chronic fatigue and chronic pain syndromes, or an acute health issue such as cancer.
FY 2011	
Goal FY 2011	Improve the health and quality of life for those that suffer from physical and emotional stresses, chronic illness or acute health issues through access to special modalities of care.
2011 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> Increase volunteerism and community partnerships in order to extend services to more clients. Outreach through MercyClinic Folsom to capture underserved clients. Increase number of clients participating in the program by 5%.
Baseline	The program addresses the need to provide education and treatment services that are not available elsewhere in the community. The number of clients served in FY 10, (839), and the number of volunteer hours in FY 10 (1,864) provided the basis for measuring success in FY 11.
Intervention Strategy for Achieving Goal	Meetings with MercyClinic Folsom, physicians, and other community partners.
Result FY 2011	<ul style="list-style-type: none"> 920 clients served. 93 new clients 1,920 volunteer hours; 81 more than FY 10. Maintained 46 weeks of operation during year.
Hospital's Contribution / Program Expense	\$1,150 supplies, other direct expenses. Program manager's salary included in Community Health Education Department.
FY 2012	
Goal 2012	Improve the health and quality of life for those that suffer from physical and emotional stresses, chronic illness or acute health issues through access to special modalities of care.
2012 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> Increase volunteer hours by 10%. 50 new participants in program. Maintain 45 weeks of operation.
Baseline	The program addresses the need to provide education and treatment services that are not available elsewhere in the community. The number of clients served in FY 11 (920) and number of volunteer hours (1,920) in FY 11 provides the basis measurement for FY 12.
Intervention Strategy for Achieving Goal	Continue collaboration with MercyClinic Folsom. Work with Community Benefit Department to outreach to community-based partners.
Community Benefit Category	A1-c Community Health Education – Individual Health Ed. For Un-/Under-insured.

WELLNESS EDUCATION – SIERRA NEVADA MEMORIAL HOSPITAL	
Hospital CB Priority Areas	<ul style="list-style-type: none"> Access to Care ✓ Chronic Disease Prevention, Education and Management Continuum of Care to End Homelessness Women's and Children's Health and Safety Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity Collaborative Governance
Link to Community Needs Assessment	Education on health and well-being is not offered elsewhere in the community. The hospital's program fulfills this need. The program focuses on priority health issues known in the community and evidenced by hospital utilization rates.
Program Description	Wellness Education offers a broad range of free or discounted classes including asthma, which is an identified priority health issue in the community; diabetes; chronic disease self-management; smoking cessation; aging; healthy cooking, and prenatal care. The Wellness program also conducts outreach at Health Fairs, Job Fairs and other community events.
FY 2011	
Goal FY 2011	Enhance the self-awareness and responsibility of individuals to develop and maintain healthy lifestyles and provide the education, tools and skills to prevent and manage illness and disease.
2011 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> Continue support for program. Improve reporting of persons served and programs offered. Increase awareness of Wellness program offerings in the community through outreach.
Baseline	Responds to lack of education and prevention offerings in the community. The number of persons served through Wellness Education in FY 10(527) provided basis for measurement in FY 11.
Intervention Strategy for Achieving Goal	Regular evaluation of Wellness programs to align with needs of community; feedback from group participants.
Result FY 2011	<ul style="list-style-type: none"> 527 residents enrolled in Wellness programs with outreach to approximately 335 at local health fairs New community outreach materials developed and distributed.
Hospital's Contribution / Program Expense	<ul style="list-style-type: none"> \$17,900. \$11,856 in education and outreach material development.
FY 2012	
Goal 2012	Enhance the self-awareness and responsibility of individuals to develop and maintain healthy lifestyles and provide the education, tools and skills to prevent and manage illness and disease.
2012 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> Continue support for services. Increase awareness of Wellness program offering in the community demonstrated by an increased number of program participants.
Baseline	Responds to lack of education and prevention offerings in the community. The number of persons served (527) and programs offered in FY 11 provide the basis for measuring success in FY 12.
Intervention Strategy for Achieving Goal	Regular evaluation of Wellness programs to align with needs of community; feedback from group participants.
Community Benefit Category	A1-a Community Health Education – Lectures/Workshop.

YOUR LIFE, TAKE CARE– WOODLAND HEALTHCARE	
Hospital CB Priority Areas	<ul style="list-style-type: none"> Access to Care ✓ Chronic Disease Prevention, Education and Management Continuum of Care to End Homelessness Women's and Children's Health and Safety Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment	Obesity, Heart Disease, Stroke, Asthma, Cancer and Diabetes are among the top chronic diseases identified as priority health issues in the 2010 CAN above the state average. The program specifically targets uninsured and underserved Hispanic residents in Yolo county who are at greater risk for these diseases.
Program Description	The Your Life, Take Care Chronic Disease Self Management Program offers free, six-week courses taught in both Spanish and English in Yolo County, to help people cope with ongoing health issues and chronic diseases. Chronic diseases – such as heart disease, cancer and diabetes, arthritis, obesity, depression – have been identified as a priority health issue in Yolo County. The program, taught by four Master Trainers who have been Stanford University certified, focuses on goal setting and problem solving, nutrition, communication skills, relaxation techniques, medication usage, community resources and partnering with your doctor.
FY 2011	
Goal FY 2011	Improve the health of the target population in the community by providing education to enable them to manage their chronic disease and improve overall well-being.
2011 Objective Measure/Indicator of Success	Enroll 100 people in sessions. Train 10 Promotoras (Community Health Educators) Lay Leaders. Measure success by attendance in classes and improved health status
Baseline	Yolo County is home to the largest Hispanic population of all 4 surrounding counties. Diabetes and Heart Disease within this community is the second highest cause for ED admissions.
Intervention Strategy for Achieving Goal	Targeted outreach to the Hispanic community to promote free classes; identify new participants at health screening fairs; referrals from community physicians
Result FY 2011	. In FY 11, 120 people benefited from the 6 week classes. A Promotora (Community Health Educator) Lay Leader training was held for 20 people.
Hospital's Contribution / Program Expense	\$9,116.
FY 2012	
Goal 2012	Improve the health of the target population in the community by providing education to enable them to manage their chronic disease and improve overall well-being.
2012 Objective Measure/Indicator of Success	Enroll 140 people in sessions. Train 10 Promotoras (Community Health Educators) Lay Leaders. Measure success by attendance in classes and improved health status
Baseline	Yolo County is home to the largest Hispanic population of all 4 surrounding counties. Diabetes and Heart Disease within this community is the second highest cause for ED admissions.
Intervention Strategy for Achieving Goal	Targeted outreach to the Hispanic community to promote free classes; identify new participants at health screening fairs; referrals from community physicians
Community Benefit Category	A1-a Community Health Education – Lectures/Workshops.

Priority 3: Continuum of Care to End Homelessness

INTERIM CARE PROGRAM (ICP) – REGION-WIDE FOR SACRAMENTO COUNTY	
Hospital CB Priority Areas	<p>Access to Care Chronic Disease Prevention, Education and Management ✓ Continuum of Care to End Homelessness Women's and Children's Health and Safety Community Health and Well-Being</p>
Program Emphasis	<p>✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance</p>
Link to Community Needs Assessment	The (ICP) responds to the growing number of homeless individuals and families in the community as a result of the recession; an issue pointed out in the 2010 CNA. The program also addresses the extremely high hospital utilization rates by this population due to lack of adequate services.
Program Description	ICP is a partnership between CHW member hospitals, other regional health systems, Sacramento County and The Effort. It provides homeless men and women a safe environment for recovery when they are ready to be discharged from the hospital. Participants receive mental health care, substance abuse treatment and social services support to help make the transition to a healthier and self-sustaining lifestyle.
FY 2011	
Goal FY 2011	Increase access to a continuum of care and social support services to meet the special needs of homeless individuals necessary to improve their health status, change hospital utilization patterns, and lead higher quality, self-sustaining lives. Implement expansion strategy to address the shortage of beds at the existing 18-bed ICP facility to respond to the growing numbers of homeless individuals.
2011 Objective Measure/Indicator of Success	<p>50 homeless patient referrals to the existing 18-bed ICP facility. 70% reduction in hospital inpatient days by those 50 patients referred (based on measurement conducted by The Effort). 70% successful completion of intervention program by those 50 patients referred (based on measurement conducted by The Effort). 100% of 50 participants enrolled in health insurance (based on measurement conducted by The Effort). Increase CB funding and development/implantation of plan to expand existing ICP beds.</p>
Baseline	The issue of homelessness is growing in the region and no other services exist that provide this continuum of care.
Intervention Strategy for Achieving Goal	Meetings and ongoing check-ins with hospital Case Management teams and tour of ICP facility; quarterly ICP oversight committee meetings; development of hospital internal methodology for measuring quarterly outcomes for planned expansion.
Result FY 2011	<p>71 persons served in existing ICP facility, with measures of success achieved. Added new 5-bed skilled nursing unit to existing program. There were 822 days spent by homeless discharged patients in the 5-bed Mercy unit alone, which otherwise would have been days spent in hospital. 65% of patients in the new unit received case management and transitioned to permanent housing.</p>
Hospital's Contribution / Program Expense	\$225,468.
FY 2012	
Goal 2012	Increase access to a continuum of care and social support services to meet the special needs of homeless individuals necessary to improve their health status, change hospital utilization patterns, and lead higher quality, self-sustaining lives.
2012 Objective Measure/Indicator of Success	75 successful homeless patient referrals to ICP, with continued positive outcomes.
Baseline	The issue of homelessness is growing in the region and no other services exist that provide this continuum of care. Homeless patients served in FY 11 (71) serves as the basis for measurement in FY 12.
Intervention Strategy for Achieving Goal	Quarterly tracking of new unit utilization and patient outcomes. Ongoing check-ins with case management; quarterly ICP oversight committee meetings.
Community Benefit Category	E1-a Cash Donations – Contributions to Nonprofit Orgs/Community Groups.

Priority 4: Women's and Children's Health and Safety

MERCY PERINATAL RECOVERY NETWORK (Mercy PRN) – MERCY SAN JUAN MEDICAL CENTER	
Hospital CB Priority Areas	<p>Access to Care Chronic Disease Prevention, Education and Management Continuum of Care to End Homelessness ✓ Women's and Children's Health and Safety Community Health and Well-Being</p>
Program Emphasis	<p>✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance</p>
Link to Community Needs Assessment	<p>An estimated 10 to 15% of women who give birth each year are abusing alcohol and other drugs; over 2,000 infants born in Sacramento County alone each year are exposed to drugs during the prenatal period; and over 12,000 children under the age of five in the county live with a parent who has a substance abuse problem.</p>
Program Description	<p>Through Mercy PRN, pregnant women and new mothers battling substance abuse learn to overcome their addictions, deliver healthier babies, prevent their children from being placed in foster care, and live a higher quality and more productive life. Mercy PRN is a drug and alcohol recovery treatment program for vulnerable, at-risk women and their children offered in a home-like environment. Nationally, approximately 37% of individuals who begin substance abuse treatment complete 90 days, which is the benchmark for greater success in achieving long term sobriety. Over 70% of the women entering treatment at Mercy PRN complete 90 days of treatment.</p>
FY 2011	
Goal FY 2011	<p>Improve the health status of vulnerable at-risk women by providing access to care to overcome addictions, deliver healthy babies, learn how to properly care and nurture children to keep them from being placed in foster care, and live healthier and more productive lifestyles.</p>
2011 Objective Measure/Indicator of Success	<p>Provide same level of service, with ongoing assessment and pursuit of additional partners. Seek grant opportunities to augment program.</p>
Baseline	<p>Up to 15% of women who give birth each year in Sacramento County are abusing alcohol and other drugs, with significant implications to children born. There are also 12,000 children under the age of five in the county living with parents who battle substance abuse. Mercy PRN is a model program in the community responding to this issue and having outcomes far above the national norm.</p>
Intervention Strategy for Achieving Goal	<p>Continue collaboration with community to leverage resources. Engagement by Community Advisory Board.</p>
Result FY 2011	<p>250 women were served. Over 70% entering treatment completed the full 90 day program, delivering healthy babies, preventing their children from being placed in foster care, and going on to live a healthier, higher lifestyle. Nationally, approximately 37% of individuals who begin substance abuse treatment complete 90 days, which is the benchmark for greater success in achieving long term sobriety.</p>
Hospital's Contribution / Program Expense	<p>\$957,952.</p>
FY 2012	
Goal 2012	<p>Improve the health status of vulnerable at-risk women by providing access to care to overcome addictions, deliver healthy babies, learn how to properly care and nurture children to keep them from being placed in foster care, and live healthier and more productive lifestyles.</p>
2012 Objective Measure/Indicator of Success	<p>Provide same level of service, with ongoing assessment and pursuit of additional partners. Seek grant opportunities to augment program.</p>
Baseline	<p>Need is evidenced in the community for Mercy PRN services. Service to 250 underserved at-risk women and outcomes above standards is the basis for measuring success annually.</p>
Intervention Strategy for Achieving Goal	<p>Continue collaboration with community to leverage resources. Engagement by Community Advisory Board.</p>
Community Benefit Category	<p>C3 – Hospital Outpatient Services.</p>

SAFE KIDS SACRAMENTO AND CAR SEAT EDUCATION PROGRAM – MERCY SAN JUAN MEDICAL CENTER AND METHODIST HOSPITAL OF SACRAMENTO	
Hospital CB Priority Areas	<p>Access to Care Chronic Disease Prevention, Education and Management Continuum of Care to End Homelessness</p> <ul style="list-style-type: none"> ✓ Women's and Children's Health and Safety Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment	Unintentional injury is a priority issue identified in the 2010 CNA. In the greater Sacramento, region motor vehicle accidents represent the fourth leading cause of death and injury for children ages 14 and under. Safe Kids specifically targets families with children living in poverty and families with children in immigrant communities, particularly Hmong, Russian and Hispanic, where the need for education and support is greater.
Program Description	Safe Kids is part of the Mercy San Juan Trauma Prevention Program, providing outreach and education, free or low-cost car seats, and safety checks to parents and caregivers of children ages 0 to 14 to reduce the prevalence of child death and injury from motor vehicle accidents. Mercy San Juan Medical Center is the only organization offering car seat education to the three largest non-English speaking cultures in the area – Hispanic, Russian and Hmong. Methodist Hospital of Sacramento participates in the SAFE Kids program. Safe Kids Sacramento is a community collaborative of hospitals, fire and police departments, state and local agencies, which provides safety programs and builds capacity within the community. Mercy San Juan Medical Center has led this program since 1993.
FY 2011	
Goal FY 2011	Reduce the number of deaths and unintentional injury to children through proper equipment, outreach, education and collaboration.
2011 Objective Measure/Indicator of Success	Continue to maintain level of service and outreach with reduced staff. Seek grant funding opportunities to augment program.
Baseline	In the greater Sacramento, region motor vehicle accidents represent the fourth leading cause of death and injury for children ages 14 and under. Number of persons served in FY 10 (2,832) provided the basis for measurement for FY 11.
Intervention Strategy for Achieving Goal	Increase efficiencies in department in order to maintain service level with reduced staff. Seek grant funding to augment program. Continue collaborative regional efforts.
Result FY 2011	257 served through car seat classes and 3,000 served through car seat program (significant increase over projected levels of service due to staff reductions). Evaluated bilingual car seat program and refined program to improve quality. Outreach to 97 through involvement in SAFE Kids Sacramento. Outreach to 10,470 through participation in health and safety fairs. \$105,000 Office of Traffic Safety Grant awarded. Led collaborative effort to develop new data-driven drowning prevention program.
Hospital's Contribution / Program Expense	SAFE Kids Car Seat and other Educational/Safety Classes - \$231,153.
FY 2012	
Goal 2012	Reduce the number of deaths and unintentional injury to children through proper equipment, outreach, education and collaboration.
2012 Objective Measure/Indicator of Success	Continue to maintain high level of service and outreach, with emphasis on low-income and minority families. Bring drowning prevention message to targeted audiences. Build capacity for pedestrian safety activities in the community. Seek grant funding opportunities to augment programs.
Baseline	In the greater Sacramento, region motor vehicle accidents represent the fourth leading cause of death and injury for children ages 14 and under. Persons served in FY 11 (3,257) provide basis for measurement for FY 12.
Intervention Strategy for Achieving Goal	Continue collaborative regional efforts and pursue grant opportunities. Continue to find and train highly qualified bilingual car seat technicians to maintain quality of service; and develop outreach and fundraising plan for drowning prevention curriculum.
Community Benefit Category	A1-a Community Health Education – Lectures/Workshops and A1-b Community Health Education – Public Dissemination of Materials and Information.

Priority 5: Community Health and Well-Being

GROWING WELL WITH MERCY – MERCY HOSPITAL OF FOLSOM	
Hospital CB Priority Areas	<ul style="list-style-type: none"> Access to Care Chronic Disease Prevention, Education and Management Continuum of Care to End Homelessness Women's and Children's Health and Safety ✓ Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention Seamless Continuum of Care ✓ Build Community Capacity ✓ Collaborative Governance
Link to Community Needs Assessment	Growing Well with Mercy fills an unmet need for local school districts by providing a Health and Wellness plan.
Program Description	Serving elementary schools in the eastern suburbs of Sacramento County and neighboring foothill communities of El Dorado County, Growing Well with Mercy provides hands-on education in collaboration with teachers, parents and school health officials. In this interactive program, students in K-6 learn about the importance of good nutrition and healthy habits.
FY 2011	
Goal FY 2011	Improve the health of children through education by filling a gap in the Health and Wellness Plan for school districts.
2011 Objective Measure/Indicator of Success	Maintain support and level of program service, broaden focus to obesity prevention Hire new program manager (previous manager left for new position)
Baseline	Local school districts can no longer afford to provide this type of health education. The number of students reached in FY 10 (10,790) and number of schools in district served in FY 10 (29) provided basis for measurement in FY 11.
Intervention Strategy for Achieving Goal	Recruitment for new program manager. Meetings with Folsom Cordova Unified School District Health Advisory Committee.
Result FY 2011	The program was offered at 15 elementary schools during the year, including Title 1 schools, and reached 10,000 students. A new program manager was hired during FY 11. School gardens were introduced as a central element of the program's health curriculum.
Hospital's Contribution / Program Expense	\$17,750.
FY 2012	
Goal 2012	Improve the health of children, parents, staff and community members through education by filling a gap in the Health and Wellness Plan for school districts.
2012 Objective Measure/Indicator of Success	Enhance focus on the nation-wide issue of childhood obesity. Maintain support and level of program service in 15 schools. Evaluate/refresh program materials.
Baseline	Local school districts can no longer afford to provide this type of health education. The number of students reached (10,000) in FY 11, and number of schools served (15) in FY 11 provides the basis for measurement in FY 12.
Intervention Strategy for Achieving Goal	Meetings with Folsom Cordova Unified School District Health Advisory Committee. Build school gardens and provide nutrition and health eating instruction using the gardens as a "living classroom". Partner with local and national organizations to educate and inform.
Community Benefit Category	A1-a Community Health Education – Lectures/Workshops.

ALZHEIMER'S OUTREACH PROGRAM (AOP) – SIERRA NEVADA MEMORIAL HOSPITAL	
Hospital CB Priority Areas	<ul style="list-style-type: none"> Access to Care Chronic Disease Prevention, Education and Management Continuum of Care to End Homelessness Women's and Children's Health and Safety ✓ Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs Primary Prevention ✓ Seamless Continuum of Care ✓ Build Community Capacity Collaborative Governance
Link to Community Needs Assessment	The presence of Alzheimer's in Nevada County is significant and growing due to an aging population within the community.
Program Description	Offered by the hospital's Home Care group, the Alzheimer's Outreach Program offers a series of classes and support groups designed to assist and empower care givers with knowledge and skills to help them prevent the mental and physical distresses involved in caring for those with Alzheimer's and other forms of dementia. The program teaches care givers and family members how to provide quality care for Alzheimer's patients still living at home. Home visits, telephone consultations and a resource website are important components of the program. With the significant elderly population in the community served by the hospital, the AOP responds to a priority health need.
FY 2011	
Goal FY 2011	Improve quality of care and quality of life for Alzheimer's patients by providing assistance, education, training and resources to care givers and families, and support the mental and physical needs of care givers involved in this difficult and stressful field of care.
2011 Objective Measure/Indicator of Success	Continue support for program. Increase awareness in community of services provided for this growing health issue.
Baseline	The hospital is the only provider of this service in the community. The numbers served (98) in FY 10 and participant feedback provided basis for measurement in FY 11.
Intervention Strategy for Achieving Goal	Communication to physicians and organizations in the community about the availability of program.
Result FY 2011	148 served (significant growth in number of participants).
Hospital's Contribution / Program Expense	\$18,678.
FY 2012	
Goal 2012	Improve quality of care and quality of life for those with Alzheimer's and other forms of dementia by providing assistance, education, training and resources to care givers and families, and support the mental and physical needs of care givers involved in this difficult and stressful field of care.
2012 Objective Measure/Indicator of Success	Continue support for services. Expand "Yes I Can" class series to meet new demand (currently have waiting list). Consider instituting four new course offerings for professional caregivers based on interest and need expressed by program participants (Behavior and Communications; Incontinence; Personal Care; Body Mechanics).
Baseline	Number of persons served in FY 11 and feedback from participants provide basis for measurement in FY 12.
Intervention Strategy for Achieving Goal	Increase budget and/or obtain grant funding to enable new course offerings. Ongoing evaluation of programs to align with and meet needs of community.
Community Benefit Category	A1-a Community Health Education – Lectures/Workshops.

SUPPORT GROUPS – SIERRA NEVADA MEMORIAL HOSPITAL	
Hospital CB Priority Areas	<ul style="list-style-type: none"> Access to Care Chronic Disease Prevention, Education and Management Continuum of Care to End Homelessness Women's and Children's Health and Safety ✓ Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs Primary Prevention ✓ Seamless Continuum of Care Build Community Capacity Collaborative Governance
Link to Community Needs Assessment	The hospital is the only provider of support groups within the community it serves.
Program Description	The hospital provides various support groups to help patients and families cope with health issues associated with cancer, traumatic brain injury, diabetes, stroke, and other illnesses. These support groups bring people with similar illnesses together to share experiences, decrease sense of isolation, provide counseling and education, and serve as an important resource.
FY 2011	
Goal FY 2011	Improve the ability of patients and families to cope and manage life-threatening or life-altering health issues by decreasing psychological stress through counseling, providing skills, education and resources to support specific health conditions, reducing isolation, and bringing people together to exchange experiences.
2011 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> Continue support for services. Increase awareness of support group offerings in the community. Regular evaluation of support groups; feedback from group participants.
Baseline	Support groups offered by the hospital are otherwise not available in the community. The number of persons served through support groups in FY 10 (5,014) provided the basis for measurement for FY 11.
Intervention Strategy for Achieving Goal	Regular evaluation of support groups; feedback from group participants.
Result FY 2011	2,698 persons served.
Hospital's Contribution / Program Expense	\$73,160; increase of 42% over FY 2010.
FY 2012	
Goal 2012	Improve the ability of patients and families to cope and manage life-threatening or life-altering health issues by decreasing psychological stress through counseling, providing skills, education and resources to support specific health conditions, reducing isolation, and bringing people together to exchange experiences.
2012 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> Continue support for services. Increase awareness of support group offerings in the community.
Baseline	Support groups offered by the hospital are otherwise not available in the community. The numbers of persons served through support groups in FY 11 serve as the basis for measurement in FY 12.
Intervention Strategy for Achieving Goal	Regular evaluation of support groups; feedback from group participants. Ongoing communication through healthcare providers, WHC website, press releases, and community presentations will ensure the public is aware of the services/support available.
Community Benefit Category	A1-d Community Health Education – Support Groups.

SUPPORT GROUPS – WOODLAND HEALTHCARE	
Hospital CB Priority Areas	<ul style="list-style-type: none"> Access to Care Chronic Disease Prevention, Education and Management Continuum of Care to End Homelessness Women's and Children's Health and Safety ✓ Community Health and Well-Being
Program Emphasis	<ul style="list-style-type: none"> ✓ Disproportionate Unmet Health-Related Needs Primary Prevention ✓ Seamless Continuum of Care Build Community Capacity Collaborative Governance
Link to Community Needs Assessment	The prevalence of cancer and stroke, indicated in the 2010 CNA, creates a need for support groups to improve the mental well-being of those in the community suffering from these illnesses.
Program Description	Woodland Healthcare offers support groups to cancer and stroke patients, and their family and friends to assist in coping with the diagnosis, treatment and side effects of cancer and stroke.
FY 2011	
Goal FY 2011	Provide support services to those affected by cancer and strokes.
2011 Objective Measure/Indicator of Success	<p>Continue to provide cancer and stroke support groups to address the issues that accompany a diagnosis and assist participants in solving the common issues arising from living with that diagnosis and treatment.</p> <p>Increase community awareness of support groups.</p> <p>Success is measured by repeated attendance and periodic satisfaction surveys.</p>
Baseline	<p>Of the top 5 causes for hospitalization in Yolo County, cancer is #4 and stroke is #5.</p> <p>Of the top 5 causes of mortality in Yolo County - cancer is #1 and stroke is #3.</p> <p>No other support groups are available within the hospital's service area for cancer and stroke victims.</p>
Intervention Strategy for Achieving Goal	<p>Outreach in community.</p> <p>Physician referral processes.</p>
Result FY 2011	<p>352 cancer participants and 238 stroke participants served.</p> <p>Support group information is now listed on website and presentations have been made in the community about stroke awareness and services available.</p>
Hospital's Contribution / Program Expense	\$8,169.
FY 2012	
Goal 2012	Provide support services for those affected by cancer and stroke.
2012 Objective Measure/Indicator of Success	Continue to provide support groups to address the issues that accompany the diagnosis of cancer and stroke; assist participants in solving the common issues arising from living with their diagnosis and treatment.
Baseline	<p>Of the top 5 causes for hospitalization in Yolo County, cancer is #4 and stroke is #5.</p> <p>Of the top 5 causes of mortality in Yolo County - cancer is #1 and stroke is #3.</p> <p>No other support groups are available within the hospital's service area for cancer and stroke victims. The number of participants of the support group classes in FY 2011 provides basis for FY 2012.</p>
Intervention Strategy for Achieving Goal	Ongoing communication through healthcare providers, WHC website, press releases, and community presentations will ensure the public is aware of the services/support available.
Community Benefit Category	A1-d Community Health Education – Support Groups.

COMMUNITY BENEFIT AND ECONOMIC VALUE

Classified Summaries of Un-sponsored Community Benefit Expense

Mercy General Hospital

FY 2011 Complete Summary - Classified Including Non Community Benefit (Medicare)

For period from 7/1/2010 through 6/30/2011

This hospital uses cost accounting methodology

	Persons Served	Total Expense	Offsetting Revenue	Net Benefit	% of Organization	
					Expenses	Revenues
Benefits for Those Living in Poverty						
Traditional Charity Care	2,227	4,523,249	0	4,523,249	1.0	0.9
Unpaid Cost of Medicaid	27,007	103,886,599	70,573,822	33,312,777	7.3	6.4
Means-Tested Programs	796	3,496,411	2,209,930	1,286,481	0.3	0.2
Community Services						
Cash and In-Kind Contributions	8	1,029,399	0	1,029,399	0.2	0.2
Community Benefit Operations	0	220,202	0	220,202	0.0	0.0
Community Building Activities	0	6,219	0	6,219	0.0	0.0
Community Health Improvement Services	23,553	1,504,655	0	1,504,655	0.3	0.3
Subsidized Health Services	15,607	2,484,940	189,837	2,295,103	0.5	0.4
Totals for Community Services	39,168	5,245,415	189,837	5,055,578	1.1	1.0
Totals for Those Living in Poverty	69,198	117,151,674	72,973,589	44,178,085	9.7	8.4
Benefits for Broader Community						
Community Services						
Cash and In-Kind Contributions	5,848	913,300	0	913,300	0.2	0.2
Community Building Activities	0	15,331	0	15,331	0.0	0.0
Community Health Improvement Services	16,294	1,360,090	810	1,359,280	0.3	0.3
Health Professions Education	522	14,651	0	14,651	0.0	0.0
Research	115	338	0	338	0.0	0.0
Subsidized Health Services	289	129,726	0	129,726	0.0	0.0
Totals for Community Services	23,068	2,433,436	810	2,432,626	0.5	0.5
Totals for Broader Community	23,068	2,433,436	810	2,432,626	0.5	0.5
Totals - Community Benefit	92,266	119,585,110	72,974,399	46,610,711	10.2	8.9
Unpaid Cost of Medicare	18,095	120,636,077	109,534,481	11,101,596	2.4	2.1
Totals with Medicare	110,361	240,221,187	182,508,880	57,712,307	12.6	11.0
Totals Including Medicare	110,361	240,221,187	182,508,880	57,712,307	12.6	11.0

Mercy San Juan Medical Center

FY 2011 Complete Summary - Classified Including Non Community Benefit (Medicare)

For period from 7/1/2010 through 6/30/2011

This hospital uses cost accounting methodology

	Persons Served	Total Expense	Offsetting Revenue	Net Benefit	% of Organization	
					Expenses	Revenues
Benefits for Those Living in Poverty						
Traditional Charity Care	2,250	4,234,144	0	4,234,144	0.9	0.8
Unpaid Cost of Medicaid	43,829	140,112,704	109,930,966	30,181,738	6.5	5.4
Means-Tested Programs	1,438	10,629,883	6,877,337	3,752,546	0.8	0.7
Community Services						
Cash and In-Kind Contributions	1	2,562,428	0	2,562,428	0.6	0.5
Community Benefit Operations	0	212,280	0	212,280	0.0	0.0
Community Building Activities	0	5,832	0	5,832	0.0	0.0
Community Health Improvement Services	8,577	2,208,428	25,866	2,182,562	0.5	0.4
Subsidized Health Services	2,597	2,053,128	73,343	1,979,785	0.4	0.4
Totals for Community Services	11,175	7,042,096	99,209	6,942,887	1.5	1.2
Totals for Those Living in Poverty	58,692	162,018,827	116,907,512	45,111,315	9.7	8.0
Benefits for Broader Community						
Community Services						
Cash and In-Kind Contributions	3,629	911,566	0	911,566	0.2	0.2
Community Building Activities	154	12,827	0	12,827	0.0	0.0
Community Health Improvement Services	13,257	223,521	460	223,061	0.0	0.0
Health Professions Education	83	419,493	0	419,493	0.1	0.1
Subsidized Health Services	914	348,829	0	348,829	0.1	0.1
Totals for Community Services	18,037	1,916,236	460	1,915,776	0.4	0.3
Totals for Broader Community	18,037	1,916,236	460	1,915,776	0.4	0.3
Totals - Community Benefit	76,729	163,935,063	116,907,972	47,027,091	10.1	8.4
Unpaid Cost of Medicare	48,205	121,936,940	107,778,492	14,158,448	3.0	2.5
Totals with Medicare	124,934	285,872,003	224,686,464	61,185,539	13.1	10.9
Totals Including Medicare	124,934	285,872,003	224,686,464	61,185,539	13.1	10.9

Methodist Hospital of Sacramento

FY 2011 Complete Summary - Classified Including Non Community Benefit (Medicare)

For period from 7/1/2010 through 6/30/2011

This hospital uses cost accounting methodology

	Persons Served	Total Expense	Offsetting Revenue	Net Benefit	% of Organization	
					Expenses	Revenues
Benefits for Those Living in Poverty						
Traditional Charity Care	2,164	2,266,018	0	2,266,018	1.1	0.9
Unpaid Cost of Medicaid	34,424	91,853,193	69,131,989	22,721,204	10.6	9.4
Means-Tested Programs	918	2,684,538	2,054,096	630,442	0.3	0.3
Community Services						
Cash and In-Kind Contributions	7,598	892,268	0	892,268	0.4	0.4
Community Benefit Operations	0	94,351	0	94,351	0.0	0.0
Community Building Activities	0	7,279	0	7,279	0.0	0.0
Community Health Improvement Services	7,459	766,895	0	766,895	0.4	0.3
Subsidized Health Services	23,256	5,609,702	1,742,342	3,867,360	1.8	1.6
Totals for Community Services	38,313	7,370,495	1,742,342	5,628,153	2.6	2.3
Totals for Those Living in Poverty	75,819	104,174,244	72,928,427	31,245,817	14.6	12.9
Benefits for Broader Community						
Community Services						
Cash and In-Kind Contributions	1,374	566,460	0	566,460	0.3	0.2
Community Building Activities	0	54,270	0	54,270	0.0	0.0
Community Health Improvement Services	0	2,557	0	2,557	0.0	0.0
Health Professions Education	171	736	0	736	0.0	0.0
Subsidized Health Services	693	268,913	0	268,913	0.1	0.1
Totals for Community Services	2,238	892,936	0	892,936	0.4	0.4
Totals for Broader Community	2,238	892,936	0	892,936	0.4	0.4
Totals - Community Benefit	78,057	105,067,180	72,928,427	32,138,753	15.0	13.3
Unpaid Cost of Medicare	12,565	46,173,052	43,840,933	2,332,119	1.1	1.0
Totals with Medicare	90,622	151,240,232	116,769,360	34,470,872	16.1	14.3
Totals Including Medicare	90,622	151,240,232	116,769,360	34,470,872	16.1	14.3

Mercy Hospital of Folsom

FY 2011 Complete Summary - Classified Including Non Community Benefit (Medicare)

For period from 7/1/2010 through 6/30/2011

This hospital uses cost accounting methodology

	Persons	Total	Offsetting	Net	% of Organization	
	Served	Expense	Revenue	Benefit	Expenses	Revenues
Benefits for Those Living in Poverty						
Traditional Charity Care	2,176	1,346,344	0	1,346,344	1.1	0.9
Unpaid Cost of Medicaid	8,354	18,899,144	8,748,271	10,150,873	8.6	6.5
Means-Tested Programs	461	1,963,424	953,267	1,010,157	0.9	0.6
Community Services						
Cash and In-Kind Contributions	0	107,063	0	107,063	0.1	0.1
Community Benefit Operations	0	91,225	0	91,225	0.1	0.1
Community Building Activities	0	6,032	0	6,032	0.0	0.0
Community Health Improvement Services	7,984	383,870	0	383,870	0.3	0.2
Subsidized Health Services	4,412	1,020,917	56,563	964,354	0.8	0.6
Totals for Community Services	12,396	1,609,107	56,563	1,552,544	1.3	1.0
Totals for Those Living in Poverty	23,387	23,818,019	9,758,101	14,059,918	12.0	8.9
Benefits for Broader Community						
Community Services						
Cash and In-Kind Contributions	160	618,240	0	618,240	0.5	0.4
Community Health Improvement Services	1,145	109,013	2,940	106,073	0.1	0.1
Subsidized Health Services	294	112,070	0	112,070	0.1	0.1
Totals for Community Services	1,599	839,323	2,940	836,383	0.7	0.5
Totals for Broader Community	1,599	839,323	2,940	836,383	0.7	0.5
Totals - Community Benefit	24,986	24,657,342	9,761,041	14,896,301	12.7	9.5
Unpaid Cost of Medicare	6,027	29,756,517	19,302,276	10,454,241	8.9	6.6
Totals with Medicare	31,013	54,413,859	29,063,317	25,350,542	21.6	16.1
Totals Including Medicare	31,013	54,413,859	29,063,317	25,350,542	21.6	16.1

Woodland Healthcare

FY 2011 Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2010 through 6/30/2011

This hospital uses cost accounting methodology

	Persons Served	Total Expense	Offsetting Revenue	Net Benefit	% of Organization	
					Expenses	Revenues
Benefits for Those Living in Poverty						
Traditional Charity Care	704	763,669	0	763,669	0.6	0.6
Unpaid Cost of Medicaid	12,148	23,825,637	15,306,040	8,519,597	7.0	6.8
Means-Tested Programs	1,479	2,924,532	1,377,926	1,546,606	1.3	1.2
Community Services						
Cash and In-Kind Contributions	2,334	202,219	0	202,219	0.2	0.2
Community Benefit Operations	0	23,676	0	23,676	0.0	0.0
Community Building Activities	1,925	21,111	0	21,111	0.0	0.0
Community Health Improvement Services	3,191	167,493	168	167,325	0.1	0.1
Totals for Community Services	7,450	414,499	168	414,331	0.3	0.3
Totals for Those Living in Poverty	21,781	27,928,337	16,684,134	11,244,203	9.2	9.0
Benefits for Broader Community						
Community Services						
Cash and In-Kind Contributions	0	292,244	0	292,244	0.2	0.2
Community Benefit Operations	0	498	0	498	0.0	0.0
Community Building Activities	4,219	18,635	0	18,635	0.0	0.0
Community Health Improvement Services	4,047	42,119	0	42,119	0.0	0.0
Health Professions Education	51	131,030	0	131,030	0.1	0.1
Subsidized Health Services	532	1,540,068	938,527	601,541	0.5	0.5
Totals for Community Services	8,849	2,024,594	938,527	1,086,067	0.9	0.9
Totals for Broader Community	8,849	2,024,594	938,527	1,086,067	0.9	0.9
Totals - Community Benefit	30,630	29,952,931	17,622,661	12,330,270	10.1	9.8
Unpaid Cost of Medicare	12,621	25,221,940	19,256,915	5,965,025	4.9	4.8
Totals with Medicare	43,251	55,174,871	36,879,576	18,295,295	15.0	14.6
Totals Including Medicare	43,251	55,174,871	36,879,576	18,295,295	15.0	14.6

Sierra Nevada Memorial Hospital

FY 2011 Complete Summary - Classified Including Non Community Benefit (Medicare)

For period from 7/1/2010 through 6/30/2011

This hospital uses cost accounting methodology

	Persons Served	Total Expense	Offsetting Revenue	Net Benefit	% of Organization	
					Expenses	Revenues
Benefits for Those Living in Poverty						
Traditional Charity Care	5,981	1,676,906	0	1,676,906	1.4	1.3
Unpaid Cost of Medicaid	21,021	16,029,380	15,857,537	171,843	0.1	0.1
Means-Tested Programs	4,399	2,936,402	1,338,387	1,598,015	1.3	1.2
Community Services						
Cash and In-Kind Contributions	21	727,759	0	727,759	0.6	0.6
Community Benefit Operations	0	52,393	0	52,393	0.0	0.0
Community Building Activities	0	2,884	0	2,884	0.0	0.0
Community Health Improvement Services	977	189,922	0	189,922	0.2	0.1
Totals for Community Services	998	972,958	0	972,958	0.8	0.8
Totals for Those Living in Poverty	32,399	21,615,646	17,195,924	4,419,722	3.7	3.4
Benefits for Broader Community						
Community Services						
Cash and In-Kind Contributions	679	489,586	0	489,586	0.4	0.4
Community Building Activities	0	14,683	0	14,683	0.0	0.0
Community Health Improvement Services	3,958	226,927	0	226,927	0.2	0.2
Health Professions Education	62	27,044	2,000	25,044	0.0	0.0
Research	0	7,976	0	7,976	0.0	0.0
Totals for Community Services	4,699	766,216	2,000	764,216	0.6	0.6
Totals for Broader Community	4,699	766,216	2,000	764,216	0.6	0.6
Totals - Community Benefit	37,098	22,381,862	17,197,924	5,183,938	4.3	4.0
Unpaid Cost of Medicare	88,548	59,809,505	47,174,911	12,634,594	10.5	9.8
Totals with Medicare	125,646	82,191,367	64,372,835	17,818,532	14.7	13.9
Totals Including Medicare	125,646	82,191,367	64,372,835	17,818,532	14.7	13.9

TELLING THE STORY

Effectively telling the community benefit story is essential to create an environment of awareness, understanding and interest in the priority health issues challenging the region and importantly, to inform the public about the ways in which these issues are being addressed by CHW hospitals in the greater Sacramento region. The 2011 Community Benefit Report and 2012 Plan will be widely distributed to Hospital Leadership and Management Teams and all employees engaged in community benefit activities. It will serve as a valuable tool for ongoing community benefit training. A summary of the report and plan is under development for broader distribution to all departments within the organization and to community-based organizations, community partners, government officials, and community leaders in the greater Sacramento region. Summary reports for each hospital can be found under “Community Health” in the “Who We Are” section on www.CHWhealth.org. Highlights will also be featured on the CHW Sacramento Service Area community benefit webpage at www.mercysacramento.org/communitybenefit.

APPENDIX A

Community Board and Community Benefit Board Committee Rosters

2011 Sacramento Community Board Members

Patrice Coyle
Katherine Hamilton, OP
Julius Cherry
Sr. Patricia Manoli
Sr. Brenda O'Keefe
Sr. Bridget McCarthy
Gill Albiani
Roger Niello
Daniel Cooper, DO
Jack Wood, DO
Christian Swanson, MD
Amir Sweha, MD
Brian Ivie
Don Hudson
Denny Powell

2011 Sacramento Community Health Committee Members

Patrice Coyle
Sr. Clare M. Dalton
Jill Dryer
Marjorie Ginsburg
Sr. Katherine Hamilton
Don Hudson
Sr. Gabrielle Jones
Gerardine McInerney
Sr. Cornelius O' Connor
Marcia Wells
Allison Sadler
Linda Cutler
Rosemary Younts
Kaci Simpson

2011 Woodland Healthcare Community Board Members

Jeannie Oropeza
Marcela Obregon-Enriquez
Jose Martinez
Kathy Glatter, MD
Cindy Holst
Carol Kimball, MD
Alborz Alali, MD
John Bringhurst, MD
Clyde Brooker
Mark Ewens, MD
Marianne MacDonald
Jim Nielsen
Christopher Rumery, MD
Kevin Vaziri

2011 Woodland Healthcare Community Benefit Committee Members

Colleen Brock
Jeannie Oropeza
Viola DeVita
Tim Wilson
Bob Ekstrom
Tom March, MD
Heidi Mazeres
Josie Enriquez
Carol Brehmer

2011 Sierra Nevada Memorial Hospital Community Board Members

Crin Stanford
Leo Granucci
Don Coots
Michele White
Sarah Woerner, M.D.
Bob Liddle
Kevin Vaziri
Michele White
Joseph Britton, M.D.
Jerry Angove
Katherine A. Medeiros

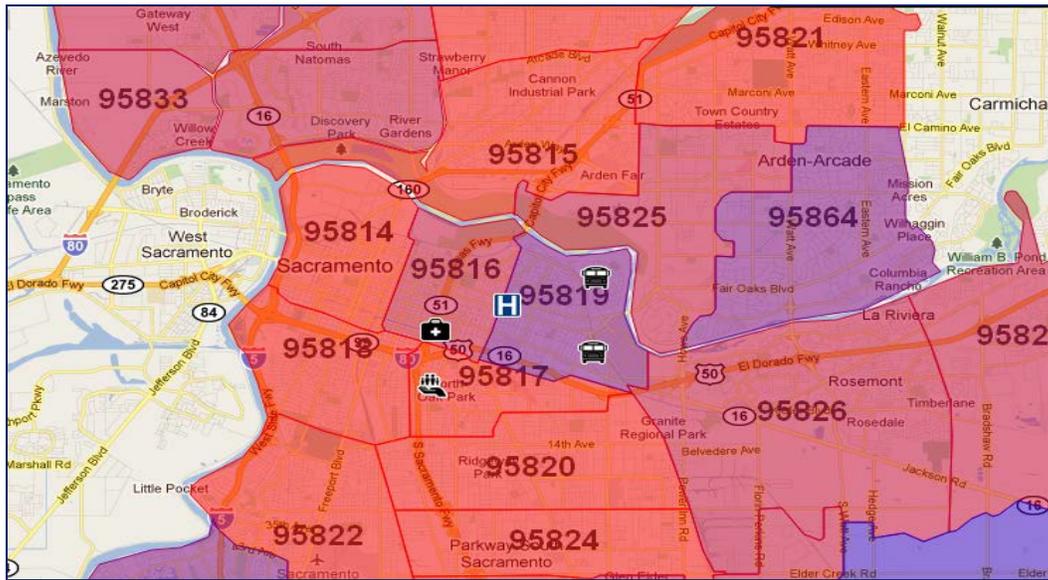
APPENDIX B

Community Needs Index Data

Mercy General Hospital

Community Need Index

The Community Need Index highlights by zip code the areas of greatest risk for preventable hospitalizations. The data was derived from the socio-economic indicators that contribute to health disparities (income, education, insurance, housing and culture/language) and was validated by hospital discharge data. Using statistical modeling, the combination of above barriers results in a score between 1 (less needy) and 5 (most needy).



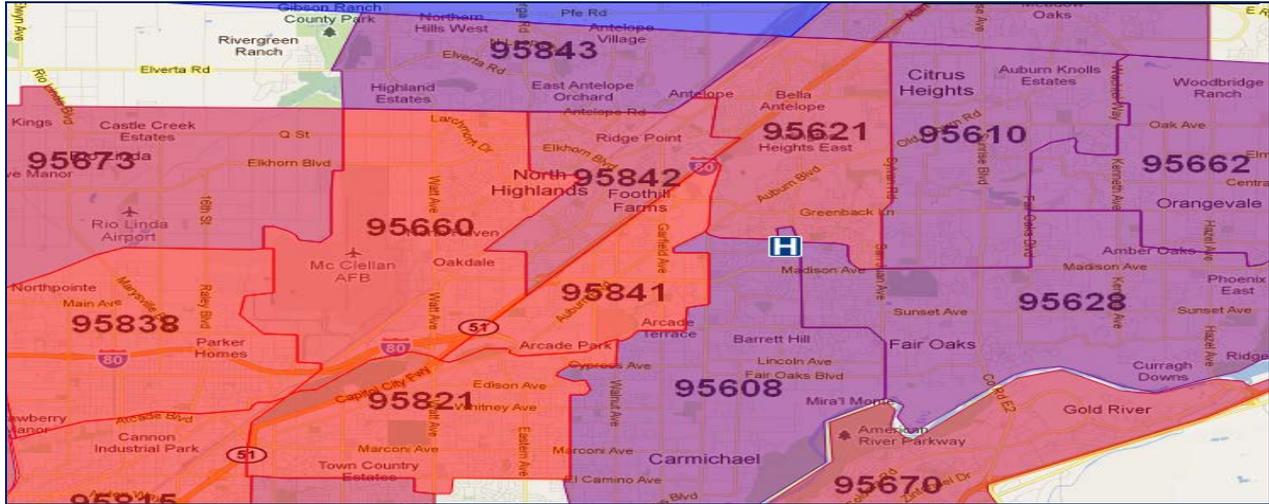
Lowest Need **Highest Need**
■ 1 – 1.7 Lowest ■ 1.8 – 2.5 2nd Lowest ■ 2.6 – 3.3 Mid ■ 2nd Highest ■ 4.2 – 5 Highest

	Zip Code	CNI Score	Population		Zip Code	CNI Score	Population
	95814	4.6	9880		95829	1.8	21717
	95815	5	26485		95830	2.2	821
	95816	3.6	16614		95831	3	45357
	95817	4.8	15138		95832	5	12248
	95818	4.2	21096		95833	3.8	37466
	95819	2.6	16343		95834	3.8	18858
	95820	4.8	38616		95835	2.6	33508
	95821	4.2	35127		95836	2.8	68
	95822	4.6	46499		95837	2.6	3137
	95823	4.6	77660		95838	5	39491
	95824	5	32355		95841	4.2	20417
	95825	3.8	32441		95842	3.8	31908
	95826	3.6	38635		95843	2.6	48024
	95827	3.6	21061		95864	2.8	21985
	95828	4	59247				

Mercy San Juan Medical Center

Community Need Index

The Community Need Index highlights by zip code the areas of greatest risk for preventable hospitalizations. The data was derived from the socio-economic indicators that contribute to health disparities (income, education, insurance, housing and culture/language) and was validated by hospital discharge data. Using statistical modeling, the combination of above barriers results in a score between 1 (less needy) and 5 (most needy).



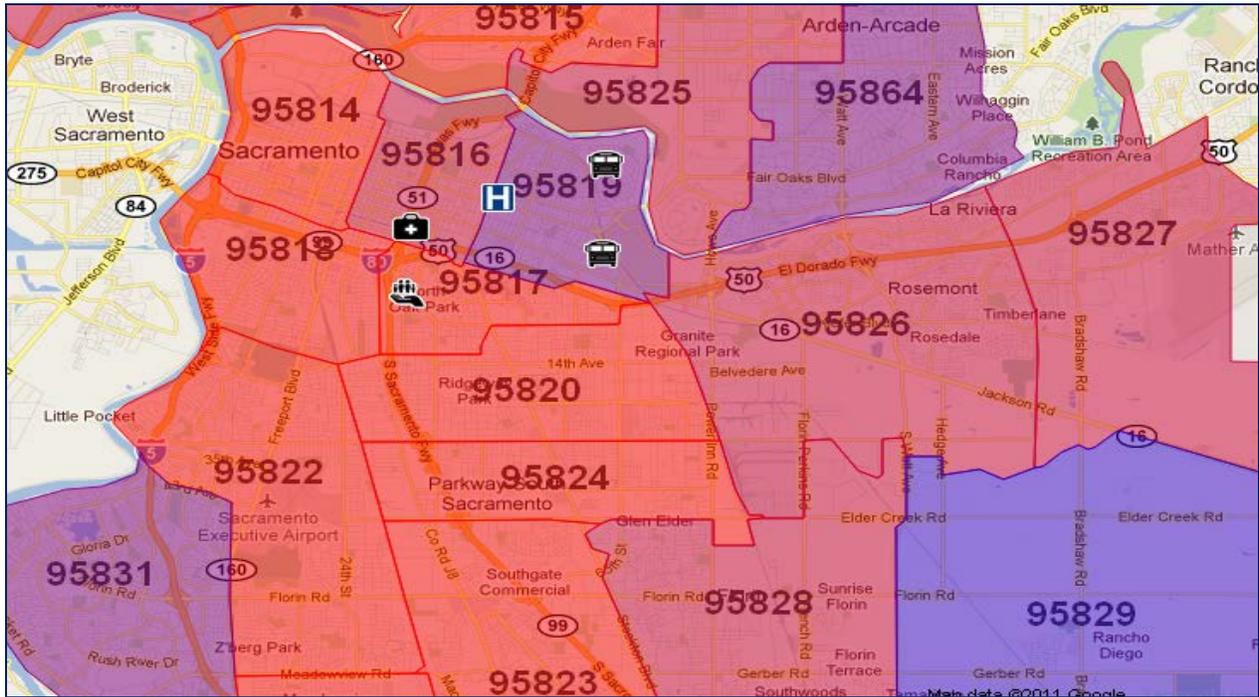
Lowest Need Highest Need
■ 1 - 1.7 Lowest ■ 1.8 - 2.5 2nd Lowest ■ 2.6 - 3.3 Mid ■ 3.4 - 4.1 2nd Highest ■ 4.2 - 5 Highest

Zip Code	CNI Score	Population	City	County
95608	3.2	57526	Carmichael	Sacramento
95610	3.2	45733	Citrus Heights	Sacramento
95621	3.4	40277	Citrus Heights	Sacramento
95628	2.8	40156	Fair Oaks	Sacramento
95630	2.2	70424	Folsom	Sacramento
95648	3	68762	Lincoln	Placer
95660	4.6	30477	North Highlands	Sacramento
95661	3	27325	Roseville	Placer
95662	2.6	30039	Orangevale	Sacramento
95670	3.8	57496	Rancho Cordova	Sacramento
95673	3.6	14213	Rio Linda	Sacramento
95678	2.8	41360	Roseville	Placer
95747	1.6	47960	Placer County	Placer
95815	5	26485	Sacramento	Sacramento
95821	4.2	35127	Arden-Arcade	Sacramento
95825	3.8	32441	Sacramento	Sacramento
95833	3.8	37466	Sacramento County	Sacramento
95838	5	39491	Sacramento	Sacramento
95841	4.2	20417	North Highlands	Sacramento
95842	3.8	31908	Foothill Farms	Sacramento
95843	2.6	48024	Sacramento County	Sacramento

Methodist Hospital of Sacramento

Community Need Index

The Community Need Index highlights by zip code the areas of greatest risk for preventable hospitalizations. The data was derived from the socio-economic indicators that contribute to health disparities (income, education, insurance, housing and culture/language) and was validated by hospital discharge data. Using statistical modeling, the combination of above barriers results in a score between 1 (less needy) and 5 (most needy).



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

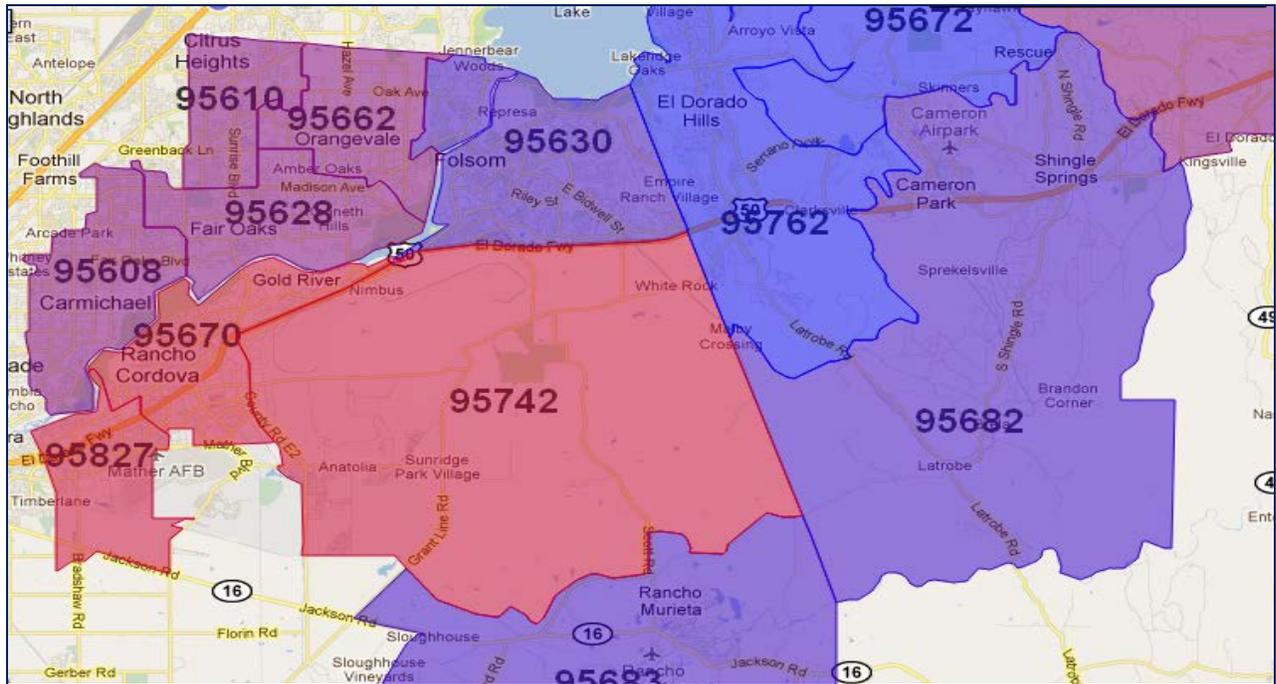
	Zip Code	CNI Score	Population	City	County
■	95814	4.6	9880	Sacramento	Sacramento
■	95815	5	26485	Sacramento	Sacramento
■	95816	3.6	16614	Sacramento	Sacramento
■	95817	4.8	15138	Sacramento	Sacramento
■	95818	4.2	21096	Sacramento	Sacramento
■	95819	2.6	16343	Sacramento	Sacramento
■	95820	4.8	38616	Sacramento	Sacramento
■	95821	4.2	35127	Sacramento	Sacramento
■	95822	4.6	46499	Sacramento	Sacramento
■	95823	4.6	77660	Sacramento	Sacramento
■	95824	5	32355	Sacramento	Sacramento
■	95825	3.8	32441	Sacramento	Sacramento
■	95826	3.6	38635	Sacramento	Sacramento
■	95827	3.6	21061	Sacramento	Sacramento
■	95828	4	59247	Sacramento	Sacramento
■	95829	1.8	21717	Sacramento	Sacramento

95830	2.2	821	Sacramento	Sacramento
95831	3	45357	Sacramento	Sacramento
95832	5	12248	Sacramento	Sacramento
95833	3.8	37466	Sacramento	Sacramento
95834	3.8	18858	Sacramento	Sacramento
95835	2.6	33508	Sacramento	Sacramento
95836	2.8	68	Sacramento	Sutter
95837	2.6	3137	Sacramento	Sacramento
95838	5	39491	Sacramento	Sacramento
95841	4.2	20417	Sacramento	Sacramento
95842	3.8	31908	Sacramento	Sacramento
95843	2.6	48024	Sacramento	Sacramento
95864	2.8	21985	Sacramento	Sacramento
95624	1.8	56656	Elk Grove	Sacramento
95632	3.8	30272	Galt	Sacramento
95693	2.2	6384	Wilton	Sacramento
95758	2	61375	Laguna	Sacramento

Mercy Hospital of Folsom

Community Need Index

The Community Need Index highlights by zip code the areas of greatest risk for preventable hospitalizations. The data was derived from the socio-economic indicators that contribute to health disparities (income, education, insurance, housing and culture/language) and was validated by hospital discharge data. Using statistical modeling, the combination of above barriers results in a score between 1 (less needy) and 5 (most needy).



Lowest Need

Highest Need

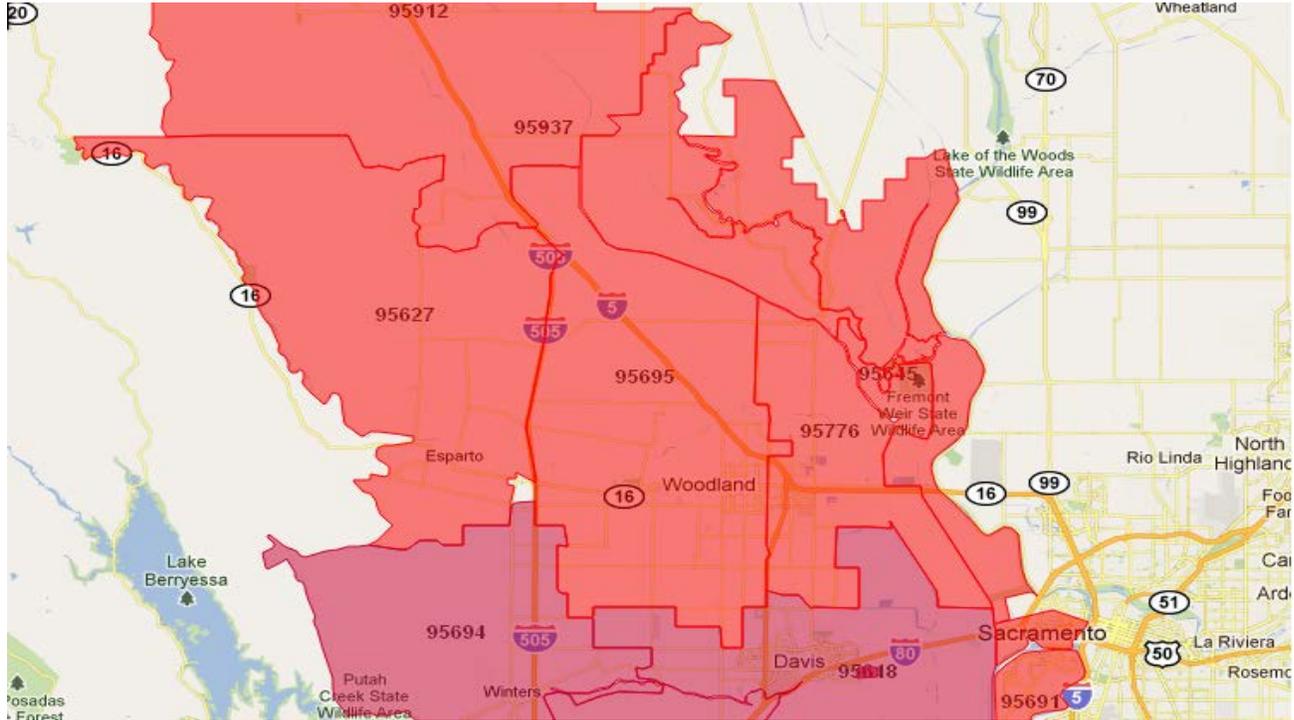
■ 1 - 1.7 Lowest
 ■ 1.8 - 2.5 2nd Lowest
 ■ 2.6 - 3.3 Mid
 ■ 3.4 - 4.1 2nd Highest
 ■ 4.2 - 5 Highest

Zip Code	CNI Score	Population	City	County	State
95608	3.2	57526	Carmichael	Sacramento	California
95610	3.2	45733	Citrus Heights	Sacramento	California
95628	2.8	40156	Fair Oaks	Sacramento	California
95630	2.2	70424	Folsom	Sacramento	California
95662	2.6	30039	Orangevale	Sacramento	California
95667	3.2	37457	Placerville	El Dorado	California
95670	3.8	57496	Rancho Cordova	Sacramento	California
95672	1.4	4518	El Dorado County	El Dorado	California
95682	2.2	27833	Cameron Park	El Dorado	California
95683	2	6069	Rancho Murieta	Sacramento	California
95742	3.4	1400	Sacramento County	Sacramento	California
95762	1.6	35139	El Dorado Hills	El Dorado	California
95827	3.6	21061	Rancho Cordova	Sacramento	California

Woodland Healthcare

Community Need Index

The Community Need Index highlights by zip code the areas of greatest risk for preventable hospitalizations. The data was derived from the socio-economic indicators that contribute to health disparities (income, education, insurance, housing and culture/language) and was validated by hospital discharge data. Using statistical modeling, the combination of above barriers results in a score between 1 (less needy) and 5 (most needy).



Lowest Need

1 - 1.7 Lowest

1.8 - 2.5 2nd Lowest

2.6 - 3.3 Mid

3.4 - 4.1 2nd Highest

Highest Need

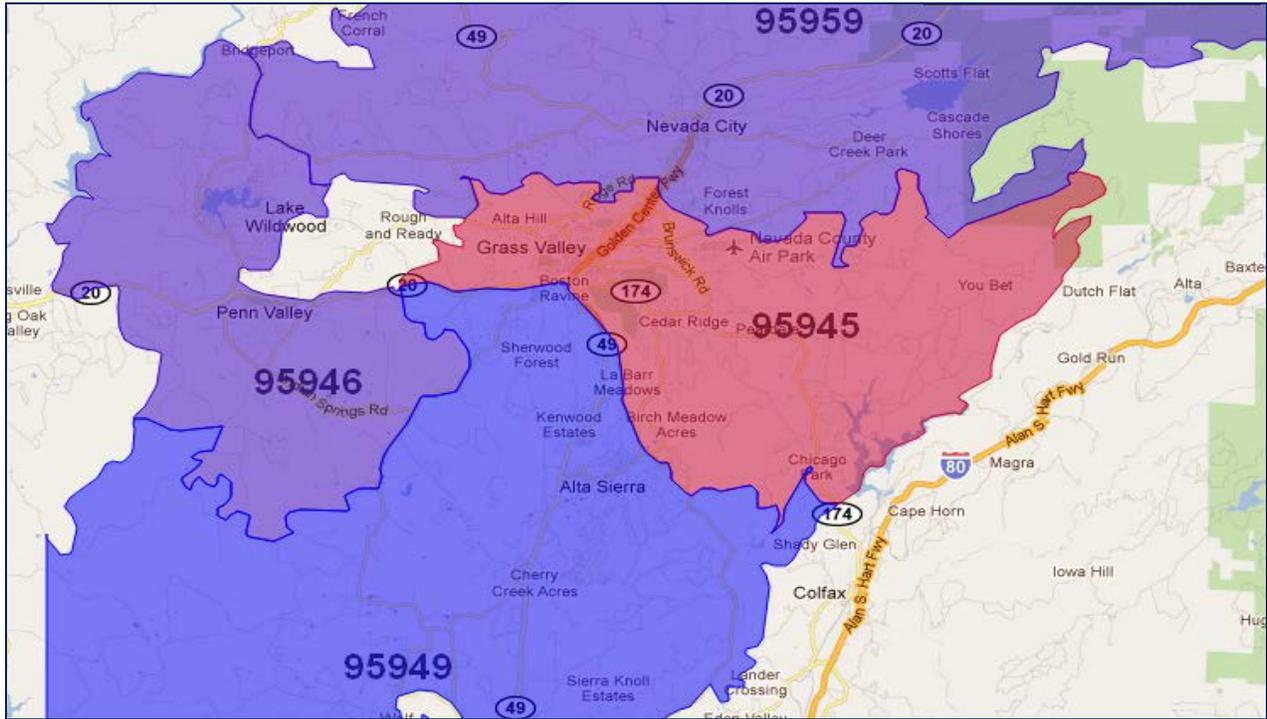
4.2 - 5 Highest

Zip Code	CNI Score	Population	City	County
95616	3.6	46850	Davis	Yolo
95618	3.4	27250	El Macero	Yolo
95620	3.4	20190	Dixon	Solano
95627	4.4	2915	Esparto	Yolo
95645	4.8	1834	Knights Landing	Yolo
95691	4.4	33912	West Sacramento	Yolo
95694	4	9499	Winters	Yolo
95695	4.2	39952	Woodland	Yolo
95776	4.2	19564	Woodland	Yolo
95912	4.6	5199	Arbuckle	Colusa
95937	3.8	1293	Dunnigan	Yolo

Sierra Nevada Memorial Hospital

Community Need Index

The Community Need Index highlights by zip code the areas of greatest risk for preventable hospitalizations. The data was derived from the socio-economic indicators that contribute to health disparities (income, education, insurance, housing and culture/language) and was validated by hospital discharge data. Using statistical modeling, the combination of above barriers results in a score between 1 (less needy) and 5 (most needy).



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
95945	3.6	24842	Grass Valley	Nevada
95946	1.8	9656	Lake Wildwood	Nevada
95949	1.6	20163	Alta Sierra	Nevada
95959	2.4	17279	Nevada City	Nevada

APPENDIX C

Summary of Patient Financial Assistance Policy



185 Berry Street, Suite 300
San Francisco, CA 94107
(415) 438-5500 telephone
(415) 438-5724 facsimile

CATHOLIC HEALTHCARE WEST SUMMARY OF PATIENT FINANCIAL ASSISTANCE POLICY (June 2008)

Policy Overview:

Catholic Healthcare West (CHW) is committed to providing financial 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, CHW strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Financial assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with CHW's procedures for obtaining financial 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 Financial Assistance:

- Eligibility for financial 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 financial 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:
 - a. 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;
 - b. the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay;
 - c. a reasonable effort by the CHW 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 financial assistance and a determination of financial need occur prior to rendering of services. The need for financial 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 financial assistance becomes known.
- CHW's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of financial assistance. Requests for financial assistance shall be processed promptly, and the CHW facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

Patient Financial 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 determination 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 CHW 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 CHW 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 CHW facility.
- CHW's administrative policy for Eligibility and Application for Payment Assistance shall define what qualifies as *income* for these purposes.

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

- Information about patient financial assistance available from CHW, including a contact number, shall be disseminated by the CHW 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 CHW facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the CHW facility.
- Any member of the CHW facility staff or medical staff may make referral of patients for financial assistance. The patient or a family member, a close friend or associate of the patient may also make a request for financial assistance.

Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient financial assistance will be included within the Social Accountability Budget of the CHW facility. CHW facilities will report patient financial assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.
- Patient financial 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:

- CHW system management shall develop policies and procedures for internal and external collection practices by CHW facilities that take into account the extent to which the patient qualifies for financial assistance, a patient's good faith effort to apply for a governmental program or for financial assistance from CHW, and a patient's good faith effort to comply with his or her payment agreements with the CHW facility.
- For patients who qualify for financial assistance and who are cooperating in good faith to resolve their hospital bills, CHW 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, CHW management and CHW facilities shall comply with all federal, state and local laws, rules and regulations that may apply to activities conducted pursuant to this policy.

ATTACHMENT 1

2010 Community Needs Assessment