



MERCY GENERAL HOSPITAL

COMMUNITY BENEFIT REPORT 2012 COMMUNITY BENEFIT IMPLEMENTATION PLAN 2013

**A Message from the President and Chief Executive Officer of Mercy General Hospital
and the Dignity Health Sacramento Service Area Community Board Chair**

At Mercy General Hospital, we share a commitment to optimize the health of the community we are privileged to serve. Vital to this effort is the collaboration we enjoy with our community partners. How we contribute to the quality of life and the environment in our communities has always been a key measure of our success and it will continue to be so as we move forward.

In January 2012, Dignity Health, formerly Catholic Healthcare West, announced changes in our governance structure and name that will better position the system to welcome new partners in a changing health care landscape. The new name, Dignity Health, was chosen because dignity has been one of our core values since our founding. It is deeply embedded in our culture and clearly describes who we are and what we stand for. Our new governance structure more accurately reflects our current composition of both religiously sponsored and community sponsored hospitals.

During fiscal year 2012 we, like the nation, were impacted by the continuing economic downturn and experienced both successes and challenges. Despite declining revenue from government sponsored patients, we provided \$46,099,208 in charity care, community benefits, and unreimbursed government funded patient care, excluding Medicare.

At Mercy General Hospital, we strive to manage our resources and advance our healing ministry in a manner that benefits the common good now and in the future. Despite today's challenges we see this as a time of great hope and opportunity for the future of health care. We want to acknowledge and thank the women and men who have worked together in a spirit of collaboration to address the health priorities of our community through health and wellness programs and services.

In accordance with policy, the Dignity Health Sacramento Service Area Community Board has reviewed and approved the annual Community Benefit Report and Implementation Plan at their October 25, 2012 meeting.



Edmundo Castañeda
President and Chief Executive Officer



Julius Cherry
Chair of the Board

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EXECUTIVE SUMMARY

Mercy General Hospital's rich history in the Sacramento, CA, region began when the Sisters of Mercy opened the first hospital in the downtown area, Mater Misericordiae, in the early 1900s. In 1925, the Sisters broke ground for Mercy General Hospital at 4001 J Street, Sacramento. Mercy General Hospital is a member of Dignity Health, formerly Catholic Healthcare West (CHW)¹ and has 342 licensed acute care beds, 20 intensive care unit beds, 71 cardiac and surgical telemetry beds, and 16 emergency department beds. The hospital employs over 2,200 and offers a full range of medical services, both inpatient and outpatient, including 24-hour emergency, robotic-assisted surgery, oncology, imaging and diagnostic services, stroke treatment and neurosurgery, prevention and treatment of challenging eye diseases and disorders (The Retina Institute), and more.

Mercy General Hospital is proud to be home to the Mercy Heart & Vascular Institute (MHVI), with one of the largest, most experienced cardiac teams in the nation. The MHVI is among the leading cardiac programs nationwide, serving over 11,000 patients each year in the greater Sacramento region and beyond. Building on a legacy of proven excellence and compassionate care, the new Alex G. Spanos Heart & Vascular Center—now under construction at Mercy General Hospital—will address growing community needs and integrate even more innovations into Mercy's heart and vascular program in a new 123,000 square-foot, state-of-the-art facility.

The hospital lies within Sacramento County, which is home to three other Dignity Health member hospitals, including Mercy San Juan Medical Center, Mercy Hospital of Folsom and Methodist Hospital of Sacramento. While each hospital has distinctive service lines and areas of expertise, all are faced with the challenge of addressing the same priority health issues. The four hospitals come together through collaboration on key initiatives that support the greatest needs of the region. This regional approach to address priority needs helps leverage resources and results in programs and services that have a more meaningful and far reaching impact on community health improvement. Care coordination to improve access for disadvantaged populations, building capacity to improve the strength of a fragmented safety net, chronic disease prevention and management, and efforts to ensure a continuum of care is available within the community are priorities for all four hospitals. These priorities are aligned with, and respond to unmet health-needs identified through Community Health Needs Assessments.

Mercy General Hospital takes the regional lead on the **Congestive Heart Active Management Program, CHAMP®**, which engages all Dignity Health member hospitals in Sacramento, as well as in other surrounding counties. CHAMP® serves as a unique model of health intervention, providing support and assistance for patients who suffer from heart failure. The program responds to a priority health issue identified through Community Health Needs Assessments that indicate heart failure is the second leading cause of hospitalization for residents living in Sacramento, El Dorado, Placer, and Yolo counties. The program keeps patients linked to the medical world once they leave the hospital through symptom and medication monitoring and education. The number of participants in FY 12 (2,122) increased 17 percent over the previous year. Consistently, the program achieves an 80 percent or better reduction in hospital readmissions by participants each year.

Completing its second year of operation, the **Community Health Referral Network** continues to demonstrate its success as a model of care coordination for uninsured and underinsured (Medi-Cal) residents who are unable to navigate the region's disorganized safety net system. The ability of underserved residents to find accessible, adequate and affordable care was a major issue identified in the needs assessment, and clearly evident in the escalating trend of underserved patients admitting to emergency departments for non-urgent care. The Community Health Referral Network is a partnership effort with nonprofit health centers that utilizes shared case management services and health information exchange technology to connect patients who lack a primary care provider with permanent health care

¹ For more information on the name change, please visit www.dignityhealth.org.

homes in the community. To date, over 2,300 patients have been assisted. The need for effective care coordination only grows more urgent with Health Reform on the horizon. A market analysis commissioned by the Sierra Health Foundation has determined that an estimated 227,000 new patients will become Medi-Cal beneficiaries in 2014, with the preponderance of these patients in Sacramento County².

ReferNet is a partnership program in conjunction with El Hogar, Midtown Medical Center, and the hospital's Clinical Social Services Department, and provides a seamless referral system for people who admit to the emergency department with mental illness and/or substance abuse issues. Since it was established in February of 2011, ReferNet has provided immediate and ongoing intensive outpatient care to over 300 patients, adults and children. Mental illness is ranked as one of the top four challenges among the region's underserved populations in the Community Health Needs Assessment, and emergency department admission rates in Sacramento far exceed overall state rates for behavioral health diagnoses.

The health status for hundreds of homeless residents has been improved by the **Interim Care Program (ICP)**, which responds to the medical and social needs of individuals upon discharge from the hospital. The ICP offers safe shelter, food, healthcare coordination and case management services through a unique partnership with one of the region's federally qualified health centers, The Effort, as well as the Salvation Army, Sacramento County and the region's health systems. More than 76 percent of the participants in ICP transition to permanent housing, and 97 percent have been enrolled in health insurance, helping to break the cycle of homelessness. Mercy General Hospital and the other Dignity Health member hospitals in Sacramento County added an additional five-bed unit to the existing 18-bed ICP center at the Salvation Army to provide needed new capacity and step-up medical care during recovery.

Mercy General Hospital takes a hands-on role in the safety net through its community-based **MercyClinic Norwood**, which took care of the primary care needs of 10,548 low-income and vulnerable residents living in one of the more economically depressed areas of the region. In partnership with Sacramento County, Mercy General also operates **MercyClinic Loaves & Fishes**, which serves as one of the few pathways to primary care for homeless individuals and families. Over 3,000 patients were treated at MercyClinic Loaves & Fishes in FY 12.

The hospital is an active participant in **The SPIRIT Project** (Sacramento Physicians' Initiative to Reach Out, Innovate and Teach), which recruits volunteer physicians to provide primary and specialty care and surgery for the community's uninsured. The SPIRIT Project has helped more than 35,000 patients receive treatment; a large percentage of the surgeries take place at Mercy General Hospital. In FY 12 eight cataract and 21 hernia repair surgeries were provided; all but three were performed at Mercy General Hospital in partnership with Mercy Medical Group surgeons and the Sacramento Anesthesia Medical Group.

A new program was established in FY 12 to address the pressing issue of chronic disease in the region. The region-wide Chronic Disease Self-Management Program (CDSMP) is a comprehensive program called **Healthier Living** designed to provide patients who have chronic diseases (with emphasis on Diabetes) with the knowledge, tools and motivation needed to become proactive in their health. The workshops are offered in both clinical and community settings, including 13 clinic sites operated by the region's FQHC providers, community centers, and various low-income housing developments (in partnership with Mercy Housing).

The FY 2012 Community Benefit Report and FY 2013 Community Benefit Implementation Plan highlights Mercy General Hospital's commitment to improving the health of its community. The total value of community benefit for FY 2012 was \$46,099,208, which excludes \$16,187,591 in unpaid Medicare costs.

² Sierra Health Foundation Regional Health Care Partnership Market Analysis, January 2012.

MISSION STATEMENT

Dignity Health Mission

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

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

ORGANIZATIONAL COMMITMENT

Mercy General Hospital's Organizational Commitment

Mercy General Hospital is committed to determining the health needs in the community it serves and creating ways, with emphasis on collaboration, to meet those needs. This commitment is integrated into the governance and operational structure of the hospital and demonstrated at the leadership level and by employees throughout multiple levels of the organization. Dignity Health policy helps guide the community benefit process and oversight is provided by the Dignity Health Sacramento Service Area Community Board and Hospital Leadership Team. A dedicated Community Health Committee of the Board is charged with prioritizing, planning, implementation and ongoing evaluation of core community benefit programs and services. The identification and development of key initiatives to address pressing needs in the community is specified in the hospital's strategic plan. Strategic focus for community benefit at Mercy General Hospital is centered principally on three priorities that are aligned with community health needs assessments, and reflect the greatest health care needs identified through the hospital's close observation of underserved patients seen and treated in the hospital:

- Building capacity within the region's safety net to enhance access to physical and mental health care for low-income and vulnerable populations;
- Collaborating with other nonprofit community health providers to improve care coordination and quality of care for the underserved who lack a medical home;
- Addressing the lack of services available in the region for chronic disease prevention and management.

The Dignity Health Community Grants Program is one of several examples of how the hospital demonstrates a commitment to improve the health of the community through focused strategic planning efforts. Mercy General Hospital takes a regional approach to the grants program, conducting it in partnership with the three other Dignity Health hospitals in the Sacramento region as a way to combine and leverage resources for more meaningful impact. The intent of the program is to foster region-wide collaboration by encouraging nonprofit organizations to work together toward a shared goal. In FY 12, grant applicants were asked to directly partner with each other to develop innovative pilot projects that responded to the continuum of care - "mini" systems of care - for specifically targeted populations. Mercy General Hospital and the other Dignity Health Hospitals in Sacramento teamed with the California Institute for Mental Health (CIMH) during this grant cycle to incorporate the Institute for Healthcare Improvement's Breakthrough Series Learning Collaborative initiative. Members of CIMH and other leading experts in this statewide Learning Collaborative will work with grant recipients in group sessions throughout the year to make positive changes in practice. Changes are focused on enhancing collaboration, developing methodologies for outcome measurements, and improving the overall quality of patient services.

The Dignity Health Community Investment Program also reflects the hospital's commitment to strategic community benefit planning. The program provides financial resources for institutions that promote the health of the community and social good. In the Sacramento region specifically, the program has strategically invested funds to assist two clinics - The Effort and Midtown Medical Center for Families and Children – achieve their status as Federally Qualified Health Centers (FQHC) and enable the expansion of operations. Providing the means to allow these health centers to thrive is critical to strengthening the region's weak safety net and adding new capacity to serve the most vulnerable residents.

Community Health Committee Role and Responsibilities

The Community Health Committee is a formal entity established by the Dignity Health Sacramento Service Area Community Board. The Committee's charter is to ensure Mercy General Hospital promotes community benefit programs, and assesses community needs and assets that address the unmet health needs of the communities served. The committee is responsible for ensuring that community benefit planning and programming at Mercy General Hospital:

1. Aligns with core principles:
 - a. Focus on disproportionate unmet health-related needs.
 - b. Emphasize prevention.
 - c. Contribute to a seamless continuum of care.
 - d. Build community capacity.
 - e. Demonstrate collaborative governance.
2. Addresses the health and health-related issues identified through community health needs assessments and hospital-specific strategic plans.
3. Maximizes community health assets and resources through collaboration.

Other responsibilities of the Committee include:

1. Ensuring that the hospitals conform to uniform methods of accounting community benefit expenses as prescribed by state and federal requirements.
2. Ensuring that the Board is regularly briefed on activities and developments.
3. Reviewing and approving the annual Community Benefit Plan and Report.
4. 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.
5. Evaluating the effectiveness of existing community benefit programs and collaborative partnerships on an ongoing basis, and making recommendations for continuing or terminating support, based on each participating program's progress toward identified objectives, utilization of funds and fiscal responsibility.
6. Overseeing the annual Dignity Health Community Grants Program, including determining priorities for grant funding that are aligned with community health needs assessments and needs identified by Hospital Leadership, and the formation of a Grants Review team.

A roster of the Dignity Health Sacramento Service Area Community Board and Community Health Committee members is included in Appendix A.

Non-Quantifiable Benefits

Mercy General Hospital gives to the community in many ways that are difficult to measure. Through leadership and advocacy efforts, the hospital brings diverse stakeholders from public, private and nonprofit sectors together to look at new collaborative practices, address issues and problems, and plan strategically for the future. The hospital has a role in a number of region-wide initiatives:

- Sacramento Regional Health Care Partnership
- Sacramento County Medi-Cal Managed Care Stakeholder Advisory Board
- California Endowment's Building Healthy Communities initiative (Health Access Work Group)
- Sacramento County Public Health Advisory Board
- Capital Community Health Network
- Sacramento County Low Income Health Plan Advisory Committee

Employees at many levels of the organization actively participate as members or directors on boards of community organizations focused on health and health related improvements, as well as on boards of neighborhood revitalization, economic development, and job and career development organizations. Some of these organizations include the American Heart/Stroke Association, Midtown Medical Center, CARES, Center for Community Health and Well-Being, Sacramento Metropolitan Chamber of Commerce, East Sacramento Chamber of Commerce and the Sacramento Economic Council.

COMMUNITY

Definition of Community

Several sources of information are utilized to define the community served by Mercy General Hospital, both geographic and demographic in nature, including:

- Community Health 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.

Description of Community

The Sacramento community faces an unprecedented lack of access to safety net health services. The region's safety net is characterized by a "fragmented group of small and financially fragile health centers that together offer limited outpatient capacity."³ A recent market analysis commissioned by Sierra Health Foundation in Sacramento identified critical issues impacting the region's safety net performance and sustainability, including:

1. The primary care capacity of community health centers and emergency departments to treat the safety net population has grown, but without further efforts will likely reach capacity prior to 2016.
2. Currently, the safety net is overly dependent on expensive hospitals, and emergency departments (EDs), in particular, to provide outpatient care.
3. The number of community health centers in the Sacramento region has grown over the past few years, but falls significantly short of many other similar-sized regions in California.
4. Roughly half of the region's community health centers are financially challenged. Expenses consistently exceed revenues.
5. The region continues to struggle to respond to unmet needs for physical and mental health care for its underserved residents who are reflecting a growing level of chronic disease, including asthma, diabetes and high blood pressure, and are more at risk due to factors that include obesity and smoking⁴.

As Health Reform approaches, it is imperative that the Sacramento region step up efforts to address the many vulnerabilities and inadequacies of its safety net, while building on its strengths. The gaps cannot be closed unless there is collaboration among all health providers and community leaders. Mercy General Hospital's strategic community benefit priorities as described previously encompass the essence of this imperative.

³ California Healthcare Foundation, Sacramento Powerful Health Systems Dominate a Stable Market. <http://www.chcf.org/publications/2009/07/sacramento-powerful-hospital-systems-dominate-a-stable-market#ixzz1t5kNz6tN>

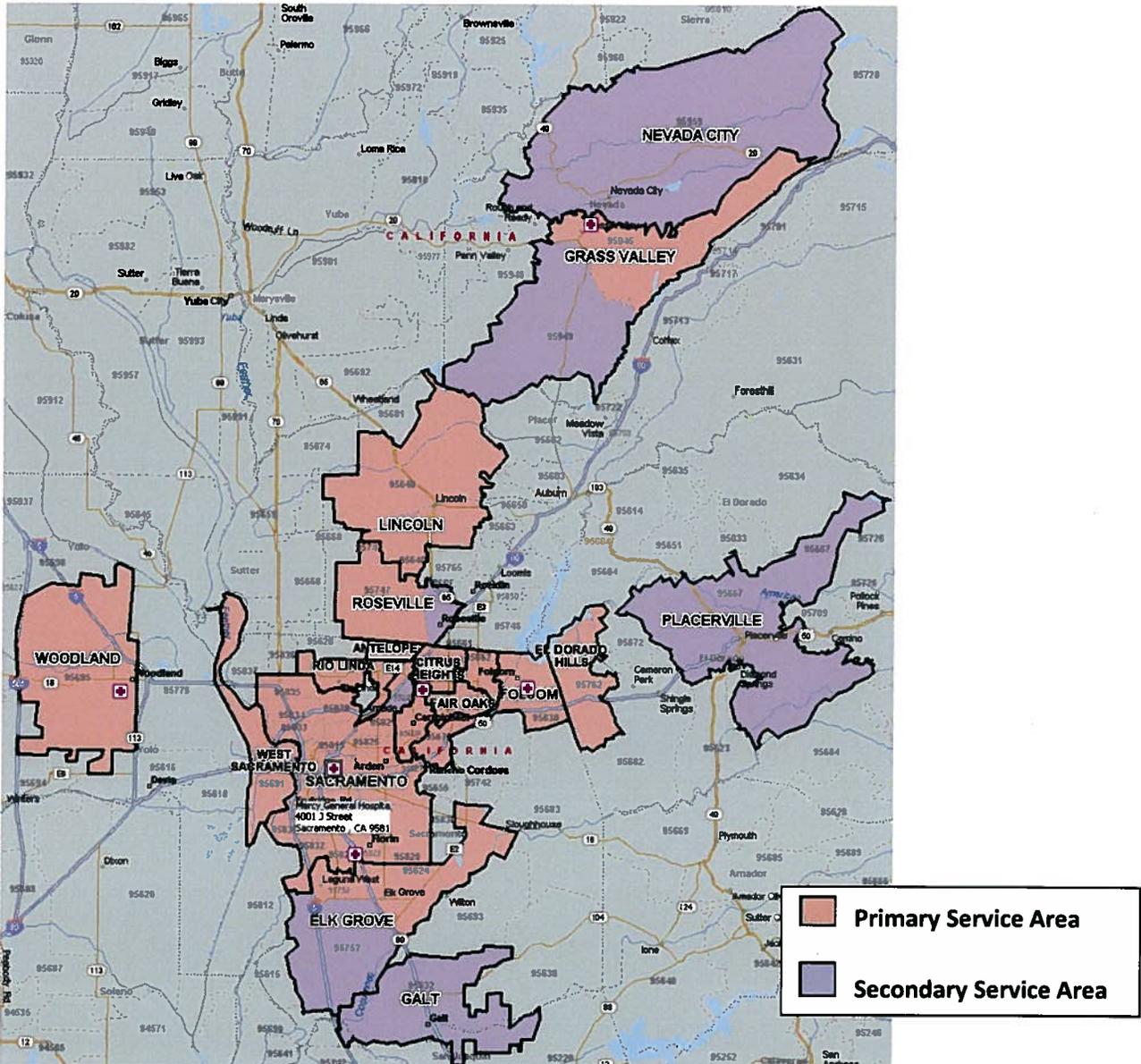
⁴ Sierra Health Foundation Regional Health Care Partnership Market Analysis, January 2012.

Community Demographics

As a tertiary care facility, Mercy General Hospital serves residents from a broad geographic area. Its primary service area lies in the central downtown area of Sacramento City, and includes multiple zip codes (see Community Needs Index Map on pages 12, 13). Demographics within this area are as follows:

- **Population:** 1,455,667
 - Under 18 = 26%
 - 18-34 = 24.5%
 - 35-64 = 38%
 - 65+ = 11%
- **Diversity**
 - Caucasian: 47.2%
 - Hispanic: 22.2%
 - Asian: 15.6%
 - African American: 9.8%
 - American Indian/Alaska Native & Other: 5.2%
- **Average Income:** \$70,464
- **Uninsured:** 9.86%
- **Unemployment:** 7.2%
- **No High School Diploma:** 14.8%
- **Renters:** 38.4%
- **Community Needs Index (CNI) Score:** 3.8
- **Medicaid Patients:** 17.21%
- **Other Area Hospitals:**
 - Sutter Health Sacramento Sierra Region
 - UC Davis Medical Center
 - Kaiser Permanente
 - Woodland Healthcare (a Dignity Health member hospital)
 - Methodist Hospital of Sacramento (a Dignity Health member hospital)
 - Mercy San Juan Medical Center (a Dignity Health member hospital)
 - Mercy Hospital of Folsom (a Dignity Health member hospital)

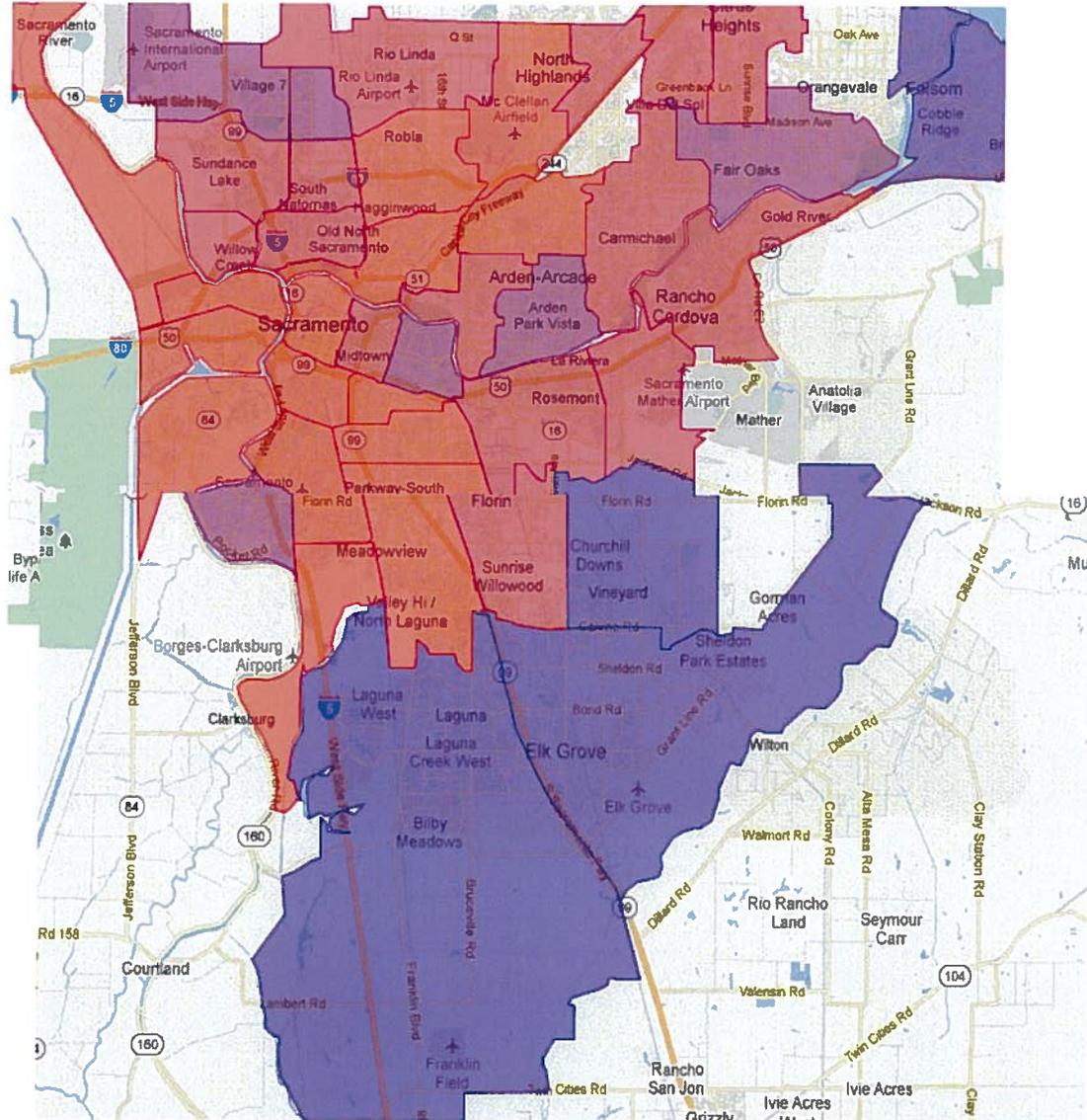
Mercy General Hospital Primary Service Area



Mercy General Hospital's Community Needs Index (CNI) Data

The hospital's CNI Score of 3.9 falls in the mid-to-high range. The CNI highlights by zip code the areas of greatest risk for preventable hospitalizations (see CNI map on page 11). The data is derived from the socio-economic indicators that contribute to health disparities (income, education, insurance, housing and culture/language) and 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).

Mercy General Hospital Community Needs Index (CNI) Map



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

	<u>Zip Code</u>	<u>CNI Score</u>	<u>Population</u>	<u>City</u>	<u>County</u>	<u>State</u>
■	95605	5	14815	West Sacramento	Yolo	California
■	95608	3.4	58717	Carmichael	Sacramento	California
■	95610	3.4	44535	Citrus Heights	Sacramento	California
■	95621	3.4	38925	Citrus Heights	Sacramento	California
■	95624	2.2	58643	Elk Grove	Sacramento	California
■	95628	2.8	40353	Fair Oaks	Sacramento	California
■	95630	2.4	69123	Folsom	Sacramento	California
■	95660	4.8	30135	North Highlands	Sacramento	California
■	95670	4	55795	Rancho Cordova	Sacramento	California
■	95673	3.8	14426	Rio Linda	Sacramento	California
■	95691	4.4	35443	West Sacramento	Yolo	California
■	95758	2.2	63578	Laguna	Sacramento	California
■	95814	4.8	9611	Sacramento	Sacramento	California
■	95815	5	25665	Sacramento	Sacramento	California
■	95816	3.8	15940	Sacramento	Sacramento	California
■	95817	5	14995	Sacramento	Sacramento	California
■	95818	4.4	20452	Sacramento	Sacramento	California
■	95819	2.6	15308	Sacramento	Sacramento	California
■	95820	4.8	37210	Sacramento	Sacramento	California
■	95821	4.4	34737	Arden-Arcade	Sacramento	California
■	95822	4.8	45093	Sacramento	Sacramento	California
■	95823	4.8	76683	Sacramento	Sacramento	California
■	95824	5	32406	Sacramento	Sacramento	California
■	95825	4	31566	Sacramento	Sacramento	California
■	95826	3.8	37846	Rosemont	Sacramento	California
■	95827	3.8	21602	Rancho Cordova	Sacramento	California
■	95828	4	59311	Florin	Sacramento	California
■	95829	2	22426	Vineyard	Sacramento	California
■	95831	3	44317	Sacramento	Sacramento	California
■	95832	5	11218	Sacramento	Sacramento	California
■	95833	4	36237	Sacramento	Sacramento	California
■	95834	3.4	21239	Sacramento	Sacramento	California
■	95835	3	36175	Sacramento	Sacramento	California
■	95838	4.8	38250	Sacramento	Sacramento	California
■	95842	3.8	31801	Foothill Farms	Sacramento	California
■	95864	2.6	21978	Arden-Arcade	Sacramento	California
■	95945	3.4	24049	Grass Valley	Nevada	California

CNI Score Median: 3.8

COMMUNITY BENEFIT PLANNING PROCESS

Community Health Needs Assessment

Process

Mercy General Hospital, in partnership with other regional Dignity Health member hospitals, Kaiser Permanente, Sutter Health Sacramento Sierra Region and UC Davis Medical center worked collaboratively and in consultation with one another and the broader community to complete the 2010 Community Health Needs Assessment (CHNA). With the assistance of Valley Vision (a nonprofit community-based organization dedicated to the quality of life in the Sacramento region), the health systems conducted the 2010 CHNA over a two-year period between October 2008 and October 2010.

The community included in the assessment was a four-county area within the greater Sacramento region, often referred to as California's Capital Region. This area is home to over two million residents. The regional approach to the assessment was selected due to the collaboration between the assessment sponsors. Each of the sponsors has multiple facilities spread across the study area.

Approach

Valley Vision and the participating partners used both qualitative and quantitative data to identify key members of the safety net community to participate in key information interviews and to help convene focus groups with their clients. The interviews and focus group information was used to verify and better understand unmet health needs identified through the quantitative data.

In all, 29 key informant interviews were conducted with health experts across the region. These included each of the participating County's Public Health Officers, Executive Directors of multiple community-based organizations delivering health-related and social services in the community, physicians delivering care to underserved populations, and others serving the community in similar capacities. Also, 12 focus groups were conducted across the study area with populations representative of community members that served as the focus of the assessment. Participants included under and uninsured populations, recent immigrants with limited English skills, homeless populations, ethnic groups and others.

Data

To identify the unmet health needs of underserved populations, a Community Health Vulnerability Index (CHVI) that identified nine socio-demographic characteristics known to contribute to poor health was created. These variables were combined to create a CHVI score for each ZIP code. The highest ranked ZIP codes were compared to the lowest, and health conditions with statistically significant differences were identified.

Focus groups and key informant interviews were conducted throughout the region to identify unmet health needs not easily measured in quantitative terms. Over the course of 2009, 15 focus groups with 134 community members were conducted throughout the region to gather qualitative data for the needs assessment. An additional 12 community members were interviewed individually. Additionally, secondary data for the years 2006, 2007 and 2008 were collected at the ZIP code level for the following variables:

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

Trend analysis was also conducted on all secondary data to identify conditions that increased consistently over the three-year collection period.

Results

Analysis of the quantitative and qualitative data revealed four conditions experienced at greater rates among underserved populations:

- Diabetes.
- Asthma.
- Mental Health.
- Hypertension.

In addition, these populations showed lower life expectancies, higher mortality rates, higher infant mortality rates, and higher rates of low birth weight infants. The following challenges were identified as barriers to improving and maintaining health among underserved populations:

- Affordability of health care services, especially health insurance.
- Locating physicians, specialists, dentists, mental/behavioral health, and other providers who accept Medi-Cal or work at reduced rates.
- Navigating a complex system of safety net and related social services.
- Poor diet resulting from lack of access to affordable and healthy foods.
- Cultural barriers, including language and social customs.
- The stress of being poor.

Healthy Living Map Website Development

An 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 provides interactive tools to display community health information in such a way that is easy for members of the community to interpret and utilize.

Assets Assessment

Information about the community's health assets was collected to better understand the resources currently available to underserved populations throughout the region and identify potential partnership linkages to leverage resources and services provided. This information was incorporated into a Provider Directory section of the Healthy Living Map (www.healthylivingmap.com).

Communicating the Results

Results of the assessment have been widely disseminated. Forums to examine the findings were conducted within the hospital, and extended 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 information and conclusions contained in the assessment report are available to all. The report can be downloaded from www.healthylivingmap.com. (See Attachment 1 for the full report).

2013 Community Health Needs Assessment

Work by the hospital and regional partners is well underway for the 2013 Community Health Needs Assessment, which will be complete June 30, 2013. As part of the 2013 assessment process, more detailed information about community health assets providing services related to specific health outcomes is being gathered. Partners are also working in collaboration with Sierra Health Foundation to 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.

Developing the Hospital's Implementation Plan

The 2010 CHNA provides a comprehensive view of the region's health that helps steer Mercy General Hospital's community benefit planning. The assessment reflects that the community is challenged by instability and not fully serving the needs of its residents. A historically weak safety net further deteriorated during the recession and recovery lags well behind most of the nation. Mercy General continues to fill a major gap by providing much needed care to uninsured and underinsured populations with a specific emphasis on priority issues identified in the assessment that include primary care, mental health care, and chronic disease self-management skills and education. The new Healthier Living Chronic Disease Self-Management Program implemented in FY 12 by Mercy General Hospital in collaboration with other Dignity Health member hospitals in Sacramento County is an example of how the CHNA informs community benefit planning and programming. Healthier Living is the only program in the region offered at the community level in response to the major issue of chronic disease in the region.

In efforts to fill this gap, Mercy General works in partnership not only with other Dignity Health member hospitals in the region, but with the other health systems and community and public health providers to respond to priority needs through collaborative initiatives. Doing so provides an opportunity to extend the reach and scope of programs and services provided to affect a greater number of community members. The health environment is at a critical stage where cooperative and coordinated efforts must occur if the region intends to adequately care for its underserved populations.

The Sacramento Region Health Care Partnership, launched by Congresswoman Doris Matsui and the Sierra Health Foundation, has also brought stakeholders together to address safety net vulnerabilities and begin building on strengths to prepare for implementation of the Patient Protection and Affordable Care Act. Mercy General Hospital has had a leading role in this effort since it began in early 2011. The goal of the partnership is to find ways to improve access, care coordination and the quality of the region's primary care system, with specific attention on community health centers. Achieving these goals is critical to accommodate the estimated influx of more than 200,000 newly insured Medi-Cal residents anticipated in 2014. The Partnership has just completed two studies involving a market analysis that identifies current capacity within the safety net, and is completing its strategic plan, which will reflect the immediate steps needed for positive transformation. Evaluating the Partnership strategic plan against the 2013 CHNA work being done currently and determining ways to move strategic plan initiatives forward will have a bearing on Mercy General Hospital's future community benefit planning and programming.

Planning for the Uninsured/Underinsured Patient Population

Mercy General Hospital strives to ensure that the needs of the uninsured and underinsured patient population are addressed. No one should go without health care and the hospital is committed to treating patients who have financial needs with the same dignity, compassion and respect that is extended to all patients. The hospital considers each patient's ability to pay for his or her medical care, and follows the Dignity Health Patient Payment Assistance Policy, which makes free or discounted care available to uninsured individuals with incomes up to 500 percent of the federal poverty level (see Appendix B for a summary of the Dignity Health Patient Payment Assistance Policy).

Continued education to stay current on the Financial Assistance Policy is required for 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 support. 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 the hospital's emergency departments, in admitting and registration areas, and in the business and financial services office. Notices are also placed in all patient bills and include a toll-free contact number. In addition to financial assistance, the hospital further supports the specific needs of uninsured and underinsured patient populations by assisting them with government health insurance program enrollment, free prescription medications and transportation.

Enrollment Assistance

Following medical treatment, the hospital provides assistance to help uninsured patients enroll in government sponsored health insurance programs. In FY 12, 1,871 uninsured patients received this free assistance. 565 patients were successfully enrolled in an insurance program. Hospital-sponsored expense for this assistance was \$1,162,105.

Transportation

Taxi and other transportation are available for patients who do not have, or cannot afford their own transportation home upon discharge from the hospital. There were 978 patients who received this service in FY 12 at a community benefit expense of \$56,166. The hospital also offers free and low-cost drug prescription programs for those that cannot afford to purchase medications.

Mental Health Consultations

The hospital provides psychiatric consults for patients who are uninsured and require psychiatric medical evaluations while hospitalized, as well as patient conservatorship services to those who are low income and lack capacity or family to help make decisions. In FY 12, 232 patients received this service at an expense of \$116,730.

PLAN REPORT AND UPDATE

INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

Summary of Key Programs and Initiatives – FY 2012

Core community benefit initiatives/programs provided by Mercy General Hospital in FY 12 are highlighted below. These respond to the top four priority needs identified in the CHNA. Core community benefit services will be evaluated against the new Community Health Needs Assessment in FY 13. All hospital programs are guided by 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.

Initiative I: Increasing Access to Care

- Charity care.
- Community Health Referral Network.
- MercyClinic Norwood.
- MercyClinic Loaves & Fishes.
- Mercy Family Health Center.
- ReferNet (Intensive Outpatient Mental Health Program).
- Cover the Kids (Mayor's initiative to enroll all children in health insurance).
- SPIRIT (referral program to provide specialty care for indigent and uninsured residents).
- Dignity Health Community Grants Program.
- Dignity Health Community Investment Program.
- Enrollment Assistance Program.
- School Health Nurse Program.
- Mental Health Consultations.
- Prescription Medication Program.
- Transportation.

Initiative II: Chronic Disease Prevention, Education and Management

- CHAMP® (Congestive Heart Active Management Program).
- Healthier Living Chronic Disease Self Management Program (New in FY 12).
- Cardiac conditioning and rehabilitation.
- Healthy Heart Education Series.
- Pulmonary Rehabilitation, Education and Support Program.
- Pulmonary Exercise Lab.
- Mercy Faith and Health Partnership.
- Community Health Screenings:
 - Vascular,
 - Blood Pressure,
 - Cholesterol,
 - AICD.

Initiative III: Continuum of Care to End Homelessness

- Interim Care Program (ICP).
- ICP+ (Mercy 5-bed skilled nursing unit).
- Lodging and Transitional Housing Services.

Initiative IV: Women's and Children's Health

- Women's Heart Health Program.
- The Birthing Project.
- St. John's Women's Shelter.

These community benefit programs are monitored and evaluated on an ongoing basis to ensure they provide the greatest benefit to participants. Those that are considered core among the program offerings are reviewed during the year by the Community Health Committee of the Board and Hospital Leadership. Program Digests with detailed information on several of these initiatives are provided in the following pages.

Description of Key Programs and Initiatives (Program Digests)

COMMUNITY HEALTH REFERRAL NETWORK	
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 Health Needs Assessment	Access to primary care and the difficulty in navigating the community clinic system were identified in the CHNA 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 2012	
Goal FY 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 the Dignity Health 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	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	Weekly reports from 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.
Result FY 2012	1,167 patients assisted; over 60% kept their clinic appointment; 80% were satisfied with care in a clinic setting.
Hospital's Contribution / Program Expense	\$78,746
FY 2013	
Goal 2013	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 Dignity Health 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.
2013 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. Pilot directly in hospital emergency department setting to monitor impact in outcomes.
Baseline	Conditions in the Sacramento region have not changed; access to care and the need for care coordination remains a priority.
Intervention Strategy for Achieving Goal	Weekly reports from 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.

REFERNET INTENSIVE OUTPATIENT MENTAL HEALTH CARE	
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 Health Needs Assessment	Mental health and the lack of services to treat this illness are identified as top priorities in the 2010 CHNA. The hospitals have seen a major and alarming increase in patients admitting to the EDs with crisis mental health conditions.
Program Description	El Hogar Community Services, Inc, provides 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. El Hogar also takes referrals for patients needing substance abuse treatment. El Hogar provides same or next business day psychological services for mentally ill patients that are able to be discharged and treated on an outpatient basis. The agency offers ongoing individual and group outpatient mental health treatment five days a week.
FY 2012	
Goal FY 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 = 300 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. Maintain increased level of CB funding. Ongoing tracking and evaluation of partnership.
Result FY 2012	328
Hospital's Contribution / Program Expense	\$50,000 Dignity Health Community Grant; additional \$40,000 allocated among the four hospitals in community benefit funding; Total expense - \$90,000
FY 2013	
Goal 2013	Increase access to mental health care for those that suffer from this illness.
2013 Objective Measure/Indicator of Success	Increase number of patients served in FY12.
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.

CONGESTIVE HEART ACTIVE MANAGEMENT PROGRAM (CHAMP®)	
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 Health 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	<p>CHAMP® establishes a care relationship with patients that have heart disease after discharge from the hospital through:</p> <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 2012	
Goal FY 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	Heart failure is a priority health issue for the region, identified in past and current CHNAs. The program continues to demonstrate improvements in the health of participants suffering from this chronic disease. 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.
Result FY 2012	2,122 participants enrolled in program, 17% increase over FY11
Hospital's Contribution / Program Expense	\$249,938
FY 2013	
Goal 2013	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.
2013 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	2,122 participants enrolled in program in FY 2012 provides baseline for FY 2013.
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

INTERIM CARE PROGRAM (ICP) and ICP+ PROGRAM	
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 Health 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 CHNA. 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 Dignity Health 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 2012	
Goal FY 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. 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.
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.
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 2012	107 persons served in existing ICP facility, with measures of success achieved. In 5-bed skilled nursing unit to existing program, 39 persons served, 979 days spent by homeless discharged patients in the 5-bed Mercy unit alone, which otherwise would have been days spent in hospital.
Hospital's Contribution / Program Expense	\$229,118.
FY 2013	
Goal 2013	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.
2013 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 12 (107) serves as the basis for measurement in FY 13.
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.

MERCYCLINIC NORWOOD	
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 Health Needs Assessment	Access to primary care for uninsured and low-income populations identified as a top CHNA 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 2012	
Goal FY 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.
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.
Result FY 2012	10,548 patients served. The clinic significantly expanded its ability to accept new patients assisted by the Community Health Referral network.
Hospital's Contribution / Program Expense	\$956,623
FY 2013	
Goal 2013	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.
2013 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.

HEALTHIER LIVING (New in FY 12)	
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 Health Needs Assessment	Heart Disease, diabetes, stroke, asthma and cancer are among the chronic diseases plaguing the region. Chronic disease is identified as a priority health issue in the 2010 and previous CHNAs. The program specifically targets uninsured and underserved residents who may otherwise lack access to this education and are at greater risk for chronic disease.
Program Description	The Chronic Disease Self-Management Program (CDSMP) is a new comprehensive program called Healthier Living designed to provide patients who have chronic diseases (with emphasis on Diabetes) with the knowledge, tools and motivation needed to become proactive in their health. The workshops are offered in both clinical and community settings, including: 13 clinic sites operated by the region's FQHC providers, Mercy Clinics, community centers, various low-income housing developments (in partnership with Mercy Housing) and the four Sacramento hospitals, working in partnership with Case Management and Clinical Nurse Educators.
FY 2012	
Goal FY 2012	Implement this program in FY 12, and plan for rapid expansion through the identification and certification of community lay leader workshop facilitators. Goal is for participants in this evidence-based program to avoid admissions to the hospital or emergency department for the six months following their participation in the program as they improve their behavior, management skills and lifestyles through education. Be at the stage of reporting outcomes (avoidable hospital admissions) by first quarter of FY 13.
2012 Objective Measure/Indicator of Success	Hire/certify part-time program manager; certify 5 lay leaders; schedule and conduct first 3 workshops. Measure success by attendance in classes and hospital avoidance (first outcomes report in Qtr. 1, FY 13).
Baseline	The number of participants in Healthier Living classes in FY 2012 and program completion rate provides the basis for improvement FY 2012.
Intervention Strategy for Achieving Goal	Outreach to the Sacramento clinic sites operated by the region's FQHC providers, Mercy Clinics, community centers, various low-income housing developments, and the hospital's Case Management and Clinic Nurse Educators.
Result FY 2012	38 persons completed the six-part series; 3 workshops were conducted and a 4 th workshop was conducted in Spanish.
Hospital's Contribution / Program Expense	\$16,017
FY 2013	
Goal 2013	Improve the health of the target population in the community by providing education to enable them to manage chronic illnesses to lead healthier, more productive lifestyles; thus reducing avoidable hospital admissions.
2013 Objective Measure/Indicator of Success	Certify 5 new community lay leaders Double number of workshops conducted Achieve System-wide metric goal for program participants.
Baseline	The number of participants of the Healthy Living classes in FY 2012 and first outcomes in Qtr. 3 of FY 13 provides the basis for improvement.
Intervention Strategy for Achieving Goal	Ongoing collaboration with nonprofit community providers, hospital physicians, community organizations to create awareness of program, enhance participant levels, and identify new lay leaders.
Community Benefit Category	A1-a Community Health Education – Lectures/Workshops.

MERCYCLINIC LOAVES & FISHERS	
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 Health Needs Assessment	Access to primary care for the uninsured populations is identified as a top CHNA 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 2012	
Goal FY 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.
Result FY 2012	3,067 patients served.
Hospital's Contribution / Program Expense	\$309,936
FY 2013	
Goal 2013	Provide a health care safety net for the homeless and immediate access to free urgent care.
2013 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.

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

COMMUNITY BENEFIT AND ECONOMIC VALUE

Report – Classified Summary of Un-sponsored Community Benefit Expense (For Period From 7/1/2011 Through 6/30/2012). Community benefit expenses were calculated using a cost accounting methodology.

	Persons Served	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses Revenues	
<u>Benefits for Poor and Vulnerable</u>						
Financial Assistance	2,512	4,253,759	0	4,253,759	0.9	0.8
Medicaid	24,823	102,626,153	72,135,806	30,490,347	6.5	5.6
Means-Tested Programs	838	6,666,736	3,791,032	2,875,704	0.6	0.5
Community Services						
Community Benefit Operations	0	101,022	0	101,022	0.0	0.0
Community Building Activities	900	4,688	0	4,688	0.0	0.0
Community Health Improvement	21,864	1,711,645	0	1,711,645	0.4	0.3
Financial and In-Kind Contributions	33	1,024,950	0	1,024,950	0.2	0.2
Subsidized Health Services	13,847	4,163,196	1,705,866	2,457,330	0.5	0.5
Totals for Community Services	36,644	7,005,501	1,705,866	5,299,635	1.1	1.0
Totals for Poor and Vulnerable	64,817	120,552,149	77,632,704	42,919,445	9.2	7.9
<u>Benefits for Broader Community</u>						
Community Services						
Community Building Activities	0	7,920	0	7,920	0.0	0.0
Community Health Improvement	23,201	1,393,175	1,035	1,392,140	0.3	0.3
Financial and In-Kind Contributions	0	953,646	0	953,646	0.2	0.2
Health Professions Education	367	46,991	0	46,991	0.0	0.0
Research	269	722,066	0	722,066	0.2	0.1
Subsidized Health Services	228	57,000	0	57,000	0.0	0.0
Totals for Community Services	24,065	3,180,798	1,035	3,179,763	0.7	0.6
Totals for Broader Community	24,065	3,180,798	1,035	3,179,763	0.7	0.6
Totals - Community Benefit	88,882	123,732,947	77,633,739	46,099,208	9.9	8.5
Unpaid Cost of Medicare	18,285	126,782,352	110,594,761	16,187,591	3.5	3.0
Totals with Medicare	107,167	250,515,299	188,228,500	62,286,799	13.3	11.5

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 Mercy General Hospital. The 2012 Community Benefit Report and 2013 Plan will be distributed to Hospital Leadership, members of the Community Board and Community Health Committee, and the hospital's management team, as well as employees engaged in community benefit activities. It serves as a valuable tool for ongoing community benefit awareness and training.

The document will also be more broadly distributed within the organization to all departments, and outside of the organization to community leaders, government and health officials, partners and other agencies and businesses throughout the region. It will be downloadable on the www.healthylivingmap.com website, and a report can be found under "Community Health" in the "Who We Are" section on www.DignityHealth.org.

APPENDIX A

Dignity Health Sacramento Service Area Community Board and Community Health Committee Rosters

Dignity Health Sacramento Service Area Community Board

Name	Role	Business
Dave Wolf, MD	COS - Ex-Officio Voting Board Member	Mercy San Juan Medical Center
Felix Fernandez	Board Member	Retired-Regional President Northern California - Wells Fargo Bank
Gilbert Albiani	Board Member	Real Estate Broker
Glennah Trochet, MD	Board Member- Secretary	Physician
Julius Cherry	Board Member- Chair	Attorney
Ken Johnson	COS - Ex-Officio Voting Board Member	Mercy Hospital of Folsom
Michael Taylor	SVP & Ex-Officio Voting Board Member	Sr. Vice President Operations Sacramento/San Joaquin Service Area
Norm Label	COS - Ex-Officio Voting Board Member	Mercy General Hospital
Patrice Coyle	Board Member	Community Representative
Roger Niello	Board Member	President & CEO Metro Chamber; retired State Assemblyman
Sr. Brenda O'Keeffe	Board Member- Vice Chair	Mercy Medical Center Redding
Sr. Katherine Hamilton, OP	Board Member	St. Joseph Medical Center - Community Health
Sr. Patricia Manoli	Board Member	St. Elizabeth Community Hospital
Zahid Niazi, MD	COS - Ex-Officio Voting Board Member	Methodist Hospital of Sacramento
Page West	CNE	Service Area
Rodney Winegarner	CFO	Service Area
Jill Dryer	Communications	Service Area
Ian Boase	Legal Counsel	Service Area
Kelley Evans	Legal Counsel	Service Area
Linda Ubaldi	Risk Management	Service Area
Edmundo Castenada	President	Mercy General Hospital
Patti Monczewski	COO	Mercy General Hospital
Sister Clare Dalton	Mission Integration	Mercy General Hospital
Don Hudson	President	Mercy Hospital of Folsom
Theresa Nero	CNE	Mercy Hospital of Folsom
Sister Cornelius O'Connor	Mission Integration	Mercy Hospital of Folsom
Brian Ivie	President	Mercy San Juan Medical Center
Phyllis Baltz	COO	Mercy San Juan Medical Center
Belva Snyder	CNE	Mercy San Juan Medical Center
Gail Moxley	Administrative Manager & Board Coordinator	Mercy San Juan Medical Center
Sister Gabrielle Jones	Mission Integration	Mercy San Juan Medical Center
Gene Bassett	President	Methodist Hospital of Sacramento
Martina Evans-Harrison	CNE	Methodist Hospital of Sacramento
Gigi McInerney	Mission Integration	Methodist Hospital of Sacramento

Community Health Committee Roster

Don Hudson, President, Mercy Hospital of Folsom (Chair)
Sr. Gabrielle Jones, Mission Integration, Mercy San Juan Medical Center (Vice Chair)
Dr. Glennah Trochet, Retired, Sacramento County Public Health Officer
Patrice Coyle, Community Representative
Sr. Clare Dalton, Mission Integration, Mercy General Hospital
Gerardine McInerney, Mission Integration, Methodist Hospital of Sacramento
Sr. Cornelius O' Connor, Mission Integration, Mercy Hospital of Folsom
Marcia Wells, Director, Mercy Clinics, Mercy General Hospital
Kevin Duggan, President, Mercy Foundation
Jill Dyer, Director, Communication, Dignity Health Sacramento/San Joaquin Service Area
Marge Ginsberg, Executive Director, Center for Healthcare Decisions
Rosemary Younts, Director, Community Benefit, Dignity Health Sacramento Service Area

APPENDIX B

Dignity Health Summary of Patient Payment Assistance Policy

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

Policy Overview:

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

Eligibility for Patient Payment Assistance:

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

Determination of Financial Need:

- Financial need will be determined through an individual assessment that may include:
 - 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 Dignity Health facility to explore and assist patients in applying for appropriate alternative sources of payment and coverage from public and private payment programs; and will take into account the patient's assets and other financial resources.
- It is preferred but not required that a request for payment assistance and a determination of financial need occur prior to rendering of services. The need for payment assistance may be re-evaluated at each subsequent rendering of services, or at any time additional information relevant to the eligibility of the patient for payment assistance becomes known.

- Dignity Health’s values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of payment assistance. Requests for payment assistance shall be processed promptly, and the Dignity Health facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

Patient Payment Assistance Guidelines:

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

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

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

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

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

Budgeting and Reporting:

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

- Patient payment assistance statistics shall be disclosed in annual financial statements but shall not include amounts that are properly considered to be bad debt or contractual discounts.

Relationship to Collection Policies:

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

Regulatory Requirements:

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

ATTACHMENT 1

2010 Community Health Needs Assessment