



Mercy San Juan Medical Center

COMMUNITY BENEFIT REPORT 2013
COMMUNITY BENEFIT IMPLEMENTATION PLAN 2014

A message from Brian Ivie, President and CEO of Mercy San Juan Medical Center, and Julius Cherry, Chair of the Dignity Health Sacramento Service Area Community Board

When we talk about health care today, the words *budget*, *cut*, and *restraint* get used a lot. It is impersonal and it is a way to look at health care by the numbers rather than by the patient. One word that has somehow lost its meaning is also the word we believe in most of all – the word *care*. At Mercy San Juan Medical Center, we strive to reintroduce humankindness to an industry focused on finance.

The Affordable Care Act created the National Prevention Council and called for the development of a National Prevention Strategy to realize the benefits of prevention for the health of all Americans. The overarching goals of the plan are to empower people, ensure healthy and safe community environments, promote clinical and community preventive services, and eliminate health disparities.

The Dignity Health system goals reflect those of health reform, namely expanding access, redesigning the delivery system, and utilizing limited resources in better, more coordinated ways so that quality can be continuously improved and patients and communities are healthier. These goals will be achieved through thoughtful *care*, whether it is demonstrated in the hospital or through the programs and services we offer in the community.

At Mercy San Juan Medical Center, we share a commitment to optimize the health of our community. In fiscal year 2013, Mercy San Juan Medical Center provided \$60,071,827 in financial assistance, community benefit and unreimbursed patient care. Because we care, how we contribute to the quality of life and the environment in our communities has always been and will continue to be a key measure of our success.

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 24, 2013 meeting.



Brian Ivie
President and CEO



Julius Cherry
Board Chair

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EXECUTIVE SUMMARY

Mercy San Juan Medical Center, located at 6501 Coyle Avenue, in Carmichael, CA, holds a Level II trauma designation and is recognized nationally as a leader in trauma care. Established in 1967, the Hospital is a member of Dignity Health. The Hospital has 2,379 employees, 370 licensed acute care beds, and 35 Emergency Department (ED) beds, including four Fast Track beds. Tertiary care specialties at Mercy San Juan Medical Center include a 26-bed Neonatal Intensive Care Unit that is ranked among the best in the world for survival rates of premature infants, bariatric surgery program, and da Vinci and other robotic surgical systems. The Hospital is also well respected for its work in collaboration with Mercy General Hospital to provide care for complex diseases affecting the brain in the Mercy Neurological Institute of Northern California.

In this critical period of health reform, developing much needed safety net capacity to ensure access to care for the region's most vulnerable, and fostering collaboration to develop a coordinated continuum of care across multiple health and social service providers underscore the Hospital's community benefit efforts. These efforts are guided by the Community Health Needs Assessment (CHNA) process. Specifically, Mercy San Juan Medical Center is focused on four priority issues that continue to impact health and quality of life within the community it serves:

- Health care access
- Mental health and substance abuse treatment
- Health prevention
- Transportation

This report highlights a number of new and existing initiatives that respond to these priorities. One in particular is the new **Patient Navigation Program** in Mercy San Juan Medical Center's ED. This comprehensive program builds upon a successful demonstration pilot project, and brings Mercy San Juan Medical Center and its sister hospitals in the region together in partnership with other health providers, health plans and community-based nonprofit organizations. Partners are working together to make sure patients receive the right care and support they need on a timely basis, reduce reliance on the ED for non-urgent care, and lower health care costs.

The Hospital continues to grow and expand the reach of another collaborative initiative - the Chronic Disease Self-Management Program (CDSMP). This evidence-based program, called **Healthier Living**, responds to the priority need for chronic disease prevention and management, and provides education and skills for those living with diabetes, heart disease, hypertension, cancer, depression, asthma, and other chronic illnesses. Through partnerships with the Sacramento County Public Health Department, Mercy Housing, Community Health Centers, food banks, and others, and the addition of 22 new community lay leaders, the Hospital was able to increase its CDSMP workshop offerings for those that lack access to preventative health services by tenfold in FY 2013.

Mercy San Juan Medical Center, along with Mercy Hospital of Folsom, has partnered with WellSpace Health (formerly The Effort) to increase access to primary care services in the communities they serve. WellSpace Health is one five Federally Qualified Health Centers (FQHC) in the region. Under the agreement, the Hospitals are making a \$2.8 million investment in WellSpace Health over a three year time period that will enable the organization to significantly accelerate its strategy to build three new full scope health centers. These centers will be established in the cities of Rancho Cordova, Carmichael and Folsom; areas of the region that lack safety-net services.

The new Rancho Cordova health center opened in February 2013. WellSpace Health will have the new Carmichael and Folsom sites open in FY 2014. Through a collaborative effort of outreach and education, patients utilizing Mercy San Juan Medical Center who lack a primary care provider will be directed to the WellSpace Health centers. As part of the strategic initiative, the Carmichael clinic will be less than two miles from the Hospital to ensure accessibility and to minimize transportation as a barrier.

Collaborating with WellSpace Health presents a unique opportunity that is aligned with the Hospital's mission to care for the poor, responds to the most pressing priority of the region to build safety net capacity, and better positions both the Hospitals and WellSpace Health for ACA implementation. The new health centers will help change the face of the region's safety net, building capacity to serve an additional 40,000 new patients. The Hospitals and WellSpace Health are now developing plans for integration, that include care coordination and technology connectivity in order to assist and monitor the health outcomes of patients.

The **Dignity Health Community Grants Program** continues to evolve strategically at Mercy San Juan Medical Center to foster collaboration among community nonprofit health and social service agencies. Organizations in most recent grants cycle were asked to work together to develop innovative partnership programs that provide a continuum of care for a specific target population. For example, one partnership program involves the Health and Life health center, Hmong Women's Heritage Association, Southeast Asian Assistance Center, LaFamilia Counseling Center, and Turning Point. These agencies are employing patient navigation to increase access to primary and mental health care, with emphasis on the need for improved cultural competency. Outcomes among partner organizations to date are promising.

More details on these, and other core community benefit programs, can be found in the following pages. In total, Mercy San Juan Medical Center's Fiscal Year 2013 community benefit investment in its community was \$45,192,301, which excludes \$14,879,526 in unpaid Medicare costs.

MISSION STATEMENT

We share the mission of Dignity Health:

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

The clearest demonstration of Mercy San Juan Medical Center's commitment to community is the support of and engagement in the community benefit strategic planning and budgeting process by Leadership, and the active role both Leadership and employees at multiple levels play in serving the community. As part of the Dignity Health Sacramento Service Area, community benefit oversight and governance for the Hospital is provided by the Service Area's Community Board. A dedicated Community Health Committee – a standing committee of the Board – helps guide the Hospital's community benefit practices, ensuring that programs and services offered address the unmet health needs of the community it serves and promote the broader health of the region (See Appendix A for Dignity Health Sacramento Service Area Community Board and Community Health Committee Rosters). Specific roles and responsibilities of the Community Health Committee include:

- Ensure services and programs align with the mission and values of Dignity Health and are in keeping with five core principles:
 - Focus on disproportionate unmet health and health-related needs
 - Emphasize prevention
 - Contribute to a seamless continuum of care
 - Build community capacity
 - Demonstrate collaborative governance
- Ensure the Hospital abides by uniform methods of accounting community benefit activities and expenses
- Review and approve the Community Health Needs Assessment and ensure alignment of programs and services with priority health issues, with an emphasis on communities of concern
- Evaluate and approve budget
- Evaluate program design and content
- Monitor and evaluate program progress, and determine program continuation or termination

The Community Health Needs Assessment (CHNA) provides insight into the health of the community and identifies gaps in care that require attention. It serves as the foundation for determining the Hospital's priority areas of focus for strategic community benefit investment. The Hospital is directly involved in the development of the CHNA, in partnership with numerous community leaders and nonprofit providers. Hospital Leadership, Community Board and Community Health Committee members review assessment findings, evaluate and compare priority health issues against existing community benefit programs and services to ensure they are aligned, and make recommendations regarding new initiatives. Core community benefit initiatives, such as the Hospital's Chronic Disease Self-Management Program, and the development of a system of care coordination for the underserved through patient navigation, are incorporated into the Hospital's strategic plan and tied to specific goals and measurable outcomes.

Operating in a region that lacks care coordination and struggles with a safety net characterized as fragmented and fragile¹, Mercy San Juan Medical Center also recognizes that good health is dependent upon organizations working together to address issues, and is committed to engaging the community through collaboration. The annual Dignity Health Community Grants Program is one way this is being achieved. Grant applicants are asked to partner on joint projects that offer a full continuum of care needed by specific underserved target populations living within communities of concern identified through the CHNA. Partner organization are also asked to develop improved processes for information sharing, program and care coordination, joint planning and joint program evaluation. For example, one partnership program involving six agencies matches Latino and Southeast Asian clients with culturally competent care coordinators (navigators) who assist them in accessing both primary and behavioral health care, health education and preventative services. Partners have developed a shared client health screening

¹ California HealthCare Foundation, 2009

tool, data tracking process, and whole health approach to case planning. Only six months into the project, 152 clients have been matched to a navigator and health/mental health care services.

The Dignity Health Community Investment Program is another reflection of the Hospital's commitment to improving the health of the community. The program provides financial resources for institutions or projects 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 – WellSpace Health (formerly The Effort) and Elica Health Centers (formerly Midtown Medical Center) in achieving their designations as Federally Qualified Health Centers (FQHC) and growing their 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 vulnerable residents.

Non-Quantifiable Benefits

Mercy San Juan Medical Center understands that true community health improvement cannot be achieved without collaboration and shared ownership of strategies and goals with others. Beyond the level of programs and services offered, the Hospital is committed to connecting with the community - working with public health and other government agencies, the nonprofit health and social service sectors, civic leaders and constituents - to bring about long-term change in health care quality and delivery. The Hospital is one of the health care leaders at the table of the Sacramento Region Health Care Partnership, an initiative that was organized two years ago by Congresswoman Doris Matsui and Sierra Health Foundation. In preparation for implementation of the ACA, the goal of the Partnership has been to develop and implement strategies to improve access, care coordination and quality of the Sacramento region's primary care system. Efforts by the Partnership have led to the development of two powerful reports about the state of the health care system in the region that offer a road map to creating a high quality and affordable tri-county primary care safety net, and the launch in September 2013, of the first capacity building grant cycle and new Learning Institute, co-sponsored by Sierra Health Foundation and regional health systems.

Mercy San Juan Medical Center is one of the founding members of Sacramento County's Medi-Cal Managed Care Stakeholder Advisory Committee, chartered to improve access, quality, and care coordination for managed care system beneficiaries. Input and advocacy by committee members focuses on issues concerning quality, policies and processes that improve coordination and capacity, health plan reporting to the Department of Health Care Services, and transitioning of target populations into managed care, including network expansion, consumer outreach and care coordination.

As part of the Respite Partnership Collaborative, the Hospital is addressing the region's mental health crisis. The Collaborative is a public-private partnership of the County of Sacramento Division of Behavioral Health Services, Sierra Health Foundation: Center for Health Program Management, selected stakeholders and community members. Formed in 2012, the Collaborative supports the development of a continuum of respite services. Already, work by the Coalition has resulted in nearly half a million dollars in funding to increase mental health respite service options that offer healing alternatives to hospitalization for community members who are experiencing a mental health crisis.

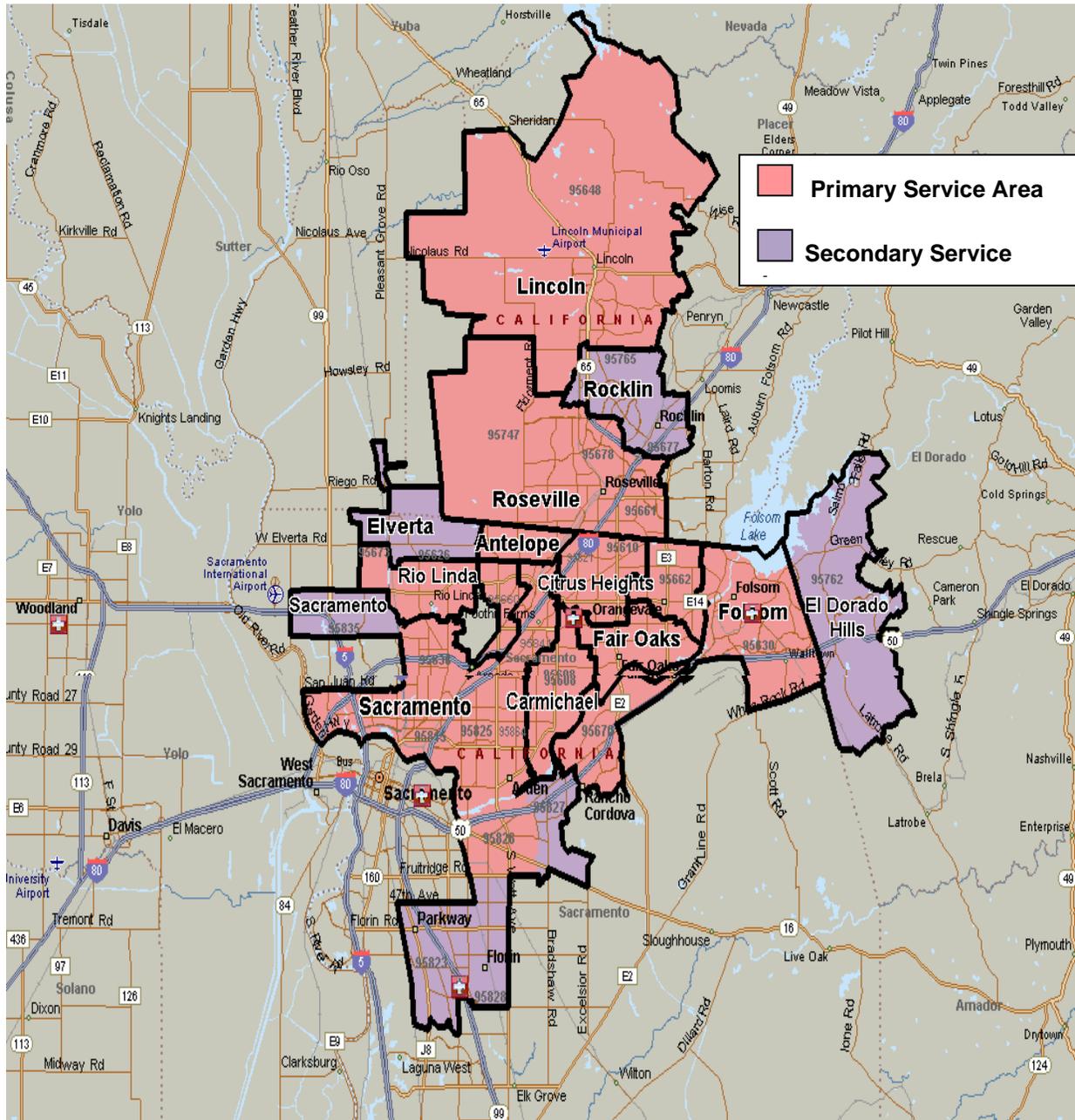
In many other ways, employees at Mercy San Juan Medical Center engage in the community, through regular service as members or directors of community and civic boards, or lending a hand in neighborhood revitalization, economic development, or job and career development initiatives.

COMMUNITY

Definition of Community

Mercy San Juan Medical Center's community, or primary service area, in Sacramento County is defined as the geographic area which it serves and determined by analyzing patient discharge data. Mercy San Juan Medical Center is located in the northern suburban portion of the County, serving major communities that include Citrus Heights, Fair Oaks, North Highlands, Carmichael, Antelope, Roseville, and other neighboring cities. The Hospital's primary service area (show on the map below) is comprised of 23 zip codes (95608, 95610, 95621, 95628, 95630, 95648, 95660, 95661, 95662, 95670, 95673, 95678, 95747, 95815, 95821, 95823, 95825, 95826, 95838, 95841, 95842, 95843, and 95864).

Mercy San Juan Medical Center Primary Service Area



Description of Community

The communities served by Mercy San Juan Medical Center struggle with lack of access to safety net services and community health centers that offer limited outpatient capacity.² A market analysis commissioned by Sierra Health Foundation identified critical issues impacting the region's safety net performance and sustainability, including:

- The primary care capacity of community health centers and EDs to treat the safety net population has grown, but without further efforts will likely reach capacity prior to 2016
- Currently, the safety net is overly dependent on expensive hospitals, and EDs in particular, to provide routine outpatient care
- 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
- Roughly half of the region's community health centers are financially challenged. Expenses consistently exceed revenues
- 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 smoking³

Community Demographics

- **Population: Population:** 895,356
 - Under 18 = 25.24%
 - 18-44 = 37.82%
 - 45-64 = 24.74%
 - 65+ = 12.2%
- **Diversity:**
 - Caucasian: 61.1%
 - Hispanic: 19.4%
 - Asian: 8.5%
 - African American: 6.3%
 - American Indian/Alaska Native & Other: 4.7%
- **Average Income:** \$71,471
- **Uninsured:** 16.3%
- **Unemployment:** 6.9%
- **No High School Diploma:** 11.5%
- **Renters:** 38.1%
- **Community Needs Index Score:** 3.8
- **Medicaid Patients:** 17.8%
- **Other Area Hospitals:**
 - Mercy General Hospital
 - Mercy Hospital of Folsom
 - Methodist Hospital of Sacramento

² California HealthCare Foundation, 2009

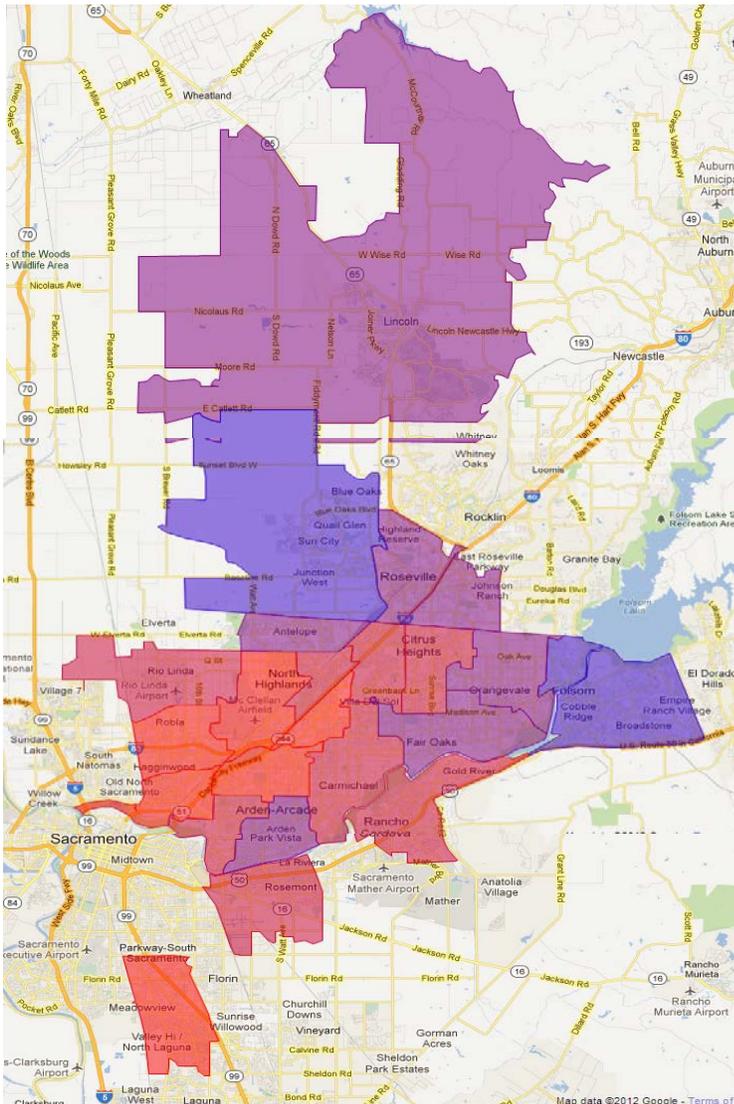
³ Sierra health Foundation Regional Health Care Partnership Market Analysis, January 2012

- Sutter Hospital
- Kaiser Permanente
- UC Davis Medical Center

Mercy San Juan Medical Center Community Needs Index (CNI) Data

The Hospital's CNI Score of 3.8 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 12). 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 San Juan Medical Center Community Needs Index (CNI) Map: Median CNI Score: 3.8



Lowest Need

1 - 1.7
Lowest

1.8 - 2.5
Lowest

2.6 - 3.3
Mid

3.4 - 4.1
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> |
|-----------------|----------------------|-------------------|-----------------|---------------|--------------|
| 95608 | 3.4 | 58717 | Carmichael | Sacramento | California |
| 95610 | 3.4 | 44535 | Citrus Heights | Sacramento | California |
| 95621 | 3.4 | 38925 | Citrus Heights | Sacramento | California |
| 95628 | 2.8 | 40353 | Fair Oaks | Sacramento | California |
| 95630 | 2.4 | 69123 | Folsom | Sacramento | California |
| 95648 | 2.8 | 57078 | Lincoln | Placer | California |
| 95660 | 4.8 | 30135 | North Highlands | Sacramento | California |
| 95661 | 3 | 29551 | Roseville | Placer | California |
| 95662 | 3 | 29835 | Orangevale | Sacramento | California |
| 95670 | 4 | 55795 | Rancho Cordova | Sacramento | California |
| 95673 | 3.8 | 14426 | Rio Linda | Sacramento | California |
| 95678 | 3 | 44039 | Roseville | Placer | California |
| 95747 | 1.8 | 52536 | Roseville | Placer | California |
| 95815 | 5 | 25665 | Sacramento | Sacramento | California |
| 95821 | 4.4 | 34737 | Arden-Arcade | Sacramento | California |
| 95823 | 4.8 | 76683 | Sacramento | Sacramento | California |
| 95825 | 4 | 31566 | Sacramento | Sacramento | California |
| 95826 | 3.8 | 37846 | Rosemont | Sacramento | California |
| 95838 | 4.8 | 38250 | Sacramento | Sacramento | California |
| 95841 | 4.2 | 19992 | North Highlands | Sacramento | California |
| 95842 | 3.8 | 31801 | Foothill Farms | Sacramento | California |
| 95843 | 2.8 | 48447 | Antelope | Sacramento | California |
| 95864 | 2.6 | 21978 | Arden-Arcade | Sacramento | California |

COMMUNITY BENEFIT PLANNING PROCESS

A. COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

Mercy San Juan Medical Center's recently completed 2013 Community Health Needs Assessment (CHNA) was conducted in partnership with community stakeholders and Valley Vision, a nonprofit community research and service organization. A team of experts from multiple sectors within the Hospital's service area was assembled to conduct the assessment, including: 1) a local public health expert with over a decade of experience in conducting CHNAs; 2) a geographer with expertise in using GIS technology to map health-related characteristics of populations across large geographic areas, and 3) local public health practitioners and consultants to collect and analyze data.

The assessment followed a community-based participatory research approach, led by a workgroup that was comprised of Mercy San Juan Medical Center's community benefit staff, as well as representatives from Sutter, Kaiser, and UC Davis health systems, and Sierra Health Foundation. Various health and community experts involved in the process included the Sacramento County Public Health Officer, the Sacramento City Unified School District Chief Family and Community Engagement Center Officer, and physicians and leaders of community health and social service organizations. In addition, data was collected from over 70 attendees at multiple Healthy Sacramento Coalition meetings over a nine-month period.

The CHNA was guided by the following objective: *In order to provide necessary information for the Mercy San Juan Medical Center community health improvement plan, identify communities and specific groups within these communities experiencing health disparities, especially as these disparities relate to chronic disease, and further identify contributing factors that create both barriers and opportunities for these populations to live healthier lives.*

The World Health Organization defines *health needs* as "objectively determined deficiencies in health that require health care, from promotion to palliation." Building from this, the CHNA used the following definitions for health *need* and *driver*:

Health Need: *A poor health outcome and its associated driver.*

Health Driver: *A behavioral, environmental, and/or clinical factor, as well as more upstream social economic factors that impact health*

Methodology

The assessment used a mixed methods data collection approach that included primary data such as key informant interviews, community focus groups, and a community assets assessment. Secondary data included health outcomes, demographic data, behavioral data, and environmental data.

Unit of analysis and study area

The study area of the assessment included Mercy San Juan Medical Center's service area, as previously described. A key focus was to show specific communities (defined geographically) experiencing disparities as they related to chronic disease and mental health. Zip code boundaries were selected as the unit-of-analysis for most indicators. This level of analysis allowed for examination of health outcomes at the community level that are often hidden when data are aggregated at the county level. Some indicators (demographic, behavioral, and environmental in nature) were included in the assessment at the census tract, census block, or point prevalence level, which allowed for deeper community level examination.

Selection of data criteria

Criteria were established to help identify and determine all data to be included for the study. Data were included only if they met three standards: 1) all data were to be sourced from credible and reputable sources; 2) data must be consistently collected and organized in the same way to allow for future

trending, and: 3) data must be available at the zip code level or smaller.

County, state, and Healthy People 2020 targets (when available) were used as benchmarks to determine severity. All rates are reported per 10,000 of population. Health outcome indicator data were adjusted using Empirical Bayes Smoothing, where possible, to increase the stability of estimates by reducing the impact of the small number problem. To provide relative comparison across zip codes, rates of ED visits and hospitalization for heart disease, diabetes, hypertension, and stroke were age adjusted to reduce the influence of age.

Primary data – the Voice of the Community

Primary data collection included qualitative data gathered in four ways: 1) input from the Dignity Health community benefit team; 2) key informant interviews with area health and community experts; 3) focus groups with area community members, and; 4) community health asset collection via phone interviews and website analyses.

Key informants are health and community experts familiar with populations and geographic areas residing within the Mercy San Juan service area. To gain a deeper understanding of the health issues pertaining to chronic disease and populations living in more vulnerable communities, 31 key informants participated in the CHNA process. Interviews were conducted with these informants using a theoretically grounded interview guide. Each interview was recorded and content analysis was conducted to identify key themes and important points pertaining to each geographic area. Findings from these interviews were also used to help identify communities most appropriate for focus groups.

Members of the community representing subgroups, defined as groups with unique attributes (race and ethnicity, age, sex, culture, lifestyle, or residents of a particular neighborhood within the service area), were recruited to participate in focus groups. A standard protocol was used for the focus groups in order to better understand the experiences of these community members as they relate to health disparities and chronic disease. Six focus groups were conducted. Content analysis was performed on the focus group interview notes to identify salient health issues affecting these community residents.

Secondary Quantitative Data

Secondary quantitative data used in the assessment are listed below in Tables 1 and 2.

Table 1: ED visits, hospitalization, and mortality

| ED and Hospitalization | | Mortality | |
|---------------------------------------|------------------------|-----------------------------------|------------------|
| Accidents | Hypertension* | All-Cause Mortality* | Infant Mortality |
| Asthma | Mental Health | Alzheimer’s Disease | Injuries |
| Assault | Substance Abuse | Cancer | Life Expectancy |
| Cancer | Stroke* | Chronic Lower Respiratory Disease | Liver Disease |
| Chronic Obstructive Pulmonary Disease | Unintentional Injuries | Diabetes | Renal Disease |
| Diabetes* | Self-inflicted injury | Heart Disease | Stroke |
| Heart Disease* | | Hypertension | Suicide |

*Age adjusted by 2010 California standard population

Table 2: Socio-demographic, behavioral, and environmental data profiles used in the CHNA

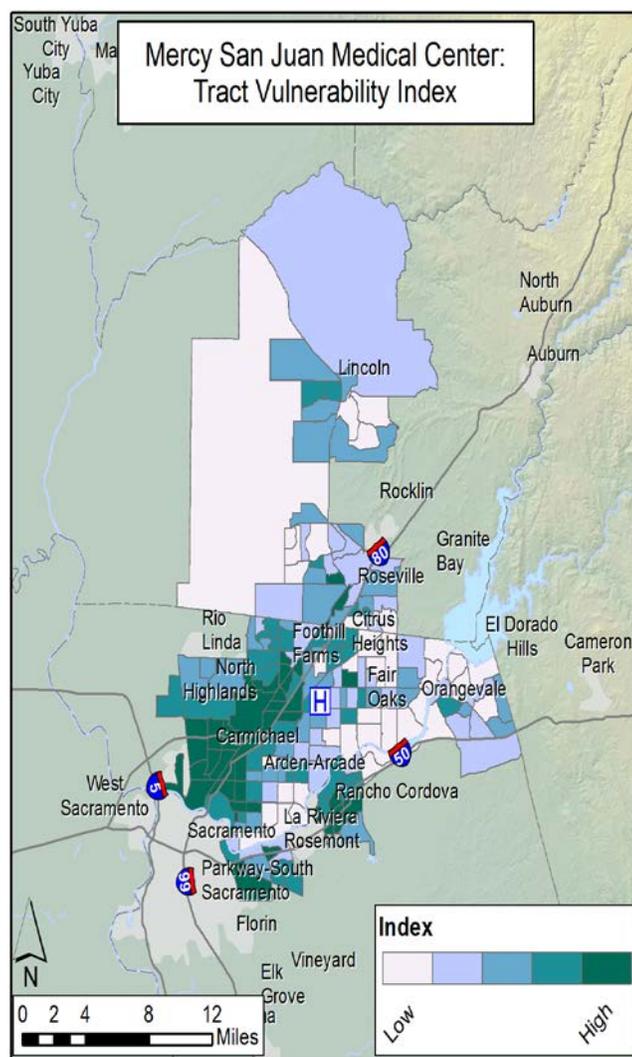
| Socio-Demographic | |
|-------------------|---|
| Total Population | Limited English Proficiency |
| Family Make-up | Percent Uninsured |
| Poverty Level | Percent over 25 with No High School Diploma |

| | |
|--|--|
| Age | Percent Unemployed |
| Race/Ethnicity | Percent Renting |
| Behavioral and Environmental Profiles | |
| Safety Profile <ul style="list-style-type: none"> Major Crime Assault Unintentional Injury Fatal Traffic Accidents Accidents | Food Environment Profile <ul style="list-style-type: none"> Percent Obese/Percent Overweight Fruit and Vegetable Consumption (≥ 5/day) Farmers Markets Food Deserts Modified Retail Food Environment Index (mRFEI) |
| Active Living Profile <ul style="list-style-type: none"> Park Access | Physical Wellbeing Profile <ul style="list-style-type: none"> Age-adjusted Overall Mortality Life Expectancy Infant Mortality Health Care Professional Shortage Areas Health Assets |

Data Analysis - Identifying Vulnerable Communities
 Socio-demographics were examined to identify neighborhoods in the service area with high vulnerability to chronic disease disparities and poor mental health outcomes. Race/ethnicity, household make-up, income, and age variables were combined into a *vulnerability index* that described the level of vulnerability of each census tract. This index was then mapped for the entire service area. A tract was considered more vulnerable, or more likely to have higher unwanted health outcomes than others, if it had higher: 1) percent Hispanic or non-White population; 2) percent single parent headed households; 3) percent below 125% of the poverty level; 4) percent under five years old; and 5) percent 65 years of age or older living in the census tract. This information was used in combination with input from the CHNA workgroup to identify prioritized areas for which key informants would be sought. The vulnerability index for the service area is shown at right.

Focus Group Selection
 The selection for the focus group was determined by feedback from key informants and analysis of health outcome indicators (ED visits, hospitalization, and mortality rates). Key informants were asked to identify populations that were most at risk for health disparities and mental health issues. In addition, analysis of health outcome indicators by zip code, race and ethnicity, age, and sex, revealed communities with high rates that exceeded established benchmarks of the state and county, as well as Healthy People 2020 targets. This information was compiled to determine the location of focus groups within the service area.

Communities of Concern
 To identify Communities of Concern, primary data from key informant interviews, detailed analysis of secondary data, health outcome indicators, and socio-demographics were examined. Zip code communities with rates that exceeded county, state, or Healthy



People 2020 benchmarks for ED utilization, hospitalization, or mortality were considered. The health outcome data analysis was triangulated with primary data and socio-demographic data to identify specific Communities of Concern.

Data on socio-demographics of residents living in these communities, which included socio-economic status, race and ethnicity, educational attainment, housing status, employment status, and health insurance status, were examined. Area health needs were determined via in depth analysis of qualitative and quantitative data, and then confirmed by socio-demographic data.

Health Needs Identified: Assessment Findings

Analysis of data revealed six Communities of Concern listed in Table 3.

Table 3: Identified Communities of Concern

| Communities of Concern | | | |
|--|--|---------------|--------------------|
| <i>Zip Code</i> | <i>Community/Area</i> | <i>County</i> | <i>Population*</i> |
| 95660 | North Highlands | Sacramento | 30,714 |
| 95673 | Rio Linda | Sacramento | 15,455 |
| 95815 | S. Del Paso Heights, Arden Arcade, N. Sacramento Areas | Sacramento | 24,680 |
| 95821 | North Watt, Marconi Area | Sacramento | 33,550 |
| 95838 | Dell Paso Heights Area | Sacramento | 36,764 |
| 95841 | Foothill Farms Area | Sacramento | 19,448 |
| Total Population in Communities of Concern | | | 160,611 |

(*Source: 2010 Census data)

The six Communities of Concern within Mercy San Juan Medical Center’s service area are home to more than 160,000 residents. The Communities of Concern consist of zip codes that include the areas of North Highlands, Rio Linda, North Sacramento, North Arden Arcade, Del Paso Heights, and the Interstate 80 corridor southeast of North Highlands and Foothill Farms. While large portions of the Communities of Concern are urban areas, other areas such as Rio Linda are fairly rural. The six Communities of Concern are highly diverse, have high rates of poverty, low educational attainment, high unemployment, high un-insurance rates, and a high number of residents who rent their homes. Three of the six zip codes had over 50% of residents reporting to be either non-White or Hispanic. Within the Communities of Concern, zip code 95815 had the highest percentage of residents over the age of five with limited English proficiency at 13.1%.

All six zip codes had a higher percentage of single female-headed households living in poverty than the national average of 31.2%. Two of the six Communities of Concern, 95815 and 95838, had a higher percentage of residents over the age of 65 years living in poverty, compared to the national benchmark of 9%. All but one of the six zip codes had a percentage of families with children living in poverty higher than the national average of 15%, with the percentage in zip code 95815 more than double this national average. All zip code Communities of Concern had a higher percentage of residents over the age of 25 years without a high school diploma compared to the national average, with the highest being 36.2 % in 95815. Three of the zip codes had a higher percentage of unemployed residents compared to the state rate at 9.8%. All of the zip codes had a higher percentage of uninsured residents compared to the national rate at 16.3%, with two zip codes having rates more than twice the national benchmark. The percentage of residents who rent in the six Communities of Concern all exceeded the national average, ranging from 27.7% in 95673 to 63.8% in 95815.

Priority Health Needs

Multiple priority health needs were identified through the analysis of both quantitative and qualitative data. These were prioritized according to the degree of support in the findings. All needs are noted as a “health driver”, or a condition or situation that contributed to a poor health outcome. Priority health needs include:

- Access to primary care and preventative services
- Access to mental health and substance abuse services
- Access to specialty care
- Access to affordable fresh fruits and vegetables
- Safe places to be active
- Improved transportation services
- Education on health, wellness, and nutrition
- Cultural competence in providers
- Basic needs including adequate shelter and food
- Access to dental care

Diabetes, heart disease, stroke, and hypertension were consistently mentioned in the qualitative data as conditions affecting many area residents. All but one zip code had rates of ED visits and hospitalization for diabetes higher than both the county and state benchmarks, with three zip codes having rates of ED visits for diabetes two times greater than the state benchmark. Diabetes was the most frequently discussed health condition among key informant interviews and focus groups. Participants described difficulties in obtaining regular checkups, the high cost of medications and equipment, and a lack of available diabetes education and support services. Area experts and community members consistently reported the immense struggle they had in maintaining positive mental health and accessing treatment for mental illness. Such struggles ranged from the stress brought on by personal and financial pressures to the management of severe mental illness. In addition, key informants and focus groups commonly reported that substance abuse is a major issue within the community. Community members also mentioned crime as a deterrent to utilizing parks and exercising outdoors and the risk of crime impacted their mental health and wellbeing. Many members expressed concern over violence witnessed by children, the potential for post-traumatic stress disorder, and noted that they are hesitant to leave their houses.

Communicating the Results

Results of the assessment are being widely disseminated. Forums to examine the findings are planned within the hospital. Copies of the assessment will be made available to local government officials and all of the nonprofit community-based organizations. The assessment is posted on the Hospital website as well as the Dignity Health Website, www.DignityHealth.org. (See Attachment 1 for the full report.)

B. ASSETS ASSESSMENT

Communities require resources in order to maintain and improve their health. These include health related assets, including health care professionals and community-based nonprofit organizations. An assessment of these resources revealed nearly 40 assets that could potentially provide opportunities for partnerships. In fact, Mercy San Juan Medical Center has established partnerships with a number of those agencies listed. The Hospital is linked through its Patient Navigator program with WellSpace Health (formerly The Effort), and Elica Health Centers (both FQHCs) and with Health for All, and HALO, two FQHC Look-Alike health centers. Partnerships were also established with several organizations during the 2013 Dignity Health Community Grants program cycle, including United Lu-Mien Community Inc., Turning Point, Hmong Women's Heritage, Southeast Asian Assistance Center and La Familia Counseling Center, Inc. Among the resources visibly missing within the Hospital's service area are those that respond to the need for crisis and outpatient mental health care. (A listing of health assets can be found at the back of the CHNA in Attachment 1.)

C. DEVELOPING THE HOSPITAL'S IMPLEMENTATION PLAN

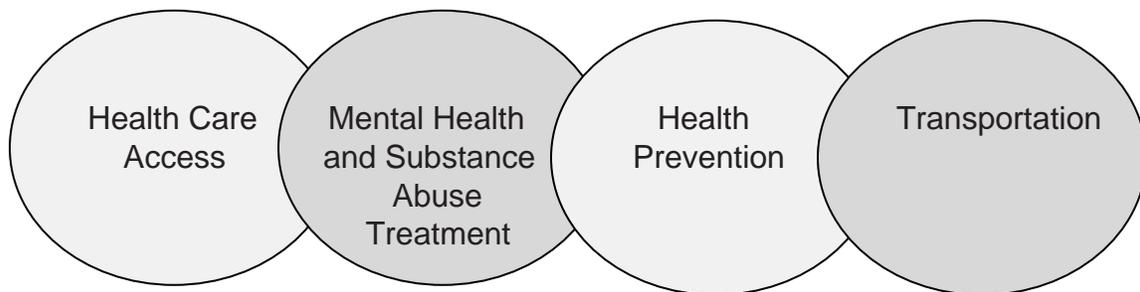
Process for Prioritization

Mercy San Juan Medical Center Leadership worked closely with the Sacramento Service Area

Community Board, Community Health Committee of the Board and community benefit staff to prioritize health needs identified in the CHNA to be addressed in FY 2014. This ensured a well balanced planning process that included knowledge and expertise from community stakeholders. The following criteria were applied for the needs prioritization:

- An assessment identified the issue as significant and important to a diverse group of community stakeholders
- The issue affects a large number of individuals
- The issue is linked to high Hospital ED and inpatient utilization
- The problem is not currently being addressed in the community
- There are currently significant community resources focused on the issue
- The potential for collaboration with community partners exists
- CHNA trending over time reflects the issue is becoming more serious
- The issue is likely to grow worse if left unaddressed
- Mercy San Juan Medical Center has the required expertise and human/financial resources to respond in a way that is impactful

Results of the planning process determined that Mercy San Juan Medical Center would build upon existing programs and services that are already addressing priority health needs, and implement new initiatives to address unmet healthcare needs in the community, with a focus on four overarching priority health areas:



Through the planning process, it was also determined that special emphasis for programs and services that address these four priority areas will be on:

- Collaboration with community partners and health systems to build capacity
- Regionalization for greater impact by leveraging shared resources with sister Dignity Health Hospitals in the Sacramento region that are addressing the same health issues
- Extension of programs and services and enhanced outreach in specific Communities of Concern identified through the CHNA
- Improved data collection by Hospital and partners to measure and demonstrate health improvements
- Lower health care costs through reduced need for ED and inpatient admissions

Implementation Strategies/Action Plans

1. Health Care Access

The CHNA identified a number of significant barriers that contribute to poor access, including:

- a. Uncoordinated referral systems between safety net providers
- b. Residents unable to navigate complex safety net environment
- c. Residents have long wait times for medical appointments
- d. Medi-Cal insured residents lack information about plan providers
- e. Residents confused about Medi-Cal eligibility requirements

These contributors are also impacting ED operations at Mercy San Juan Medical Center where 59% of visits to the ED are for primary care as determined by discharge diagnoses. The Hospital is working in partnership with several community-based nonprofit providers to address this priority health need in several ways:

Increase Primary Care Capacity

Mercy San Juan Medical Center, along with Mercy Hospital of Folsom, has partnered with WellSpace Health (formerly The Effort) to increase access to primary care services in the communities served by Mercy Hospital of Folsom. WellSpace Health is one five FQHCs in the region. Under the agreement, Mercy San Juan Medical Center and Mercy Hospital of Folsom are making a \$2.8 million investment in WellSpace Health over a three year time period that will enable the organization to significantly accelerate its strategy to build three new full scope health centers. These centers will be established in the cities of Rancho Cordova, Carmichael and Folsom; areas of the region that lack safety-net services.

The new Rancho Cordova health center opened in February 2013. WellSpace Health will open the Carmichael site in FY 2014. Through a collaborative effort of outreach and education, patients utilizing the Mercy San Juan Medical Center who lack a primary care provider will be directed to the WellSpace Health centers. As part of the strategic initiative, the Carmichael clinic will be less than two miles from the Hospital to ensure accessibility and to minimize transportation as a barrier.

Collaborating with WellSpace Health presents a unique opportunity that is aligned with the Hospital's mission to care for the poor, responds to the most pressing priority of the region to build safety net capacity, and better positions both the Hospitals and WellSpace Health for ACA implementation. The new health centers will help change the face of the region's safety net, building capacity to serve an additional 40,000 new patients. The Hospitals and WellSpace Health are now developing plans for integration that include care coordination and technology connectivity in order to assist and monitor the health outcomes of patients.

Patient Navigator Program

Working with Medi-Cal Managed Care plan, Health Net and community nonprofit, Sacramento Covered, the Hospital is building upon a successful demonstration pilot program by implementing a navigator program in its ED to coordinate care for underserved patients. The goal of this program is to improve access to timely regular care in an appropriate setting (health home), reduce reliance on the ED for primary care, and lower health care costs. The full-scale program provides:

- Onsite assistance to patients prior to discharge from the ED to connect/reconnect patients to their Primary Care Provider (PCP) and other services (i.e. specialty care recommended by PCP, social support), or to find patients a PCP or medical home in a community clinic
- Next day phone outreach to patients admitting to the ED after hours (template to identify patients and obtain demographics already incorporated into MS4 system through existing pilot program)
- Patient assistance/navigation services include:
 - Assist patients in determining their PCP and/or in finding a PCP or clinic
 - Assist patients in reassignment to a new PCP when necessary
 - Make timely follow-up appointments for patients with PCP/clinic (and other appointments as needed and/or recommended by PCP)
 - Conduct follow up reminder calls to patients for appointments, and stay connected to patients throughout cycle
 - Place special emphasis on frequent ED users (multiple readmits)
 - Educate patients on current health plan coverage including resources available
 - Enroll patients in Dignity Health's no-cost community services, including the Chronic Disease Self-Management and Diabetes Self-Management Healthier Living Programs, and CHAMP (CHF) program
 - Connect patients to resources offered by partner organizations
 - Determining eligibility for patients with no coverage
 - Assist with retention of coverage

- Assistance with other public benefits such as CalFresh
- Share patient ED health data with PCPs/clinics
- Ensure patients have transportation to appointments
- Assess patient satisfaction with levels of care

Dignity Health Community Grants Program

The Hospital has restructured its annual grants program to foster collaboration among community based nonprofit provider organizations as a means to increase access to care. Organizations are being asked to work together to develop innovative partnership programs that provide access to a continuum of care for a specific target population. Outcomes to date are promising. For example, five partners have created a new network of primary and behavioral health care, case management and prevention services for victims of violent crime, particularly within the Lu-Mien community. In addition to increasing access to care, this partnership responds to the priority health issue surrounding safety and meets a secondary CHNA need for cultural competency. A second partnership is focused on increasing access to care within Southeast Asian and Hispanic communities through navigation services and in the first few months of their program have served over 150 clients.

2. Mental Health and Substance Abuse Treatment

Mercy San Juan Medical Center, along with its affiliate Hospitals in the region, takes a lead role with the California Hospital Council in the Community Mental Health Partnership, advocating for reinstatement of Sacramento County mental health services. This partnership was developed in response to county budget cuts that eliminated 50 beds in its residential treatment facility, closed the crisis stabilization unit, and reduced numerous other mental health services, which created a crisis in the region. Several positive steps have been made to reinstate critical services. The County is reopening its crisis stabilization unit on a limited basis, and has increased some beds for residential treatment. Other initiatives include:

ReferNet

Mercy San Juan Medical Center has established a partnership with community-based mental health provider El Hogar, to provide a seamless way for individuals who admit to the ED with mental illness and substance abuse issues to receive immediate and ongoing intensive outpatient treatment for these issues upon discharge from the Hospital.

WellSpace Health Center Expansion

Mercy San Juan Medical Center's work in partnership with WellSpace Health to establish a new full service health center in the community will provide a more accessible pathway to residents in need of substance abuse treatment. WellSpace Health operates a 45-bed residential rehabilitation center, which is a mainstay for the region's addiction treatment system. The center also houses a detoxification program. Patients being established in a medical home at WellSpace Health can be referred into the treatment and rehabilitation program.

Established programs addressing mental health and substance abuse

The Hospital will continue to provide several well-established core services that address mental health, including:

- The **Interim Care Program (ICP)** responds to the mental health, substance abuse treatment, and social needs of homeless individuals upon discharge from the hospital. In addition to care, 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, WellSpace Health (formerly The Effort), as well as the Salvation Army, Sacramento County, and other health systems in the region.

3. Health Prevention

Mercy San Juan Medical Center will further expand its Chronic Disease Self-Management and Diabetes Self-Management Program - **Healthier Living** – which follows the evidence-based Stanford model. A specific target population for program expansion will be residents living within the Communities of Concern identified through the CHNA. Programs are taught in both English and Spanish and are

designed to provide patients who have chronic diseases with the knowledge, tools and motivation needed to become proactive in their health. The workshops are offered in both clinical and community settings.

The Hospital is also working with the Healthy Sacramento Coalition, which was established by Sierra Health Foundation after receipt of Community Transformation Grant funding. The coalition's policy workgroup has recommended that Healthier Living be adopted as one of several region-wide Preventive Services Policies.

Established programs addressing health prevention

The Hospital will continue to provide several well-established core services that address the need for health prevention, including:

- The **Congestive Heart Active Management Program (CHAMP®)** engages all Dignity Health member Hospitals in Sacramento, as well as in other surrounding counties. CHAMP® provides support and assistance for patients who suffer from heart failure, and responds to a priority health issue of heart disease. The program keeps patients linked to the medical world once they leave the hospital through symptom and medication monitoring and education. The program also provides education and health screenings in the community. Consistently, the program achieves an 80% or better reduction in hospital readmissions by participants each year.
- **SAFE KIDS**, a core program for Mercy San Juan Medical Center, involves a group of healthcare, law enforcement, fire department and other community members who work together to raise the public awareness of health and safety for children, including car seat education and seat belt safety. The Car Seat program is part of Mercy San Juan Medical Center's Trauma Prevention Program, which provides outreach, education and car seats to parents, caregivers and children to prevent serious injury and deaths. 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. This includes Safe Kids Car Seat Classes and Health/Safety Education at no cost to families with children living in poverty and to families with children in immigrant communities, where the need is greatest. Safe Kids health and safety fairs are part of the overall Safe Kids program sponsored by Mercy San Juan Medical Center. They provide a venue to provide safety education to parents, care-givers and children in the community.

4. **Transportation**

With limited public transportation options within its service area, Mercy San Juan Medical Center is currently working to ensure transportation resources are readily available to underserved residents, with particular attention to residents living within the Communities of Concern identified through the CHNA.

Patient Navigator Program

Mercy San Juan Medical Center's Patient Navigator Program (described under access to primary care) has added transportation assistance to help patients attend primary care and specialty appointments. Navigators will provide bus tokens or arrange for taxi transportation when patient has not other means. Navigators will also assist patients in learning bus routes to and from appointments to ensure transportation does not remain a barrier.

When developing the agreement with WellSpace Health, where to locate the new health centers was a major consideration for ease of transportation by residents. In alignment with the priority CHNA needs, the Hospital required that the new site be in close proximity to Mercy San Juan Medical Center. The space that was selected is less than two miles from the Hospital and on an accessible bus route.

Needs Not Prioritized

The Hospital responds to priority health needs in many ways, and in times that are critical for patients in crisis. In addition to charity care, indigent care, and un-funded Medi-Cal care, a significant number of programs and services offered address the priority needs identified in the 2013 CHNA. The needs in the County are monumental and Mercy San Juan Medical Center does not have the available resources to

develop and/or duplicate initiatives to meet every priority identified, which makes collaboration with community assets critical. The Hospital does not have the expertise to address dental care. First 5 Sacramento Commission, WellSpace Health, Health and Life Organization, and the Sacramento District Dental Society are providing dental care. Mercy San Juan Medical Center has, and will continue, to provide support to enhance their efforts. The Hospital does not at this time have resources to address the need for healthy foods. This is a need that Kaiser Permanente is addressing through its Healthy Eating Active Living (HEAL) Program.

D. PLANNING FOR THE UNINSURED/UNDERINSURED PATIENT POPULATION

Mercy San Juan Medical Center 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 the Hospital serves are posted in the Hospital's EDs, 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, Mercy San Juan Medical Center provides assistance to help uninsured patients enroll in government sponsored health insurance programs. In FY 2013 3,945 uninsured patients received this free assistance. There were 802 patients successfully enrolled in an insurance program. Hospital-sponsored expense for this assistance was \$1,839,968.

Mental Health Consultations

The Hospital provides psychiatric consultations at no cost for all patients who require evaluations while hospitalized, as well as patient conservatorship services to those who lack capacity of family to help make decisions. In FY 2013, 2,009 evaluations were provided to poor and vulnerable patients, at an expense of \$668,402.

PLAN REPORT AND UPDATE

INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

Summary of Key Programs and Initiatives – FY 2013

Key community benefit initiatives and community-based programs directly provided, or substantially supported, by Mercy San Juan Medical Center in FY 2013 are summarized below. These initiatives and programs are mapped to align with the four priority health areas and are guided by five core principles:

1. Focus on disproportionate unmet health-related needs.
2. Emphasize prevention.
3. Contribute to a seamless continuum of care.
4. Build community capacity.
5. Demonstrate collaborative governance.

Initiative I: Health Care Access

- Charity care
- Patient Navigator Program (development occurred for FY 2014 launch)
- WellSpace Health Expansion (capacity increase in FY 2014)
- Sacramento Covered (formerly Cover the Kids initiative to enroll all children in health insurance)
- SPIRIT (capacity increase in FY 2014)
- Dignity Health Community Grants Program
- Dignity Health Community Investment Program
- Mercy Perinatal Recovery Network
- Enrollment Assistance Program
- School Health Nurse Program

Initiative II: Mental Health and Substance Abuse

- ReferNet Intensive Outpatient Mental Health Program (expansion planned in FY 2014)
- Interim Care Program (homeless respite and recovery program)
- Interim Care Program Plus (added capacity with 5-bed unit)
- WellSpace Health Center expansion
- Community Mental Health Partnership
- Respite Partnership Collaborative
- Mental health consultations

Initiative III: Health Prevention

- Healthier Living Chronic Disease Self Management and Diabetes Self-Management Program (expansion planned in FY 2014)
- CHAMP® (Congestive Heart Active Management Program)
- Safe Kids Car Seat Program
- Mercy Faith and Health Partnership

Initiative IV: Transportation

- Patient Navigator Program (development occurred for FY 2014 launch)
- WellSpace Health Expansion (capacity increase in FY 2014)

These key programs are continuously monitored for performance and quality with ongoing improvements to facilitate their success. The Community Benefit Committee, Executive Leadership, the Community Board and Dignity Health receive quarterly updates on program performance and news. The following Program Digests highlight a few key programs that address one or more of the initiatives listed above.

PROGRAM DIGESTS

| PATIENT NAVIGATOR PROGRAM (New in FY 2014) | |
|--|---|
| 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 safety net system were identified in the 2013 CHNA as priority issues. The need for patient navigation and assistance is extremely evident in the high rate of ED utilization for non-urgent care by Medi-Cal-insured and uninsured (59% of all admits). |
| Program Description | The program builds upon the successful Community Health Referral Network demonstration pilot project, and is a collaborative initiative between the Hospital, Health Net, Sacramento Covered and community health centers. 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 or reconnecting them with their assigned PCP. |
| FY 2013 | |
| Goal FY 2013 | Develop formal partnership with Health Net. Find competent community nonprofit partner for navigator services. Design and develop expanded program, utilizing Cerner, MS4 and MobileMD. Establish relationships with IPA and provider networks. Create ED project team and physician champions. Determine space needs in ED. Create process and orientation manual and outcomes measurement methodologies. Train and orient navigators and be prepared to launch beginning of FY 2014. |
| 2013 Objective Measure/Indicator of Success | All development work complete and ready to launch program by June 30, 2013. |
| Baseline | The region has a weak and fragmented safety net system that lacks any care coordination. 59% of all patients admitting to the ED are seeking primary care. Access to primary care is a priority health issue, identified in 2013 and past CHNAs. |
| Intervention Strategy for Achieving Goal | Weekly meetings with all partners to track development progress; support of the program from Hospital Leadership, ED project team and IT to assist in complex technology needs. |
| Result FY 2013 | 4 months of development work complete; program was ready to go live beginning of FY 2014. First outcomes report will be prepared December 2013. |
| Hospital's Contribution / Program Expense | Expense during the year included in community benefit staff time for development. Actual program expense begins FY 2014 |
| FY 2014 | |
| Goal 2014 | Assist underserved patients admitting to the EDs for primary care in finding medical homes in an appropriate community clinic setting or reconnecting them with their assigned PCP and other social support services to reduce their reliance on EDs, improve health and lower cost. |
| 2014 Objective Measure/Indicator of Success | 59% of all ED visits are for primary care and could be avoided if care were received in a physician's office or clinic setting. Program will be measured by improved access for patients, reductions in ED primary care visits by the population assisted, and reduced cost. |
| Baseline | Access to primary care is a priority CHNA health issue which results in high utilization of the ED for basic medical services by the underserved population. |
| Intervention Strategy for Achieving Goal | Weekly/monthly meetings to trouble shoot, track progress, etc. with navigators, partners and ED program teams. |
| Community Benefit Category | A3-e Health Care Support Services – Information & Referral. |

| 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 | The regional program responds to a priority health 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 ED 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 2013 | |
| Goal FY 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 Hospital 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. |
| Intervention Strategy for Achieving Goal | Regular meetings with CHAMP® Team at Hospital. Strategy meeting with FQHC; program outcome monitoring and evaluation. |
| Result FY 2013 | Nearly 3,000 participants (significant increase over FY 12) enrolled in program; over 80% did not admit to the Hospital post intervention. |
| Hospital's Contribution / Program Expense | \$357,836 |
| FY 2014 | |
| Goal 2014 | 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. |
| 2014 Objective Measure/Indicator of Success | Continue to increase enrollment of underserved through outreach and community collaboration, and maintain reduction in number of Hospital 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. |
| Intervention Strategy for Achieving Goal | Regular meetings with CHAMP® Teams at Hospital; continued partnership building with FQHCs. |
| 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 | ICP responds to the growing number of homeless individuals and families in the community and lack of access to care, a CHNA priority health issue. The program also addresses the high Hospital utilization rates by this population due to lack of adequate services. |
| Program Description | ICP is a partnership with Mercy San Juan Medical Center, affiliate Dignity Health Hospitals, other regional health systems, Sacramento County and WellSpace Health (FQHC). 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 2013 | |
| Goal FY 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 | Over 100 in total homeless patients were referred to ICP, and successfully completed the program (27% were referred by Mercy San Juan Medical Center/Dignity Health Hospitals). |
| Baseline | ICP responds to the growing number of homeless individuals and families in the community and lack of access to care, a CHNA priority health issue. The program also addresses the high Hospital utilization rates by this population due to lack of adequate services. |
| 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 2013 | 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 | \$97,496 |
| FY 2014 | |
| Goal 2014 | 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. |
| 2014 Objective Measure/Indicator of Success | Increase number of successful ICP+ referrals; evaluate need for 5-bed unit successful homeless. |
| Baseline | The (ICP) responds to the growing number of homeless individuals and families in the community and lack of access to care, a CHNA priority health issue. The program also addresses the high Hospital utilization rates by this population due to lack of adequate services. |
| Intervention Strategy for Achieving Goal | New outcomes measurement process in place for improved quarterly tracking of ICP+ 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. |

| HEALTHIER LIVING CHRONIC DISEASE SELF MANAGEMENT PROGRAM | |
|---|--|
| 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 current and past 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 comprehensive program conducted in partnership with the community called Healthier Living. It is 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 program follows the evidence-based Stanford model. Workshops are offered in both clinical and community settings, including: clinics operated by the region's FQHC providers, neighborhood centers, food banks, and low-income housing developments (in partnership with Mercy Housing). |
| FY 2013 | |
| Goal FY 2013 | Provide education and skills management to help those with chronic disease manage their symptoms and lead healthier and more productive lives; thus reducing their need to admit to the Hospital. Specifically, achieve maximum target metric goal or better – 70% of all participants avoid admission post program intervention. |
| 2013 Objective Measure/Indicator of Success | Expand workshop offerings (3 conducted in FY 12); grow lay leader workforce; achieve/exceed metric goal. |
| Baseline | Chronic disease, including, heart disease, diabetes, stroke, asthma and cancer, plagues the region, and accounts for a high ED and inpatient admission rate. Chronic disease is identified as a priority health issue in the current and past CHNAs. |
| Intervention Strategy for Achieving Goal | Outreach to the community clinics and other nonprofits. Continue to build community partnerships for expansions of workshops. Continue to identify community lay leaders |
| Result FY 2013 | Conducted 20 workshops in the community in both English and Spanish. Trained 22 new community lay leaders. Exceeded metric goal. |
| Hospital's Contribution / Program Expense | \$18,000 |
| FY 2014 | |
| Goal 2014 | Provide education and skills management to help those with chronic disease manage their symptoms and lead healthier and more productive lives; thus reducing their need to admit to the Hospital. Specifically, achieve maximum target metric goal or better – 70% of all participants avoid admission post program intervention. |
| 2014 Objective Measure/Indicator of Success | Continue to meet/exceed metric goal. Develop new lay leaders and community partners in order to expand workshop offering and build participants. Seek larger collaboration with Sierra Health Foundation to spread program throughout the community. |
| Baseline | Chronic disease, including, heart disease, diabetes, stroke, asthma and cancer, plagues the region, and accounts for a high ED and inpatient admission rate. Chronic disease is identified as a priority health issue in the current and past CHNAs. |
| Intervention Strategy for Achieving Goal | Outreach to the community clinics and other nonprofits. Continue to build community partnerships for expansions of workshops. Continue to identify community lay leaders. Strategic partnerships for growth of program |
| Community Benefit Category | A1-a Community Health Education – Lectures/Workshops. |

| 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 is a major health issue identified in the 2013 CHNA. The Hospital is experiencing alarming increases 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 San Juan Medical Center, Mercy General Hospital, Methodist Hospital of Sacramento, and Mercy Hospital of Folsom 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 2013 | |
| Goal FY 2013 | Increase access to intensive outpatient mental health care for those that suffer from this illness. |
| 2013 Objective Measure/Indicator of Success | Partner with an effective partner in the community that provides adequate services to those in need of intensive outpatient mental health care and treatment. |
| Baseline | Since the County cut services, lack of mental health services has become a crisis issue. This is indicated in the CHNA and in the Hospital's utilization rates for underserved patients in need of mental health treatment and services. |
| Intervention Strategy for Achieving Goal | Education about the partnership in the Hospital ED, and engagement of Hospital Case Management and Discharge Planners. Increasing level of community benefit funding to support the partnership. Develop effective outcomes measurement. |
| Result FY 2013 | Over 300 patients provided services; 103 successfully completed full course of intensive outpatient treatment program. |
| Hospital's Contribution / Program Expense | \$75,000 |
| FY 2014 | |
| Goal 2014 | Increase access to mental health care for those that suffer from this illness. |
| 2014 Objective Measure/Indicator of Success | Increasing number of clients served with successful outcomes. |
| Baseline | Since the County cut services, lack of mental health services has become a crisis issue. This is indicated in the CHNA and in the Hospital's utilization rates for underserved patients in need of mental health treatment and services. |
| Intervention Strategy for Achieving Goal | Maintain and/or increase level of funding to build capacity. Evaluate partner options to add substance abuse treatment. |
| Community Benefit Category | E1-a Cash Donations – Contributions to Nonprofit orgs/Community groups. |

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 7/1/2012 Through 6/30/2013). Community benefit expenses were calculated using a cost accounting methodology

| | Persons | Total Expense | Offsetting Revenue | Net Benefit | % of Organization Expenses | Revenues |
|--|----------------|--------------------|--------------------|-------------------|----------------------------|-------------|
| <u>Benefits for Living in Poverty</u> | | | | | | |
| Financial Assistance | 3,472 | 5,157,163 | 0 | 5,157,163 | 1.0 | 1.0 |
| Medicaid | 42,546 | 155,849,410 | 127,999,703 | 27,849,707 | 5.4 | 5.3 |
| Means-Tested Programs | 1,501 | 10,934,880 | 6,636,938 | 4,297,942 | 0.8 | 0.8 |
| Community Services | | | | | | |
| Community Benefit Operations | 0 | 117,362 | 0 | 117,362 | 0.0 | 0.0 |
| Community Building Activities | 0 | 3,801 | 0 | 3,801 | 0.0 | 0.0 |
| Community Health Improvement Services | 8,904 | 2,552,537 | 0 | 2,552,537 | 0.5 | 0.5 |
| Financial and In-Kind Contributions | 217 | 2,676,515 | 0 | 2,676,515 | 0.5 | 0.5 |
| Subsidized Health Services | 2,460 | 1,625,431 | 43,838 | 1,581,593 | 0.3 | 0.3 |
| Totals for Community Services | 11,581 | 6,975,646 | 43,838 | 6,931,808 | 1.3 | 1.3 |
| Totals for Living in Poverty | 59,100 | 178,917,099 | 134,680,479 | 44,236,620 | 8.6 | 8.4 |
| <u>Benefits for Broader Community</u> | | | | | | |
| Community Services | | | | | | |
| Community Building Activities | 0 | 107 | 0 | 107 | 0.0 | 0.0 |
| Community Health Improvement Services | 22,405 | 32,100 | 380 | 31,720 | 0.0 | 0.0 |
| Financial and In-Kind Contributions | 1 | 859,303 | 0 | 859,303 | 0.2 | 0.2 |
| Health Professions Education | 15 | 64,551 | 0 | 64,551 | 0.0 | 0.0 |
| Totals for Community Services | 22,421 | 956,061 | 380 | 955,681 | 0.2 | 0.2 |
| Totals for Broader Community | 22,421 | 956,061 | 380 | 955,681 | 0.2 | 0.2 |
| Totals - Community Benefit | 81,521 | 179,873,160 | 134,680,859 | 45,192,301 | 8.8 | 8.6 |
| Unpaid Cost of Medicare | 49,666 | 139,382,232 | 124,502,706 | 14,879,526 | 2.9 | 2.8 |
| Totals with Medicare | 131,187 | 319,255,392 | 259,183,565 | 60,071,827 | 11.7 | 11.4 |
| Grand Totals | 131,187 | 319,255,392 | 259,183,565 | 60,071,827 | 11.7 | 11.4 |

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 San Juan Medical Center. The 2013 Community Benefit Report and 2014 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 to 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 can be found on the Hospital website, along with the 2013 Community Health Needs Assessment, and under "Community Health" in the "Who We Are" section on Dignity Health's Website: www.DignityHealth.org.

APPENDIX A

Sacramento Service Area Hospital Community Board and Community Health Committee Rosters

Sacramento Service Area Hospital 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 | Mercy San Juan Medical Center |
| 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 |
| Sister Cornelius O'Connor | Mission Integration | Mercy Hospital of Folsom |
| Michael Cox | Mission Integration | Methodist Hospital of Sacramento |
| 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 |

Community Health Committee Roster

Sr. Gabrielle Jones, Mission Integration, Mercy San Juan Medical Center (Committee Chair)
Patrice Coyle, Community Representative
Sr. Clare Dalton, Mission Integration, Mercy General Hospital
Sr. Cornelius O' Connor, Chaplaincy, Mercy Hospital of Folsom
Sr. Bridget McCarthy, Mission Integration, Dignity Health Sacramento/San Joaquin Service Area
Michael Cox, Mission Integration, Methodist Hospital of Sacramento
Kevin Duggan, President, Mercy Foundation
Jill Dryer, 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
Ashley Brand, Community Benefit Manager, 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

2013 Community Health Needs Assessment