Sutter Health

Sutter Davis Hospital

2016 – 2018 Implementation Strategy
Responding to the 2016 Community Health Needs Assessment

2000 Sutter Place, Davis, CA 95616
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www.sutterhealth.org

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Introduction

The implementation strategy describes how Sutter Davis Hospital (SDH), a Sutter Health affiliate, plans to address significant health needs identified in the 2016 Community Health Needs Assessment (CHNA). The document describes how the hospital plans to address identified needs in calendar (tax) years 2016 through 2018.

The 2016 CHNA and the 2016 - 2018 implementation strategy were undertaken by the hospital to understand and address community health needs, and in accordance with the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

The implementation strategy addresses the significant community health needs described in the CHNA that the hospital plans to address in whole or in part. The hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and merit enhancements to the described strategic initiatives. Alternately, other organizations in the community may decide to address certain community health needs, and the hospital may amend its strategies and refocus on other identified significant health needs. Beyond the initiatives and programs described herein, the hospital is addressing some of these needs simply by providing health care to the community, regardless of ability to pay.

SDH welcomes comments from the public on the 2016 Community Health Needs Assessment and 2016 – 2018 implementation strategy. Written comments can be submitted:

- By emailing the Sutter Health System Office Community Benefit department at SHCB@sutterhealth.org;
- Through the mail by sending to 2700 Gateway Oaks, Suite 2200, Sacramento, CA 95833 ATTN: Community Benefit and
- In-person at the hospital's Information Desk.

About Sutter Health

SDH is affiliated with Sutter Health, a not-for-profit network of hospitals, physicians, employees and volunteers who care for more than 100 Northern California towns and cities. Together, we're creating a more integrated, seamless and affordable approach to caring for patients.

The hospital's mission is to enhance the well-being of people in the communities we serve through a not-for-profit commitment to compassion and excellence in health care services.

Over the past five years, Sutter Health has committed nearly $4 billion to care for patients who couldn't afford to pay, and to support programs that improve community health. Our 2015 commitment of $957 million includes unreimbursed costs of providing care to Medi-Cal patients, traditional charity care and investments in health education and public benefit programs. For example:

In 2015, Sutter Health invested $712 million more than the state paid to care for Medi-Cal patients. Medi-Cal accounted for 20 percent of Sutter Health's gross patient service revenues in 2015. Sutter Health hospitals proudly serve more Medi-Cal patients in our Northern California service area than any other health care provider.

- As the number of insured people grows, hospitals across the U.S. continue to experience a decline in the provision of charity care. In 2015, Sutter Health's investment in charity care was $52 million.
- Throughout our health care system, we partner with and support community health centers to ensure that those in need have access to primary and specialty car. We also support children's health centers, food banks, youth education, job training programs and services that provide counseling to domestic violence victims.

Every three years, Sutter Health hospitals participate in a comprehensive and collaborative Community Health Needs Assessment, which identifies local health care priorities and guides our community benefit strategies. The assessments help ensure that we invest our community benefit dollars in a way that targets and address real community needs.

For more facts and information about Sutter Davis Hospital, visit www.sutterhealth.org.

2016 Community Health Needs Assessment Summary

The purpose of this Community Health Needs Assessment (CHNA) is to identify and prioritize significant health needs of the community served by Sutter Davis Hospital (SDH). The priorities identified in this report help to guide the hospital's community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets requirements of the Patient Protection and Affordable Care Act and California Senate Bill 697 that not-for-profit hospitals conduct a community health needs assessment at least once every three years.

This report documents the processes, methods, and findings of the CHNA conducted in partnership with Sutter Davis Hospital, located at 2000 Sutter Pl, Davis, CA 95616. Building on federal and state requirements, the objective of the 2016 CHNA was to identify and prioritize community health needs and identify resources available to address those health needs, with the goal of improving the health status of the community at large and for specific locations and/or populations experiencing health disparities.

The CHNA was completed as a collaboration of the four major health systems in the Greater Sacramento region: Dignity Health, Kaiser Permanente, Sutter Health and UC Davis Health System. Together, the CHNA Collaborative represented 15 hospitals in the Sacramento Region. The CHNA Collaborative project was conducted over a period of eighteen months, beginning in January 2015 and concluding in June 2016.

The following research questions were used to guide the 2016 CHNA:

1. What is the community or hospital service area (HSA) served by each hospital in the CHNA Collaborative?
2. What specific geographic locations within the community are experiencing social inequities that may result in health disparities?
3. What is the health status of the community at large as well as of particular locations or populations experiencing health disparities?
4. What factors are driving the health of the community?
5. What are the significant and prioritized health needs of the community and requisites for the improvement or maintenance of health status?
6. What are the potential resources available in the community to address the significant health needs?

To meet the project objectives, a defined set of data collection and analytic stages were developed. Data collected and analyzed included both primary or qualitative data, and secondary or quantitative data. To determine geographic locations affected by social inequities, data were compiled and analyzed at the census tract and ZIP code levels as well as mapped by GIS systems. From this analysis as well as an initial preview of the primary data, Focus Communities were identified within the HSA. These were defined as geographic areas (ZIP codes) within the HSA that had the greatest concentration of social inequities that may result in poor health outcomes. Focus Communities were important to the overall CHNA methodology because they allowed for a place-based lens with which to consider health disparities in the HSA.

To assess overall health status and disparities in health outcomes, indicators were developed from a variety of secondary data sources (see Appendix B in full report). These "downstream" health outcome indicators included measures of both mortality and morbidity such as mortality rates, emergency department visits and hospitalization rates. They also included risk behaviors such as smoking, poor nutrition and physical activity. Health drivers/conditions or "upstream" health indicators included measures of living conditions spanning the physical environment, social environment, economic and work

environment, and service environment. This also included the indicators on social inequities that were used for the determination of Focus Communities. Overall, more than 170 indicators were included in the CHNA.

Community input and primary data on health needs were obtained via interviews with service providers and community key informants and through focus groups with medically underserved, low-income, and minority populations. Transcripts and notes from interviews and focus groups were analyzed to look for themes and to determine if a health need was identified as significant and/or a priority to address. Primary data for Sutter Davis included 16 key informant interviews with 20 participants and six focus groups conducted with 69 participants including community members and service providers. A complete list of key informant interview data sources is available in Appendix F in the full report and a complete list of focus group data is available in Appendix G, located in the full report.

The full 2016 Community Health Needs Assessment conducted by Sutter Davis Hospital is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

The community or hospital service area (HSA) is defined as the geographic area (by ZIP code) from which the hospital receives its top 80% of discharges. The Sutter Davis HSA is comprised of 17 ZIP codes in Yolo, Solano and Sutter counties, California. The Sutter Davis Hospital (SDH) Hospital Service Area (HSA) is located in Northern California and includes approximately 209,902 residents. As Tables 1 and 2 show (in the full report), the area is considerably diverse in population, economic stability (income and poverty), and insurance status. Table 1 shows the total population count for each of the 17 ZIP codes within the SDH HSA, the median age, and the median income compared to county and state benchmarks. Table 2 provides information on the presence of medically underserved, low income, and minority residents in the SDH HSA.

The population of Yolo County makes up 0.5% of all residents in the State of California. The population count at the ZIP code level varied from 29 residents in ZIP code 95679 (Rumsey) to 47,995 residents in ZIP code 95616 (Davis). The median age of Yolo County is lower than the median age of the state. The ZIP code with the youngest median age was 95616 (Davis) with a median age of 23.0 years and the ZIP code with the eldest median age was 95606 (Brooks) with a median age of 61.1 years. The median income for Yolo County was lower than the state median income at $55,981. The ZIP code in the SDH HSA with the lowest median income was 95653 (Madison) at $42,083 per year compared to the highest in ZIP code 95606 (Brooks) at $178,295 per year, a range of over $135,000 dollars a year.
In an attempt to understand the extent and location of the medically underserved, low income and minority populations living in the SDH HSA, specific indicators were examined.

The percent of population living in poverty was greater in Yolo County compared to the state benchmark. The SDH HSA ZIP code with the highest percent of population in poverty was 95616 (Davis) at 30.9%, compared to the lowest percent poverty in ZIP code 95697 (Yolo) at 6.5%. The percent of residents uninsured was lower in Yolo County compared to the state benchmark. The ZIP code with the highest percent uninsured was 95653 (Madison) at 35.1%, and the lowest percent was 1.4% in ZIP code 95637 (Guinda). The percentage of minority residents was lower in Yolo County compared to the state benchmark, with the highest percent seen in ZIP code 95697 (Yolo) at 87.0% and the lowest percent in 95607 (Capay) at 32.3%.

Demographics for the SDH HSA showed that Whites make up the highest percent of residents followed by Hispanics/Latinos and Asians.

Significant Health Needs Identified in the 2016 CHNA

The following significant health needs were identified in the 2016 CHNA:

1. Active Living and Healthy Eating

2. Access to Behavioral Health Services
3. Disease Prevention and Management
4. Safe, Crime and Violence Free Communities
5. Access to High Quality Health Care and Services
6. Basic Needs (Food Security, Housing, Economic Security, Education)
7. Affordable and Accessible Transportation
8. Pollution-Free Living and Work Environments

In order to identify and prioritize the significant health needs, the quantitative and qualitative data were synthesized and analyzed according to established criteria outlined later in this report. This included identifying eight potential health need categories based upon the needs identified in the previously conducted CHNA, the grouping of indicators in the Kaiser Permanente Community Commons Data Platform (CCDP), and a preliminary review of primary data. Indicators within these categories were flagged if they compared unfavorably to state benchmarks or demonstrated racial/ethnic disparities according to a set of established criteria. Eight potential health needs were validated as significant health needs for the service area. The data supporting the identified significant health needs can be found in the Prioritized Description of Significant Health Needs section of this report. The resources available to address the significant health needs span several counties and were compiled by using the resources listed in the 2013 CHNA report as a foundation and then verifying and expanding these resources to include those referenced through community input. Additional information regarding resources is found in the Resources section and a comprehensive list of potential resources to address health needs is located in Appendix H in the full CHNA.

2016 – 2018 Implementation Strategy

The implementation strategy describes how Sutter Davis Hospital plans to address significant health needs identified in the 2016 Community Health Needs Assessment and is aligned with the hospital's charitable mission. The strategy describes:

- Actions the hospital intends to take, including programs and resources it plans to commit;
- Anticipated impacts of these actions and a plan to evaluate impact; and
- Any planned collaboration between the hospital and other organizations in the community to address the significant health needs identified in the 2016 CHNA.

The Implementation Strategy serves as a foundation for further alignment and connection of other SDH initiatives that may not be described herein, but which together advance SDH's commitment to improving the health of the communities it serves. Each year, SDH programs are evaluated for effectiveness, the need for continuation, discontinuation, or the need for enhancement. Depending on these variables, programs may change to continue SDH's focus on the health needs listed below.

The prioritized significant health needs the hospital will address are:

1. Active Living and Healthy Eating
2. Access to Behavioral Health Services
3. Access to High Quality Health Care and Services
4. Basic Needs (Food Security, Housing, Economic Security, Education)

ACTIVE LIVING AND HEALTHY EATING

Name of program/activity/initiative	Yolo Food Bank
Description	The Yolo Food Bank offers the Kids Farmers Market program to provide Yolo County preschool and elementary school children with ongoing access to fresh fruits and vegetables through a fun, interactive farmer's market-style distribution. The program provides a free weekly after school farmers' market for preschool and elementary school children at seven schools. It allows students the opportunity to use play money to "purchase" up to 10 pounds of produce from the onsite market.
Goals	The goal of this effort is for students to learn about and sample the available fruits and vegetables, and to take home the produce, recipes, and other information about healthy living.
Anticipated Outcomes	The anticipated outcome is that students from seven schools around Yolo County, will have the opportunity to access fresh and healthy food, for themselves and their entire families. This program will reach hundreds of kids and will hopefully lead to nutrition education and families in Yolo eating healthier.
Plan to Evaluate	We will evaluate the impact of the Yolo Food Bank program on a bi-annual basis, by tracking the number of children/families reached, pounds of food distributed and other indicators.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children/families served, active schools, anecdotal stories and other successful program impacts.

ACCESS TO BEHAVIORAL HEALTH SERVICES

Name of program/activity/initiative	Area Wide Mental Health Strategy
Description	The need for mental health services and resources, especially for the underserved, has reached a breaking point across the Sutter Health Valley Operating Unit. This is why we are focused on building a comprehensive mental health strategy that integrates key elements such as policy and advocacy, county specific investments, stigma reduction, increased awareness and education, with tangible outreach such as expanded mental health resources to professionals in the workplace and telepsych options to the underserved.
Goals	By linking these various strategies and efforts through engaging in statewide partnerships, replicating best practices, and securing innovation grants and award opportunities, we have the ability to create a seamless network of mental health care resources so desperately needed in the communities we serve.
Anticipated Outcomes	The anticipated outcome is a stronger mental/behavioral safety net and increased access to behavioral/mental health resources for our community.
Plan to Evaluate	We will work with our partners to create specific evaluation metrics for each program within this strategy. The plan to evaluate will follow the same process of our other community benefit program with bi-annual reporting and partner meetings to discuss/track effectiveness of each program within this strategy.

Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories, types of services/resources provided and other successful linkages.

Name of program/activity/initiative	Suicide Prevention Follow Up Program
Description	The Emergency Department Suicide Prevention Follow Up Program is designed to prevent suicide during a high-risk period, and post discharge, provide emotional support, and continue evidence based risk assessment and monitoring for ongoing suicidality. That includes personalized safe plans, educational and sensitive outreach materials about surviving a suicide attempt and recovery, 24-hour access to WellSpace Health's Suicide Prevention Crisis lines, and referrals to community-based resources for ongoing treatment and support.
Goals	The goal of the Suicide Prevention program is to wrap patients with services and support following a suicide attempt or suicidal ideation.
Anticipated Outcomes	The anticipated outcome of the suicide prevention follow up program is to decrease instances of suicide reattempts or ideations.
Plan to Evaluate	SDH will continue to evaluate the impact of the suicide prevention program on a quarterly basis, by tracking the number of people served, number of linkages to other referrals/ services and other indicators.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of resources provided, suicide attempts post program intervention, type of resources provided and other successful linkages.

ACCESS TO HIGH QUALITY HEALTH CARE AND SERVICES

Name of program/activity/initiative	CommuniCare
Description	With access to care, including primary, mental health and specialty care continuing to be a major priority area in the SAFH HSA, we will continue to make strategic investments in our local FQHC partners to increase clinic capacity and services offered. Our relationship with CommuniCare is one of our most valued partnerships in Yolo County. CommuniCare is an FQHC offering comprehensive primary medical and dental services, perinatal services, behavioral health services, substance abuse treatment, health education and outreach services to the culturally diverse, low-income, and uninsured and Medi-Cal populations of Yolo County and eastern Solano County, including migrant and seasonal farm workers and their families.
Goals	The goal is to expand access to care.
Anticipated Outcomes	The anticipated outcome is expanded capacity to serve the underserved population with primary care, behavioral/mental health care, and dental and other specialty services.
Plan to Evaluate	The plan to evaluate will follow the same process as many of our other community benefit program with bi-annual reporting and partner meetings to discuss/track effectiveness of CommuniCare and its impact on the underserved community.

Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of appointments provided, types of services provided, anecdotal stories and other successful linkages.

Name of program/activity/initiative	Free Mammography Screenings
Description	Throughout the month of October, Sutter Diagnostic Imaging centers across the Valley OU provide free digital screening mammograms to uninsured women in honor of National Breast Cancer Awareness Month. The goal of this outreach effort was to not only provide free screenings to underinsured women in our communities, but it also serves as an opportunity to provide women with information on health and insurance resources. Free mammograms are offered in various locations, at various times, including in Placer County, to ensure as many women as possible were able to take advantage of this effort. In addition, a packet of follow up resources was created in the event that a participant had an abnormal screening, as well as insurance enrollment services.
Goals	The goal of the screening events are to provide free mammograms for women who otherwise wouldn't have access to one.
Anticipated Outcomes	The anticipated outcome of the screenings is to provide free mammograms for uninsured women and ensure they have supportive resources and connection to care if results come back abnormal.
Plan to Evaluate	SDH will continue to evaluate the impact of our Free Mammography Screenings on an annual basis, by tracking the number of people served and additional services provided, like linkages to primary care and insurance. We will also reexamine this program to ensure it evolves with the needs of the community.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories and other successful linkages.

Name of program/activity/initiative	Yolo Healthy Aging Alliance
Description	Yolo Healthy Aging Alliance works to connect older adults and persons with disabilities in Yolo County to the services and supports they need to remain safe and healthy in the community. SDH supported the creation of a Yolo Senior Resource Guide, development of a public website for services in Yolo County and planning and development of a Yolo Aging and Disability Resource Connection to provide one-stop connection to services in person and over the phone.
Goals	The goals of these efforts is to connect seniors and persons with disabilities with the resources they so desperately need, but are sometimes hard to locate or access.
Anticipated Outcomes	The Yolo Healthy Aging Alliance will reach at least 1,000 seniors and disabled persons, offering them resources and a connection to vital community and health-related services.
Plan to Evaluate	The plan to evaluate will follow the same process as many of our other community benefit program with bi-annual reporting and partner meetings to discuss/track program effectiveness and overall impact on the senior and disabled population in Yolo County.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of resource guides distributed, number and types of resources provided, anecdotal stories and other successful linkages.

BASIC NEEDS (FOOD SECURITY, HOUSING, ECONOMIC SECURITY, EDUCATION)

Name of program/activity/initiative	Children's Initiatives
Description	Yolo Crisis Nursery (YCN) is one of only four crisis nurseries in CA and the only crisis nursery in Yolo County. They offer emergency child care and wrap-around services to families in crisis which ensure continued stability and the well-being of young children at risk for child abuse. YCN's early intervention services focus on building successful and resilient children, strengthening parents and preserving families. Their work helps to stop the cycle of child abuse and its long-term impact, contributing to a healthier community for everyone. SDH is also partnering with the Yolo Children's Alliance to expand their reach, by developing a third location, aimed to serve even more children in need.
Goals	The goals of these programs/organizations include providing children with stable, loving environments, while wrapping the children and their families with services to help them end the cycle of violence, and live happy, healthy lives.
Anticipated Outcomes	These programs will reach hundreds of children in need, providing them with the stability and support, necessary for them to escape chaotic and/or dangerous situations, and set them on a more positive path.
Plan to Evaluate	The plan to evaluate will follow the same process as many of our other community benefit program with bi-annual reporting and partner meetings to discuss/track program effectiveness and overall impact on the underserved community.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children/families served, number and types of resources provided, anecdotal stories and other successful linkages.

Name of program/activity/initiative	Coordinated Exit
Description	Sacramento Steps Forward (SSF) utilizes a three-step housing crisis resolution system as a strategy to end homelessness in the Sacramento region, specifically in Sacramento, Yolo and Placer Counties. This system is based on a Housing First model that provides people with a continuum of care. The Coordinated Exit program is designed to move individuals and families out of homelessness as efficiently and as quickly as possible by placing them in emergency, transitional, or permanent housing while concurrently wrapping them with other supportive services. These services often include access to health care, coordination of social services, enrollment in employment programs and other client-centered support services to maintain ongoing stability and break the cycle of homelessness.
Goals	This effort seeks to place homeless people in permanent housing, while addressing other issues like health needs, etc.
Anticipated Outcomes	The anticipated outcomes is lower number of homeless people in the greater Sacramento region.
Plan to Evaluate	SAFH will continue to evaluate the impact of the coordinated exit program on a quarterly basis, by tracking the number of people served, number of people successfully housed, number of linkages to other referrals/services and other indicators.

Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories from staff and patients, number of people successfully housed, type of resources provided and other successful linkages.

Needs Sutter Davis Hospital Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Davis Hospital is committed to serving the community by adhering to its mission, using its skills and capabilities, and remaining a strong organization so that it can continue to provide a wide range of community benefits. The implementation strategy does not include specific plans to address the following significant health needs that were identified in the 2016 Community Health Needs Assessment:

1. Disease Prevention and Management: Disease Prevention and Management is addressed by expanding access to care at Federally Qualified Health Centers, like CommuniCare; however, this is not one of our main strategic priorities at this time.

2. Safe, Crime and Violence Free Communities: This is primarily a law enforcement issue and not something that SAFH has the expertise to effectively address.

3. Affordable and Accessible Transportation: We are continuously looking for opportunities to provide collaborative transportation options to the underserved communities; however, we have not yet found the perfect fit in Yolo County. Although we don't have current plans to address transportation, there is always a chance that one may develop in the years ahead.

4. Pollution-Free Living and Work Environments: While this is an important issue, this is not something that we are able to greatly affect through community benefit; therefore, we are focusing our resources elsewhere, especially given that regional community partners like SACOG, the Cleaner Air Partnership and others, are working on these vital issues.

Approval by Governing Board

The implementation strategy was approved by the Sutter Health Valley Area Board on 17, November, 2016.