Sutter Health

Sutter Solano Medical Center

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

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Introduction

The implementation strategy describes how Sutter Solano Medical Center (SSMC), 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.

Sutter Solano Medical Center 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
Sutter Solano Medical Center (SSMC) 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 Solano Medical Center, visit www.sutterhealth.org.

2016 Community Health Needs Assessment Summary

This Community Health Needs Assessment (CHNA) serves two purposes: to fulfill the requirements of the nonprofit hospitals to conduct a CHNA every three years and to adopt an implementation strategy to meet the community health needs identified through the CHNA, and to satisfy the Community Health Assessment (CHA) for Solano County Public Health, in preparation for the development of their Community Health Improvement Plan (CHIP).

This report documents the processes, methods, and findings of the CHNA conducted on behalf of the Solano CHNA Collaborative, a collaborative of three nonprofit hospital systems – Kaiser Permanente, NorthBay Healthcare and Sutter Health Sacramento Sierra Region – Solano County Department of Public Health and the Solano Coalition for Better Health serving Solano County, California. The Solano CHNA Collaborative project was conducted over a period thirteen months, beginning in April 2015 and concluding in May 2016. For the purposes of this assessment, the health service area (HSA) was defined by the 18 ZIP codes that make up Solano County.

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 following research questions were used to guide the 2016 CHNA:
1. What is the community or health 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 within the HSA affected by social inequities, data were compiled and analyzed at the census tract and ZIP code levels as well as mapped by geographic information systems (GIS). Additionally, indicators were collected from a variety of secondary sources (see Appendix A) to assess overall health status and disparities in health outcomes. 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. In total, primary data for the CHNA included 11 key informant interviews with 24 participants and 6 focus groups conducted with 67 community member participants.

The full 2016 Community Health Needs Assessment conducted by Sutter Solano Medical Center is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

For the purposes of this report, the health service area (HSA) is the 18 ZIP codes which make up Solano County, California. The HSA was designated as Solano County because all Solano CHNA Collaborative partners serve communities within the county. Due to data availability, the HSA was examined two separate ways. One approach was to use Solano County as the service area. While this approach was the most natural and best reflected the focus area of collaborative members, it did not allow for a consideration of variation in conditions across the county. An alternative approach was also used in which the service area was defined based on the ZIP Code Tabulation Areas (ZCTAs), as defined by the US Census Bureau. In this approach, all ZCTAs that had a meaningful overlap with Solano County were included in the analyses. The benefit of this approach was that it allowed for the calculation of morbidity and mortality rates based on data available at the ZIP code level. This allowed for a better understanding of how these conditions varied within the county.

The health service area of Solano County is located in Northern California and has approximately 417 thousand residents. As Tables 2 and 3 (in the full report) show, the area is considerably diverse in population, economic stability (income and poverty), and insurance status. Table 2 shows the total population count for the Solano County HSA, the median age of the HSA, and the median income compared to the state benchmarks. Table 3 provides information on the presence of medically underserved, low income, and minority residents in Solano County.

The population of Solano County makes up 1% of all residents in the State of California. The population count at the ZIP code level varied from 188 residents in ZIP code 95625 (Elmira) to 69,067 residents in ZIP code 94533 (East Fairfield). The median age of the county is similar to the median age of the state. The ZIP code with the youngest median age was 94535 (Travis AFB) with a median age of 21.3 years, and the ZIP code with the oldest median age was 94571 (Rio Vista) with a median age of 56.9 years. The median income for the county was higher than the state median income, at $67,177. The ZIP code in the HSA with the lowest median income was 94590 (South/Central Vallejo) at $47,819 per year compared to the highest median income in ZIP code 94512 (Elmira) at $142,885 per year, a range of nearly $95,000 dollars a year.

Demographic data for the Solano HSA showed that Whites make up the highest percent of residents in Solano County, followed by Hispanics, Asians and Blacks.

Significant Health Needs Identified in the 2016 CHNA

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

1. Access to behavioral health services

2. Healthy eating and active living

3. Safe, crime and violence free communities

4. Disease prevention, management and treatment

5. Affordable and accessible transportation

6. Basic needs (food security, housing, economic security, education)

7. Access to high quality health care and services

8. Pollution-free living and work environments

The Solano Community Health Needs Assessment (CHNA) collaborative project was conducted over a period of thirteen months, beginning in April 2015 and concluding in May 2016. The project was conducted using a series of data collection and analytical phases. The CHNA process began with the collection and analysis of secondary data indicators of social inequities and proceeded with collection of

both "upstream" and "downstream" health indicators. Primary data collection began with interviews of area health experts such as public health and social service representatives. The first stage of data analysis resulted in the identification of vulnerable communities (e.g., low-income, medically underserved and minority populations), which then guided further primary data collection including community member focus groups. These data were considered together with the data in the Kaiser Permanente Community Commons Data Platform (CCDP) to develop potential health need categories that provided an organizational structure to integrate these numerous inputs, analyze the data and identify the significant health needs for the health service area (HSA). The significant health needs were then prioritized using established criteria, and resources available to address the identified needs were compiled for the final report. The overall process to conduct the CHNAs is depicted in the CHNA Process Model (Figure 4 in the full report).

2016 – 2018 Implementation Strategy

The implementation strategy describes how Sutter Solano Medical Center 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 Sutter Solano Medical Center initiatives that may not be described herein, but which together advance SSMC's commitment to improving the health of the communities it serves. Each year, SSMC programs are evaluated for effectiveness, the need for continuation, discontinuation, or the need for enhancement. Depending on these variables, programs may change to continue SSMC focus on the health needs listed below.

The prioritized significant health needs the hospital will address are:

1. Access to behavioral health services

2. Disease prevention, management and treatment

3. Affordable and accessible transportation

4. Access to high quality health care and services

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 telepysch 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.

DISEASE PREVENTION, MANAGEMENT AND TREATMENT

Name of program/activity/initiative	Touro University Diabetes Mobile Clinic
Description	In a joint effort SSMC and Touro University will deliver care to the most vulnerable residents of Solano County. The Mobile Healthcare Clinic and Classroom would provide direct diabetes prevention programs and diabetes education services for people in Solano County. The classroom would travel into the community and provide a safe and reliable space for community members to participate in DPP.
Goals	Delivering primary health services to the underserved and connecting them to resources for ongoing care, as well as providing diabetes testing and education.
Anticipated Outcomes	The anticipated outcome of the mobile clinic is that hundreds of underserved individuals will have access to diabetes education and resources, helping them identify, manage and treat their diabetes.
Plan to Evaluate	SSMC will evaluate the impact of the mobile clinic on a bi-annual basis by tracking the number of people served, number/type of services provided, 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 services/resources provided, anecdotal stories from staff and patients, type of services/resources provided and other successful linkages.

AFFORDABLE AND ACCESSIBLE TRANSPORTATION

Name of program/activity/initiative	Delta Breeze
Description	The Rio Vista Delta Breeze provides transportation to and from medical appointments for seniors living in Rio Vista.
Goals	The goal of the Rio Vista Delta Breeze program is to provide rides to and from medical appointments for seniors and disabled residents of Rio Vista.
Anticipated Outcomes	The outcome of the Delta Breeze program is hundreds of rides to and from medical appointments each year, for people who might not otherwise have the resources to travel to these important appointments.
Plan to Evaluate	SSMC will continue to evaluate the impact of the Delta Breeze on a biannual basis, by tracking the number of people served and number of rides provided.

Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served and number of rides provided.

ACCESS TO HIGH QUALITY HEALTH CARE AND SERVICES

Name of program/activity/initiative	ED Navigator
Description	The ED Navigator is an employee of La Clinica and serves as a visible ED-based staff member. Upon referral from a Sutter employee (and after patient agreement), ED Navigators attend to patients in the ED and determines the type of resources and support this patient needs. Upon assessment, the ED Navigator identifies patient needs for community-based resources and/or case-management services, such as providing a patient linkage to a primary care provider and establishing a medical home.
Goals	The goal of the ED Navigator is to connect patients with health and social services, and ultimately a medical home, as well as other community programs when appropriate.
Anticipated Outcomes	The anticipated outcome of the ED Navigator is reduced ED visits, as patients will have a medical home and access to social services, in turn, reducing their need to come to the ED for non-urgent reasons and making the patient healthier overall.
Plan to Evaluate	The ED Navigator program has proven to be effective in improving access to care for the underserved community. SSMC will continue to evaluate the impact of the ED Navigator on a quarterly basis, by tracking the number of people served, recidivism rates, 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, type of resources provided 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 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	SSMC will continue to evaluate the impact of the 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	T3+
Description	T3+ patients are identified in an inpatient setting and are often battle complex health and social issues. The T3+ navigator follows patients after discharge and works with Sutter Health staff to provide a follow-up health plan, tele-health, pain management, etc. All of this occurs while the T3+ navigators address the patient's other needs (including housing, insurance enrollment, etc) and ensure a connection is made to primary and preventive care to reduce further hospitalization**.**
Goals	The goal of T3+ is to wrap patients with health and social services, and ultimately a medical home.
Anticipated Outcomes	The anticipated outcome of T3+ is to successfully connect patients with a medical home and social services, in turn, managing any long term health ailments and making the patient healthier overall.
Plan to Evaluate	The T3+ program has proven to be effective in improving access to care for the underserved community in Sacramento County. SSMC is currently implementing this best practice and once implemented will evaluate the impact on a quarterly basis, by tracking the number of people served, recidivism rates, 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, hospital usage post program intervention, type of resources provided and other successful linkages.

Name of program/activity/initiative	Transitional Care Program
Description	The Transitional Care Program (TCP) provides a place to discharge and connect homeless patients, who are traditionally underserved residents, with resources and support. SSMC, along with other local health providers, offer funding and support to the Solano Coalition for Better Health and the Benicia Community Action Coalition, to provide this program to some of Solano County's most vulnerable residents. This program links homeless adults to vital community services while giving them a place to heal, as well as medical follow up and case management. The clients who are enrolled in the TCP are individuals who otherwise would be discharged to the street or cared for in an inpatient setting only. In addition, the TCP allows patients to focus on recovery and developing a long-term plan to get off the streets, all while being linked to vital community and medical services. The TCP has produced impressive client outcomes by providing "wraparound" services including connection to a medical home, enrollment in eligible programs and support services for clients.
Goals	The TCP seeks to connect patients with a medical home, social support and housing.
Anticipated Outcomes	The anticipated outcome of the TCP is to help people improve their overall health by wrapping them with services and treating the whole

	person through linkage to appropriate health care, shelter and other social support services.
Plan to Evaluate	The TCP program has proven to be effective in improving access to care for the underserved community. SSMC will continue to evaluate the impact of TCP on a quarterly basis, by tracking the number of people served, recidivism rates, 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, hospital usage post program intervention, type of resources provided and other successful linkages.

Needs Sutter Solano Medical Center Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Solano Medical Center 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. Healthy eating and active living: While there are currently no healthy eating or active living SSMC community benefit programs in the SSMC HSA, we do fund programs/organizations and efforts that address this need through our sponsorship program.

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. Basic needs (food security, housing, economic security, education): While many of our programs seek to connect patients to basic needs like housing, income and food resources, this priority need is not a main focus at SSMC at this time.

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 and local jurisdictions 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.