Sutter Health

# Sutter Health
# Memorial Medical Center

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

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## Introduction

The implementation strategy describes how Memorial Medical Center, 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.

Memorial 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 using the hospital's address at 1800 Coffee Road, Suite 30, Modesto, CA 95355, Attention: Jennifer Downs-Colby and
- In-person at the hospital's Information Desk.

## About Sutter Health

Memorial Medical Center 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

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 Memorial Medical Center, visit www.sutterhealth.org.

### 2016 Community Health Needs Assessment Summary

The Community Health Needs Assessment of Stanislaus County was conducted by Ad Lucem Consulting, an independent contractor, Sutter Health Memorial Medical Center (SHMMC) and Kaiser Foundation Hospital. All secondary data cited in the report came from the Community Commons data platform (www.communitycommons.org). The data platform contains over 150 publically available indicators for Stanislaus County mapped to one or more potential health needs. During 2015, Stakeholder interviews and focus groups were conducted and provided additional insights into the priority health needs in the SHMMC service area. The prioritization process was informed by the secondary and primary data. Each need received a numerical score, which was the average score from the primary and secondary data and disparities. The full 2016 Community Health Needs Assessment conducted by Sutter Health Memorial Medical Center is available at www.sutterhealth.org.

### Definition of the Community Served by the Hospital

Sutter Health Memorial Medical Center is located in Modesto, California, and its service area includes the cities of Ceres, Hughson, Modesto, Newman, Oakdale, Patterson, Riverbank, Turlock and Waterford. The service area includes all of Stanislaus County, making Stanislaus County data a good proxy for data for the SHMMC area. The demographics include a total population of 518,321 citizens, with 76.51% white (including Hispanic), 2.82% black, 5.28% Asian, and of that population, 42.5% Latino. The population density is much higher in Stanislaus County thank California as a whole. 44.19% live in Poverty, 28.32% children are living in poverty, 10.4% are unemployed, 17.84% are uninsured and 23/59% have not graduated from High School.

### Significant Health Needs Identified in the 2016 CHNA

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

1. Obesity and Healthy Eating Active Living/Diabetes - a lifestyle that includes healthy eating and physical activity improves overall health, mental health, and cardiovascular health, thus reducing costly and life-threatening health outcomes. Obesity rates, diabetes prevalence and related hospitalizations were higher in Stanislaus County as compared to the state. Obesity was the most frequently cited health concern among stakeholders and focus groups. Lack of access to healthy food and safe places for physical activity were frequently mentioned as barriers.

2. Mental Health – Mental health and well-being is essential to living a meaningful and productive life. This provides people with the necessary skills to cope and move on from daily stressors. Access to mental health providers is limited in Stanislaus County. Compared to the state average of 157 mental health providers per 100,000 population, in Stanislaus County there are 61.9 providers per 100,000 population.

3. Access to Care: Access to high quality, culturally competent, affordable healthcare and health services is essential to the prevention and treatment of morbidity and increase the quality of life, especially for the most vulnerable. In Stanislaus County, residents have less access to dentists, primary care providers and mental health providers as compared to the income populations and those without health insurance. Lack of transportation, long wait times, difficulty scheduling appointments, language issues, and poor quality of care were frequently discussed by stakeholders and in the focus groups.

4. Cancers: Screening and early treatment of cancers saves and prolongs lives. Preventive measures and reducing behavioral risk factors (obesity, physical inactivity, smoking and UV light exposure) can be effective at reducing the incidence of cancer. Overall cancer mortality rates are greater in Stanislaus County as compared to the state. Whites are disproportionately impacted by lung cancer. Obesity, physical inactivity, and poor air quality were identified by stakeholders and in focus groups as contributors to cancer.

5. CVD/Stroke: In the US, cardiovascular disease is the leading cause of death and strokes are the third leading cause of death. The rate of heart disease and stroke mortality in Stanislaus County is higher than the state average. Ethnic/racial groups are disproportionately affected by heart disease and stroke; non-Hispanic blacks have over twice the prevalence of heart disease as compared to the county. Lack of access to safe parks, low cost exercise opportunities, and high rates of obesity were frequently cited as contributing factors.

6. Substance Abuse/Tobacco: Reducing tobacco use and treating/reducing substance abuse improves quality of life for individuals and their communities. Tobacco use is the most preventable cause of death, with second hand smoke exposure putting people around smokers at risk for the same respiratory diseases as smokers. Substance abuse is linked with community violence, sexually transmitted infections, and teen pregnancies. Tobacco usage is higher in Stanislaus County than the state. The prevalence of drugs in local parks, particularly among the homeless population, was frequently mentioned in primary data as was substance abuse, poverty and mental illness.

Sutter Health Memorial Medical Center defines a “health need” as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data. The following criteria were used to identify the community health needs for the SHMMC service area:

- The health need fits the SHMMC definition of a “health need” as described above
- The health need was confirmed by multiple data sources
- Indicators related to the health need performed poorly against a defined benchmark.
- The community prioritized the health need. A health need was prioritized based on the frequency with which stakeholders and focus groups mentioned the need. It was only included if at least three stakeholders and focus groups identified it as a need.

Process and criteria used for prioritization of the health needs

- A prioritization matrix was developed with rows for each health need and columns listing health need scores for secondary data, primary data, and ethnic/racial disparities (based on secondary data).
- A scoring rubric was applied to each data type to calculate a numerical score for the data type.
- A multi-voting method was used to prioritize the nine identified health needs as high, medium or low priorities. In addition to the prioritization matrix, participants (SHMMC leadership) were asked to consider the following criteria when prioritizing health needs: severity of the issue, opportunity

to intervene at the prevention level, existing resources dedicated to the issue, effective and feasible interventions exist.

**2016 – 2018 Implementation Strategy**

The implementation strategy describes how Sutter Health Memorial 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 needs identified in the 2016 CHNA.
- The Implementation Strategy serves as a foundation for further alignment and connection of other Sutter Health MMC initiatives that may not be described herein, but which together advance Memorial's commitment to improving the health of the hospital and other organizations in the community to address the significant communities it serves. Each year, MMC programs are evaluated for effectiveness, the need for continuation, discontinuation, or the need for enhancement. Depending on these variables, programs may change to continue Memorial's focus on the prioritized significant health needs listed below.

1. High Rate of Obesity: Healthy Eating, Active Living, Diabetes
2. Mental Health
3. Access to Care
4. Cancers
5. Cardio Vascular Disease/Stroke
6. Substance Abuse and Tobacco

**Priority Health Need #1 - High Rate of Obesity: Healthy Eating, Active Living, Diabetes**

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| **Name of program/activity/initiative** | Stanislaus County Office of Education After School Program |
| **Description** | The After School Program addresses healthy eating and improved physical activity. Youth are given training in these practices to decrease obesity rates. The After School setting is ideal for providing education to a wide variety of grammar and middle school students. MMC provides $15,000 in grant monies to support this endeavor |
| **Goals** | To increase healthy eating and active living among After School students |
| **Anticipated Outcomes** | Students will be able to make healthy food choices when given an option. Students will verbalize understanding of appropriate food choices. |
| **Plan to Evaluate** | Each student will be observed for change in practice. Surveys will be conducted throughout the year. |
| **Metrics Used to Evaluate the program/activity/initiative** | 3,200 students will be served in this program. 38 After School sites will be utilized. Skillastics program and National Education Standards are provided to evaluate the children in their acquired learning. Surveys will evaluate change in behavior. |

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| **Name of program/activity/initiative** | Modesto City School Gardens - for underserved primarily Hispanic area. |
| **Description** | The School Gardens are large planting areas that will produce vegetables and fruit for students and their families to learn and experience healthy eating with fresh foods. The gardens are supported by a teaching initiative titled “Growing Healthy Habits” and will reach 3 schools and 300 students. Burbank, Kirschen, and Robertson Road Schools are very economically depressed. There is an increase in the incidence of obesity in low income communities. This area is considered a food desert due to few grocery stores available vs. fast food restaurants. Memorial Medical Center will contribute $6,000 for this project.. |
| **Goals** | To increase use of fresh vegetables and fruit in the home setting. To improve basic knowledge of students and their families in good nutrition. |
| **Anticipated Outcomes** | 300 + students and their families will be exposed to healthy vegetables. They will be educated in growing, planning and preparing ingredients from the school gardens to serve their families. |
| **Plan to Evaluate** | Youth Nutrition and Physical Active Survey will be administered to each student. The data will be collected by class instructors. |
| **Metrics Used to Evaluate the program/activity/initiative** | 300 students will be served plus their families. The surveys and gardens will occur at 5 sites all in the 95358 zip code. |

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| **Name of program/activity/initiative** | The Congregations Building Community Center at Marshall Park. |
| **Description** | Congregations Building Community Center at Marshall Park is located in a predominately Latino community. The grant allows local residents and neighbors, opportunities to come together, work for a common good of improving their neighborhood, receive language classes, exercise, participate in health and nutrition programs and parenting classes. |
| **Goals** | To increase access to exercise and healthy nutrition classes for the neighborhood. |
| **Anticipated Outcomes** | 50 local residents will participate in exercise programs. 50 neighbors will take language classes. 50 local people will participate in nutrition classes. 20 residents will be assisted with Enrollment Assistance for insurance. |
| **Plan to Evaluate** | Pre and post surveys will be administered to participants. |
| **Metrics Used to Evaluate the program/activity/initiative** | 50 – 150 residents will be served. Outcomes will be measured by survey tools and verbal interactions as well as observation. |

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| **Name of program/activity/initiative** | FitQuest |
| **Description** | FitQuest Program is a comprehensive children’s wellness program focusing on nutrition, fitness, and mental wellness. The on-site school program geared toward 5$^{th}$ and 6$^{th}$ grad students, teaches students easy ways to incorporate healthy choices into daily living. The curriculum is designed to improve overall health in a fun and meaningful way. |
| **Goals** | To teach children and their families healthy lessons about fitness, physical activity and the importance of nutritious eating. |

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| **Anticipated Outcomes** | Students will be able to make healthy food choices when given an option. Students will verbalize understanding of appropriate food choices. |
| **Plan to Evaluate** | Evaluate the impact of the FitQuest program on a quarterly basis, by tracking the number of children/families reached, types of activities/lessons taught 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 |

**Priority Health Need #2 - Improve Access to Mental Health Programs in our community**

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| **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. |

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| **Name of program/activity/initiative** | Promotores – Center for Human Services |
| **Description** | Center for Human Services Promotores program reaches out to Latino community members to increase access to health information including mental and behavioral health programs. They also connect neighbors to medical homes and insurance plans. There are Promotores throughout Stanislaus County touching over 500 lives. Memorial Medical Center collaborating with the Center for Human Services and Behavioral Health will support the Promotores programs as it grows within the community. Planned support will be $10,000 per year. |

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| **Goals** | The Promotores will connect families to local mental health services, provide translation as needed and increase utilization of programs while decreasing the stigma of accessing these opportunities. |
| **Anticipated Outcomes** | Connect Hispanic residents with health care including medical insurance, mental health care, and a medical home when necessary. |
| **Plan to Evaluate** | Each Promotores will report metrics utilizing an impact grid. |
| **Metrics Used to Evaluate the program/activity/initiative** | Metrics will include the number of people connected to mental health programs or support groups. Also, the number of people served, the number connected to insurance and the number of community members connected or referred to a medical home or PCP will be recorded. |

**Priority Health Need #3 - Access to Care**

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| **Name of program/activity/initiative** | Valley Consortium for Medical Education (VCME) |
| **Description** | The Valley Consortium for Medical Education provides residency programs for family care providers in partnership with Health Services Agency, a Federally Qualified Medical Center, MMC and other acute care facilities. The VCME trains physicians in the primary care arena, expands the number of physicians able to see underinsured patients, increases the number of family practice practitioners in our community and provides inpatient and outpatient care to MIA, Medi-Cal and Covered California insured members.<br>MMC provides over $414,000 per year to support this endeavor. |
| **Goals** | VCME will train Family Practice MDs. Trained residents to continue practicing in our Community. These residents will provide primary care to low income, underinsured patients in our community each year. |
| **Anticipated Outcomes** | 58 Family Practice physicians will be trained over 5 year period. 50% will remain in this community. 23,000 outpatients will be seen at FQHC H.S.A. |
| **Plan to Evaluate** | Physician tracking will be completed by program staff to determine where their practice will occur post graduation. Number of inpatient visits and outpatient visits seen by residents will be recorded by H.S.A. |
| **Metrics Used to Evaluate the program/activity/initiative** | Number of people served, number connected to Primary Care physician and number of inpatient and outpatient visits by residents will be calculated. |

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| **Name of program/activity/initiative** | Mobile Clinic |
| **Description** | In a joint effort between two Federally Qualified Health Clinics, WellSpace and Goplden Valley Health Centers, will deliver care to the most vulnerable residents of Sacramento and Stanislaus Counties. Initial services will include, pediatric health and dental screenings, and women's health services. Launching in 2016, this innovative approach to health care is built on a sustainable model, and additional funding will allow the clinic to expand services in both service areas to reach more people where they are. |
| **Goals** | Delivering primary health services to the underserved and connecting them to resources for ongoing care is the goal of the Mobile Clinic. |

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| **Anticipated Outcomes** | The anticipated outcome of the mobile clinic is that at least 1,000 people will be served each year and provide with primary care to the underserved. |
| **Plan to Evaluate** | SMCS will continue to evaluate the impact of the mobile clinic on a quarterly 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. |

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| **Name of program/activity/initiative** | Recuperative Care |
| **Description** | Sutter Health Memorial Medical Center will provide financial support to post-hospital recuperative care programs serving the homeless and indigent individuals. |
| **Goals** | Homeless Individuals will recover from illness and injury in a supportive setting versus on the street. |
| **Anticipated Outcomes** | Individuals will successfully complete medical recovery.<br>Individuals, will not return to the referring hospital for the same issue within 30 days<br>Individuals will be linked to primary care physician for ongoing care<br>Individuals will receive access to public assistance as eligible |
| **Plan to Evaluate** | Internal Data Collection |
| **Metrics Used to Evaluate the program/activity/initiative** | # of people served<br># of people connected to PCP<br># of encounters<br>Average length of stay at homeless shelter<br>% of individuals completing recovery<br>% of individuals being readmitted in 30 days post recovery |

**Priority Health Need #4 - Cancers**

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| **Name of program/activity/initiative** | Complementary Therapies at MMC |
| **Description** | Complementary Therapies are a unique service provided by MMC to the cancer patient community at large. Programs included reduce the risk of recurring cancers through stress reduction and creative outlets. Programs offered include music, aquatics, yoga, Pilates, art, photography, and writing. The Complementary Therapies program was designed to improve the outcomes and quality of life of all cancer patients in our community. $172,000 is the cost of operating the Complementary Therapies program |
| **Goals** | Improve quality of life for our community's cancer patients |
| **Anticipated Outcomes** | Anticipated outcomes include improved mental and emotional state plus improvement in disease and medication side effects and reduction in stress, enjoyment of life for participating cancer patients. |
| **Plan to Evaluate** | Local college, Stanislaus State University at Stanislaus is assisting in the surveys which include a Quantitative Quality of Life tool, and Descriptive, non-random comparison group design utilizing the Likert Scale. |

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| **Metrics Used to Evaluate the program/activity/initiative** | Number of people served, number of those participating in Complementary Therapies versus a controlled group of non-participating patients. Survey tool to include questions regarding Quality of life, physical health, mental function, attitude toward life and relationships with others. |

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| **Name of program/activity/initiative** | Nutrition Seminar Series – Cancer Prevention Program |
| **Description** | The Nutrition Series is designed to promote healthy eating to avoid cancer or reduce risk. It is a series of lectures and educational programs open to the community for those with cancer, at risk for cancer and those interested in prevention of cancer. Program cost is $9,000. |
| **Goals** | The nutrition series sole objective is to decrease the incidence of cancer in our community through food awareness and healthy eating. |
| **Anticipated Outcomes** | Attendees and participants will demonstrate improved nutrition behaviors that promote health and wellness and decrease incidence of cancer |
| **Plan to Evaluate** | Each class and series will be initiated with a pre – test measuring current knowledge regarding subject. Post tests will measure participant learning and ability to articulate changes and behaviors in the home setting. |
| **Metrics Used to Evaluate the program/activity/initiative** | Number of persons served, number of classes provided, surveys to determine behavior change pre and post class. |

**Priority Health Need #5 – Cardiovascular Disease and Stroke**

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| **Name of program/activity/initiative** | Cardiac Independence Program |
| **Description** | The only Cardiac Rehabilitation offered in the community is open to any heart diagnosis or post surgery patient regardless of insurance status. Physician prescription is required for entry. Patients exercise under careful auspices of trained nursing staff and exercise physiologist. Goal is improved ability to exercise without causing stress to heart, improved ability to perform activities of daily living, improved stress levels due to heart diagnosis, improved understanding of correlation of healthy heart with nutrition, exercise and stress reduction. |
| **Goals** | Improve participating patients' heart health through exercise, diet, and stress reduction |
| **Anticipated Outcomes** | Participants will see improvement in ability to walk for a measured period of time, pre and post program. |
| **Plan to Evaluate** | Staff will evaluate each participant throughout the program but specifically for pre and post- test ability to walk for a 7 minute period without heart stress or shortness of breath. |
| **Metrics Used to Evaluate the program/activity/initiative** | Number of people served, percentage improvement from 7 minute walk test, number of classes offered. |

**Priority Health Need #6 – Substance Abuse and Tobacco**

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| **Name of program/activity/initiative** | PHAST – Promoting Health and Slamming Tobacco |
| **Description** | PHAST promotes anti-smoking behavior by mobilizing teens to decrease tobacco use through peer-focused activities in High schools and Middle schools throughout the county. PHAST is a program under auspices of the Stanislaus County Office of Education. Health Services Agency is a partner as is the Tobacco prevention program and the Heart Coalition of Stanislaus County. MMC commitment is $15,000 per year. |
| **Goals** | A large coalition of teens are trained to communicate with students the dangers and negative outcomes of smoking or tobacco use. The major objective of program is to join teens together to believe that Not Smoking is cool. Numbers of PHAST students grows with number of non-tobacco use. |
| **Anticipated Outcomes** | An overall county wide reduction in use of tobacco products among teens. |
| **Plan to Evaluate** | A California State survey comparing county statistics over a two year period benchmarks strides in changing behaviors in this youth population. |
| **Metrics Used to Evaluate the program/activity/initiative** | The number of high schools and middle schools and the number of students impacted by the program will be included in the metrics. |

Memorial 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. Asthma is an identified Low Priority Health Need that Memorial Medical Center is not addressing. The rationale for this is: There are resources available through our sister affiliate, Sutter Gould Medical Center. They offer expert physician care, an annual Asthma Fair and they participate on the community Asthma Coalition

2. Violence – this is a significant need but was identified as a “Low Priority”. The hospital has decided not to address this area as our city officials and law enforcement as well as the community are addressing this need. We will support their endeavors whenever possible.

3. Economic Security – also identified as a “Low Priority” of the Health Needs is a major concern in our community. As in Violence, the hospital has decided not to address this area as our government programs are assisting citizens to provide basic needs, food, shelter, etc. We will support their endeavors whenever possible.

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