

Sutter Health

Sutter Auburn Faith Hospital

2019 – 2021 Implementation Strategy Plan
Responding to the 2019 Community Health Needs Assessment

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Introduction

The Implementation Strategy Plan describes how Sutter Auburn Faith Hospital, a Sutter Health affiliate, plans to address significant health needs identified in the 2019 Community Health Needs Assessment (CHNA). The document describes how the hospital plans to address identified needs in calendar (tax) years 2019 through 2021.

The 2019 CHNA and the 2019 - 2021 Implementation Strategy Plan were undertaken by the hospital to understand and address community health needs, and in accordance with state law and the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

The Implementation Strategy Plan 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 Plan 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 Auburn Faith Hospital welcomes comments from the public on the 2019 Community Health Needs Assessment and 2019 - 2021 Implementation Strategy Plan. 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 11815 Education Street, Auburn, CA 95602; and
- In-person at the hospital's Information Desk.

Executive Summary

Sutter Auburn Faith Hospital is affiliated with Sutter Health, a not-for-profit public benefit corporation that is the parent of various entities responsible for operating health care facilities and programs in Northern California, including acute care hospitals, medical foundations and home health and hospice, and other continuing care operations. Together with aligned physicians, our employees and our volunteers, 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 it serves through a not-for-profit commitment to compassion and excellence in healthcare services.

Over the past five years, Sutter Health and its affiliates have committed nearly \$4 billion to care for patients who couldn't afford to pay, and to support programs that improve community health. Our 2018 commitment of \$734 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 2018, Sutter invested \$435 million more than the state paid to care for Medi-Cal patients. Medi-Cal accounted for nearly 19 percent of Sutter's gross patient service revenues in 2018.
- Throughout Sutter, we partner with and support community health centers to ensure that those in need have access to primary and specialty care. Sutter also supports 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 affiliated hospitals participate in a comprehensive and collaborative Community Health Needs Assessment, which identifies significant community health needs and guides our community benefit strategies. The assessments help ensure that Sutter invests its community benefit dollars in a way that targets and addresses real community needs.

Through the 2019 Community Health Needs Assessment process the following significant community health needs were identified:

1. Access to Quality Primary Care Health Services
2. Access to Basic Needs Such as Housing, Jobs, and Food
3. Access to Mental/Behavioral/Substance Abuse Services
4. Injury and Disease Prevention and Management
5. Access and Functional Needs
6. Access to Specialty and Extended Care
7. Active Living and Healthy Eating

The 2019 Community Health Needs Assessment conducted by Sutter Auburn Faith Hospital is publicly available at www.sutterhealth.org.

2019 Community Health Needs Assessment Summary

Community Health Insights (www.communityhealthinsights.com) conducted the assessment on behalf of Sutter Auburn Faith Hospital. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Northern California.

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model. This model of population health includes many factors that impact and account for individual health and well-being. Further, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included seven one-on-one and group interviews with 15 community health experts, social service providers, and medical personnel. Further, 25 community residents participated in four focus groups across the service area.

Focusing on social determinants of health to identify and organize secondary data, datasets included measures to describe mortality and morbidity and social and economic factors such as income, educational attainment, and employment. Further, the measures also included indicators to describe health behaviors, clinical care (both quality and access), and the physical environment. Primary and secondary data were analyzed to identify and prioritize significant health needs. This began by identifying 10 potential health needs (PHNs). These PHNs were those identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the service area. After these were identified, PHNs were prioritized based on rankings provided by primary data sources. Data were also analyzed to detect emerging health needs beyond those 10 PHNs identified in previous CHNAs.

The full 2019 Community Health Needs Assessment conducted by Sutter Auburn Faith Hospital is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

The definition of the community served included the primary service area of the hospital as defined by 10 Zip Codes – 95602, 95603, 95631, 95658, 95703, 95713, 95717, 95722, 95736, and 95949. This is the designated service area because the majority of patients served by SAFH resided in these ZIP Codes. The service area is located predominately in Placer County (with one ZIP Code extending into Nevada County) and includes the city of Auburn. This area of Placer County is often referred to as “the foothills” of the Sierra Nevada Mountain range. The SAFH service area has a population of 96,049 residents.

Significant Health Needs Identified in the 2019 CHNA

The following significant health needs were identified in the 2019 CHNA:

- 1. Access to Quality Primary Care Health Services** – Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and similar. Primary care services are typically the first point of contact when an individual seeks healthcare. These services are the front line in the prevention and treatment of common diseases and injuries in a community.
- 2. Access to Basic Needs Such as Housing, Jobs, and Food** – Access to affordable and clean housing, stable employment, quality education, and adequate food for good health are vital for survival. Maslow’s Hierarchy of Needs demonstrates that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health.
- 3. Access to Mental, Behavioral, and Substance-Abuse Services** – Individual health and well-being are inseparable from individual mental and emotional outlook. Coping with daily life stressors is challenging for many people, especially when other social, familial, and economic challenges occur concurrently. Adequate access to mental, behavioral, and substance-abuse services helps community members obtain additional support when needed.
- 4. Injury and Disease Prevention and Management** – Knowledge is important for individual health and well-being, and efforts aimed at prevention are powerful vehicles to improve community health. When community residents lack adequate information on how to prevent, manage, and control their health conditions, those conditions tend to worsen. Prevention efforts focused on reducing cases of injury and infectious disease control (e.g., sexually transmitted infection [STI] prevention, influenza shots) and intensive strategies for the management of chronic diseases (e.g., diabetes, hypertension, obesity, and heart disease) are important for community health improvement.
- 5. Access and Functional Needs – Transportation and Physical Disability** – Having access to transportation services to support individual mobility is a necessity of daily life. Without transportation, individuals struggle to meet their basic needs, including those that promote and support a healthy life. Examining the number of people that have a disability is also an important indicator for community health in an effort to ensure that all community members have access to necessities for a high quality of life.
- 6. Access to Specialty and Extended Care** – Extended care services, including specialty care, are services provided in a branch of medicine and focused on the treatment of a specific disease. Primary and specialty care go hand in hand, and without access to specialists, such as endocrinologists, cardiologists, and gastroenterologists, community residents are often left to manage chronic diseases, including diabetes and high blood pressure, on their own. In addition to specialty care, extended care refers to care extending beyond primary care services that is needed in the community to support overall physical health and wellness, such as skilled-nursing facilities, hospice care, and in-home healthcare.
- 7. Active Living and Healthy Eating** – Physical activity and eating a healthy diet are extremely important for one’s overall health and well-being. Frequent physical activity is vital for prevention of disease and maintenance of a strong and healthy heart and mind. When access to healthy

foods is challenging for community residents, many turn to unhealthy foods that are convenient, affordable, and readily available. Communities experiencing social vulnerability and poor health outcomes are often overloaded with fast food and other establishments where unhealthy food is sold.

Primary and secondary data were analyzed to identify and prioritize the significant health needs within the Sutter Auburn Faith Hospital service area. This included identifying seven potential health needs (PHNs) in these communities. These PHNs were those identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the hospital's service area.

Once identified for the area, the final set of SHNs was prioritized. To reflect the voice of the community, significant health need prioritization was based solely on primary data. Key informants and focus group participants were asked to identify the three most significant health needs in their communities. These responses were associated with one or more of the potential health needs. This, along with the responses across the rest of the interviews and focus groups, was used to derive two measures for each significant health need.

First, the total percentage of all primary data sources that mentioned themes associated with a significant health need at any point was calculated. This number was taken to represent how broadly a given significant health need was recognized within the community. Next, the percentage of times a theme associated with a significant health was mentioned as one of the top three health needs in the community was calculated. Since primary data sources were asked to prioritize health needs in this question, this number was taken to represent the intensity of the need.

These two measures were next rescaled so that the SHN with the maximum value for each measure equaled one, the minimum equaled zero, and all other SHNs had values appropriately proportional to the maximum and minimum values. The rescaled values were then summed to create a combined SHN prioritization index. SHNs were ranked in descending order based on this index value so that the SHN with the highest value was identified as the highest-priority health need, the SHN with the second highest value was identified as the second-highest-priority health need, and so on.

2019 – 2021 Implementation Strategy Plan

The implementation strategy plan describes how Sutter Auburn Faith Hospital plans to address significant health needs identified in the 2019 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 2019 CHNA.

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

1. Access to Quality Primary Care Health Services
2. Access to Basic Needs Such as Housing, Jobs, and Food
3. Access to Mental/Behavioral/Substance Abuse Services
4. Injury and Disease Prevention and Management
5. Access and Functional Needs
6. Active Living and Healthy Eating

Access to Quality Primary Healthcare Services

Name of program/activity/initiative	Triage, Transport, Treat (T3)
Description	T3 provides case management services for people who frequently access the SAFH EDs for inappropriate and non-urgent needs, by connecting vulnerable patients to vital resources such as housing, primary care, mental and behavioral health services, transportation, substance abuse treatment and other key community resources. By linking these patients to the right care, in the right place, at the right time and wrapping them with services, we see a drastic improvement to the health and overall quality of life for this often underserved, patient population.
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 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.
Metrics Used to Evaluate the program/activity/initiative	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	Emergency Department Navigator
Description	The ED Navigator is an employee of an FQHC and serves as a visible ED-based staff member. Upon referral from a Sutter employee (and after patient agreement), the ED Navigator attends to patients in the ED and completes an assessment for T3 case-management services. Upon assessment, the ED Navigator determines and 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 programs (like T3) 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.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, anecdotal stories, type of resources provided, number of patients referred to T3 and other successful linkages.

Name of program/activity/initiative	Promotora Program
Description	The Promotora program provides culturally sensitive support to Spanish speaking patients in need of health and social services. Case management wraparound services provided by the Promotora often transcend the patient and extend to the entire family to ensure they have

	necessary resources. This investment provides health care access and services to the Latino community, focusing on serving recent immigrants and monolingual Spanish-speaking families who face greater challenges and barriers to receiving services.
Goals	Our goal is to increase access to primary care, preventative care, and services for the underinsured and uninsured, and ultimately help them establish a medical home.
Anticipated Outcomes	The anticipated outcome of the Promotora is reduced hospital usage, 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.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, anecdotal stories, type of resources provided and other successful linkages.

Access to Basic Needs Such as Housing, Jobs, and Food

Name of program/activity/initiative	Interim Care Program
Description	Offered in partnership with a nonprofit homeless shelter, the Placer Interim Care Program (ICP) is a respite-care shelter for homeless patients discharged from the hospital. The ICP wraps people with health and social services, while giving them a place to heal. The ICP links people in need to vital community services while giving them a place to heal. The clients who are enrolled in the ICP are homeless adult individuals who otherwise would be discharged to the street or cared for in an inpatient setting only. The program is designed to offer clients up to six weeks during which they can focus on recovery and developing a plan for their housing and care upon discharge.
Goals	The ICP seeks to connect patients with a medical home, social support and housing.
Anticipated Outcomes	The anticipated outcome of the ICP 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.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, hospital usage post program intervention, type of resources provided, and other successful linkages.

Access to Mental/Behavior/Substance-Abuse Services

Name of program/activity/initiative	Suicide Prevention 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 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	SAFH 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	Number of people served, number of resources provided, suicide attempts post program intervention, type of resources provided and other successful linkages.
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. In addition, we will identify opportunities to build and foster mental health programs and resources locally in the SAFH service area.
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.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, anecdotal stories, types of services/resources provided, and other successful linkages.

Injury and Disease Prevention and Management

Name of program/activity/initiative	Diabetes Outreach and Education
Description	This program will identify and educate diabetic Latinos in Placer County on daily diabetes self-management; making healthy food choices, staying physically active, monitoring blood sugar and taking medications as prescribed.
Goals	The intent is to provide culturally competent diabetes education classes for undocumented Latino immigrants in Placer County, as well as get the undocumented Latinos registered for appropriate benefits such as Medi-Cal and MediCare.
Anticipated Outcomes	Patients will have a better understanding of how to manage their diabetes, resulting in healthier choices and decreased visits to the hospital.
Metrics Used to Evaluate the program/activity/initiative	Number of patients served, resource referrals, services provided, and anecdotal stories.

Access and Functional Needs

Name of program/activity/initiative	Transportation Program for Seniors
Description	This investment will provide non-emergency medical transportation on an advance reservation, shared-ride basis for eligible residents of Placer County. Because we know scheduling and keeping non-emergency medical appointments is essential to preventative health this program will provide transportation to and from medical appointments for Placer County's underserved, vulnerable and elderly population, who are unable to access necessary medical care, due to transportation constraints.
Goals	Our goal is to provide transportation assistance for seniors and disabled individuals to consistently attend their medical appointments.
Anticipated Outcomes	This program will result in thousands of rides to and from medical appointments each year, for people who might not otherwise have the resources to travel to these important appointments.
Metrics Used to Evaluate the program/activity/initiative	Number of people served and number of rides provided.

Active Living and Healthy Eating

Name of program/activity/initiative	Senior Recreation Program
Description	This program is designed to offer a change of pace and sense of independence to seniors with physical or memory impairments, as well as support for their caregivers. This includes planned program of activities designed to promote well-being through social and health related services. Participants take part in physical activities, mentally stimulating activities (arts and crafts), and social interaction and are fed nutritious meals.
Goals	The goal is to provide a social, physical and mentally stimulated environment for seniors with physical or memory impairments.
Anticipated Outcomes	The outcome of this successful program is hundreds of seniors and their caregivers participating in the Recreation and Respite program every year, which improves their quality of life.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, anecdotal stories and other successful program impacts.

Name of program/activity/initiative	Health Education and Physical Fitness Program for Youth
Description	We will invest in a comprehensive children's wellness program focusing on nutrition, fitness, and mental wellness. The on-site school program, geared toward 5th and 6th grade students, will teach 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.
Anticipated Outcomes	The anticipated outcome of this program is teaching children and their families how to live a healthier and more active lifestyle, creating lifelong habits.
Metrics Used to Evaluate the program/activity/initiative	Number of children/families served, active schools, anecdotal stories and other successful program impacts.

Needs Sutter Auburn Faith Hospital Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Auburn Faith 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 plan does not include specific plans to address the following significant health needs that were identified in the 2019 Community Health Needs Assessment for the following reasons:

1. **Access to Specialty and Extended Care** – Our strategy does not directly focus on increasing access to specialty and extended care, because we feel there is a greater need for increased primary care services in this community. We are bolstering our efforts to increase access to primary care, which will in turn lead to healthier outcomes and decreased health risks for the community.

Approval by Governing Board

The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Health Valley Hospitals Board on November 21, 2019.