

Sutter Health

Sutter Amador Hospital

2019 – 2021 Community Benefit Plan

Responding to the 2019 Community Health Needs Assessment

Submitted to the Office of Statewide Health Planning and Development May 2020

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Note: This community benefit plan is based on the hospital's implementation strategy, which is written in accordance with Internal Revenue Service regulations pursuant to the Patient Protection and Affordable Care Act of 2010. This document format has been approved by OSHPD to satisfy the community benefit plan requirements for not-for-profit hospitals under California SB 697.

Introduction

The Implementation Strategy Plan describes how Sutter Amador 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 Amador 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 2700 Gateway Oaks Drive, Suite 2200, Sacramento, CA 95833, Attn: Community Benefit and
- In-person at the hospital's Information Desk.

About Sutter Health

Sutter Health is nearly 60,000 people strong thanks to its integrated network of clinicians, employees and volunteers. Headquartered in Sacramento, California, Sutter Health provides access to high quality, affordable care for more than 3 million Northern Californians through its network of hospitals, medical foundations, urgent and walk-in care centers, home health and hospice services. Nearly 14,000 doctors and advanced practice clinicians care for Sutter patients.

Recognized as a national leader in quality and access, Sutter's integrated healthcare system provides access to some of the best medical care in the country that outperforms state and national averages in nearly every quality measure. Through integration, Sutter Health fosters medical innovation and enables care teams to share best practices across the system. This gives patients access to a full range of treatments and services—helping lead to healthier outcomes.

Grounded in its not-for-profit mission, Sutter Health heavily reinvests in its communities, committing hundreds of millions of dollars annually to support programs and organizations that provide healthcare access and services for those in need. From deploying technology that improves the patient experience to supporting strong community partnerships, the strength of Sutter's integrated system provides a model that can shape the future of healthcare.

Sutter Health's total investment in community benefit in 2019 was \$830 million. This amount includes traditional charity care and unreimbursed costs of providing care to Medi-Cal patients, as well as investments in community health programs to address prioritized health needs as identified by regional community health needs assessments.

- As part of Sutter Health’s commitment to fulfill its not-for-profit status and serve the most vulnerable in its communities, Sutter hospitals, affiliated medical foundations and other healthcare providers offer charity care policies to ensure that patients can access needed medical care regardless of their ability to pay. Sutter’s charity care policies, which have been in place for many years, offer financial assistance to uninsured and underinsured patients earning less than 400 percent of the annually adjusted Federal Poverty Level. In 2019, Sutter Health invested \$125 million in charity care, compared to \$89 million in 2018.
- Overall, since the implementation of the Affordable Care Act, greater numbers of previously uninsured people now have more access to healthcare coverage through the Medi-Cal and Medicare programs. The payments for patients who are covered by Medi-Cal and Medicare do not cover the full costs of providing care. In 2019, Sutter Health invested \$499 million more than the state paid to care for Medi-Cal patients.
- Examples of regional prioritized health needs include access to mental health and addiction care, disease prevention and management, access to basic needs such as housing, jobs and food, as well as increased access to primary care services.

See more about how Sutter Health reinvests into the community by visiting sutterpartners.org.

In addition, 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 visit www.sutterhealth.org.

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

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

The 2019 Community Healthy Needs Assessment conducted by Sutter Amador Hospital is publicly available at www.sutterhealth.org.

2019 Community Health Needs Assessment Summary

The purpose of this community health needs assessment (CHNA) was to identify and prioritize significant health needs of the Sutter Amador Hospital (SAH) service area. The priorities identified in this report help to guide nonprofit hospitals’ community health improvement programs and community benefit activities as well as their collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets the requirements of the Patient Protection and Affordable Care Act (and in California, Senate Bill 697) that nonprofit hospitals conduct a community health needs assessment at least once every three years. The CHNA was conducted by Community Health Insights (www.communityhealthinsights.com).

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 11 one-on-one and group interviews with 52 community health experts, social-service providers, and medical personnel. Further, 25 community residents participated in three 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.

The full 2019 Community Health Needs Assessment conducted by Sutter Amador 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 which included 20 ZIP Codes—95225, 95226, 95232, 95245, 95248, 95252, 95254, 95255, 95257, 95601, 95629, 95640, 95642, 95665, 95666, 95669, 95675, 95685, 95689, and 95699. Though the service area includes both Amador and Calaveras Counties, geographically the majority of the SAH service area resides in Amador County, CA. SAH is in the city of Jackson, which is also the Amador County seat and home to approximately 4,500 area residents. The total population of the service area is 57,993.

Significant Health Needs Identified in the 2019 CHNA

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

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

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.

2019 – 2021 Implementation Strategy Plan

The implementation strategy plan describes how Sutter Amador 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 Amador 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 Mental/Behavioral/Substance Abuse Services
2. Access to Quality Primary Care Health Services
3. Access to Basic Needs Such as Housing, Jobs, and Food
4. Injury and Disease Prevention Management
5. Access and Functional Needs
6. Access to Dental Care and Preventive Services
7. Access to Specialty and Extended Care

Access to Mental/Behavioral/Substance Abuse Services

Name of program/activity/initiative	Suicide Prevention Follow-up Program
Description	The Suicide Prevention Follow-up Program was designed to help take the important first steps toward recovery after a suicidal crisis. Participation can help keep patients safe from suicide post-discharge. Support from the program provides hope and a safe, confidential space to talk about what patients have been experiencing, cope with the challenges and feelings that may arise after visiting the Emergency Department (ED). In addition, continuity in care is provided through emotional support, treatment referrals, coping skills, an action plan for times of crisis, and materials for suicide attempt survivors and those who have felt suicidal.
Goals	By linking patients who have attempted suicide or presented with suicidal ideations in our ED, we have the ability to provide patients with the support and additional resources needed for suicide attempt survivors and those who have felt suicidal.
Anticipated Outcomes	The anticipated outcome is to reduce suicide attempts and thoughts in patients participating through the program.
Metrics Used to Evaluate the program/activity/initiative	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 programs with bi-annual reporting and partner meetings to discuss/track effectiveness of each program within this strategy.

Access to Quality Primary Care Health Services

Name of program/activity/initiative	Primary Care Program – HPV Vaccinations
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Description	The Primary Care program provides services and education of HPV vaccinations to prevent cervical cancer. Patients will be connected to discuss findings and receive follow up care. This program addresses multiple prioritized significant health needs, such as access to quality primary care health services; and injury and disease prevention management.
Goals	Funding will allow for the implementation of 5 HPV vaccination strategies. HPV vaccinations will target 11-12-year-old boys and girls, the American Cancer Society and CDC recommended age.
Anticipated Outcomes	The anticipated results are the implementation of multiple evidence-based interventions to improve HPV vaccination rates while creating sustainability with workflows, policies, and reporting beyond project period.
Metrics Used to Evaluate the program/activity/initiative	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 programs with bi-annual reporting and partner meetings to discuss/track effectiveness of each program within this strategy.

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

Name of program/activity/initiative	TBD
Description	Sutter Amador Hospital plans to identify partnerships and strengthen relationships with organizations in the near future to collaborate on initiatives to address food insecurity in Amador County.
Goals	TBD
Anticipated Outcomes	TBD
Metrics Used to Evaluate the program/activity/initiative	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 programs with bi-annual reporting and partner meetings to discuss/track effectiveness of each program within this strategy.

Injury and Disease Prevention Management

Name of program/activity/initiative	Primary Care Program – HPV Vaccinations
Description	The Primary Care program provides services and education of HPV vaccinations to prevent cervical cancer. Patients will be connected to discuss findings and receive follow up care. This program addresses multiple prioritized significant health needs, such as access to quality primary care health services; and injury and disease prevention management.
Goals	Funding will allow for the implementation of 5 HPV vaccination strategies. HPV vaccinations will target 11-12-year-old boys and girls, the American Cancer Society and CDC recommended age.
Anticipated Outcomes	The anticipated results are the implementation of multiple evidence-based interventions to improve HPV vaccination rates while creating sustainability with workflows, policies, and reporting beyond project period.
Metrics Used to Evaluate the program/activity/initiative	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 programs with bi-annual

reporting and partner meetings to discuss/track effectiveness of each program within this strategy.

Name of program/activity/initiative	Primary Care Program – Colorectal Screenings
Description	The Primary Care Program will provide services and education of colorectal screenings. Patients will be connected to discuss findings and receive follow up care. This program addresses multiple prioritized significant health needs, such as injury and disease prevention management; and access to specialty and extended care.
Goals	Funding will allow for the engagement in colorectal cancer prevention strategies on 10 evidence-based interventions for colorectal cancer screenings. In addition, the program will host a colorectal cancer learning collaborative to share best practices and evidence-based interventions with health centers and stakeholders.
Anticipated Outcomes	The anticipated results are the implementation of multiple evidence-based interventions to improve colorectal screening rates while creating sustainability with workflows, policies, and reporting beyond project period.
Metrics Used to Evaluate the program/activity/initiative	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 programs with bi-annual reporting and partner meetings to discuss/track effectiveness of each program within this strategy.

Name of program/activity/initiative	Amador Lifeline
Description	Amador Lifeline is a paid subscription program that allows for seniors and individuals with disabilities, chronic illnesses and those in rehabilitative care in Amador County to remain living independently in their own homes with some sense of security and peace of mind. We are helping to supplement funding, which ensures that low-income Amador County residents can afford the paid subscription program by utilizing a sliding scale schedule.
Goals	The goal of this program is to link isolated, disabled and/or senior residents of Amador County with assistance and resources with the simple touch of a button. Given Amador’s rural environment, this program is incredibly important to seniors.
Anticipated Outcomes	The anticipated outcomes are for clients to maintain their self- respect, confidence, dignity and independence by continuing to live in their own residences with the safety and security with the help of the program’s emergency response service.
Metrics Used to Evaluate the program/activity/initiative	We will track and report the number of individuals served by the Lifeline program each year, as well as success stories and other programmatic outcomes. We will look at metrics including (but not limited to) number of people served, number/type of resources provided, anecdotal stories and other successful linkages.

Access and Functional Needs

Name of program/activity/initiative	Amador Rides
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Description	Amador Rides utilizes volunteer drives to provide transportation to and from medical appointments for Amador County's underserved who are unable to access necessary medical care, due to transportation constraints, especially in the rural areas of Amador County. Scheduling and keeping non-emergency medical appointments is essential to maintaining quality of life, preventing injury, and treating illness.
Goals	The goal of Amador Rides is to provide rides to and from medical appointments for seniors and disabled residents of Amador County.
Anticipated Outcomes	The anticipated outcome of the Amador Rides 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.
Metrics Used to Evaluate the program/activity/initiative	SAH will continue to evaluate the impact of Amador Rides on a biannual basis, by tracking the number of people served and number of rides provided. We will look at metrics including (but not limited to) number of people served and number of rides provided.

Access to Dental Care and Preventative Services

Name of program/activity/initiative	Expansion of Pediatric Dental Program
Description	The expansion of the Pediatric Dental Program provided to children and adolescents will allow for the best possible opportunity for good oral health that will last a lifetime. Untreated tooth decay can cause pain and infection that can lead to problems with eating, speaking and overall health. Through this program, patients are referred to specialists as needed. Dental services, include: comprehensive examinations, recall examinations, emergency visits/examinations and diagnosis, regular and deep cleanings, full-mouth & individual x-rays, fluoride treatments, dental sealants, oral hygiene instruction, temporary fillings, dental fillings and restorations, crowns for primary and permanent teeth, space maintainers, and routine extractions.
Goals	The goals of the program are to increase access to pediatric dental services.
Anticipated Outcomes	The anticipated outcomes are for more adolescents and children to have improved oral health.
Metrics Used to Evaluate the program/activity/initiative	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 programs with bi-annual reporting and partner meetings to discuss/track effectiveness of each program within this strategy.

Access to Specialty and Extended Care

Name of program/activity/initiative	Primary Care Program – Colorectal Screenings
Description	The Primary Care Program will provide services and education of colorectal screenings. Patients will be connected to discuss findings and receive follow up care. This program addresses multiple prioritized significant health needs, such as injury and disease prevention management; and access to specialty and extended care.
Goals	Funding will allow for the engagement in colorectal cancer prevention strategies on 10 evidence-based interventions for colorectal cancer screenings. In addition, the program will host a colorectal cancer learning

	collaborative to share best practices and evidence-based interventions with health centers and stakeholders.
Anticipated Outcomes	The anticipated results are the implementation of multiple evidence-based interventions to improve colorectal screening rates while creating sustainability with workflows, policies, and reporting beyond project period.
Metrics Used to Evaluate the program/activity/initiative	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 programs with bi-annual reporting and partner meetings to discuss/track effectiveness of each program within this strategy.

Needs Sutter Amador Hospital Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Amador 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:

N/A

Approval by Governing Board

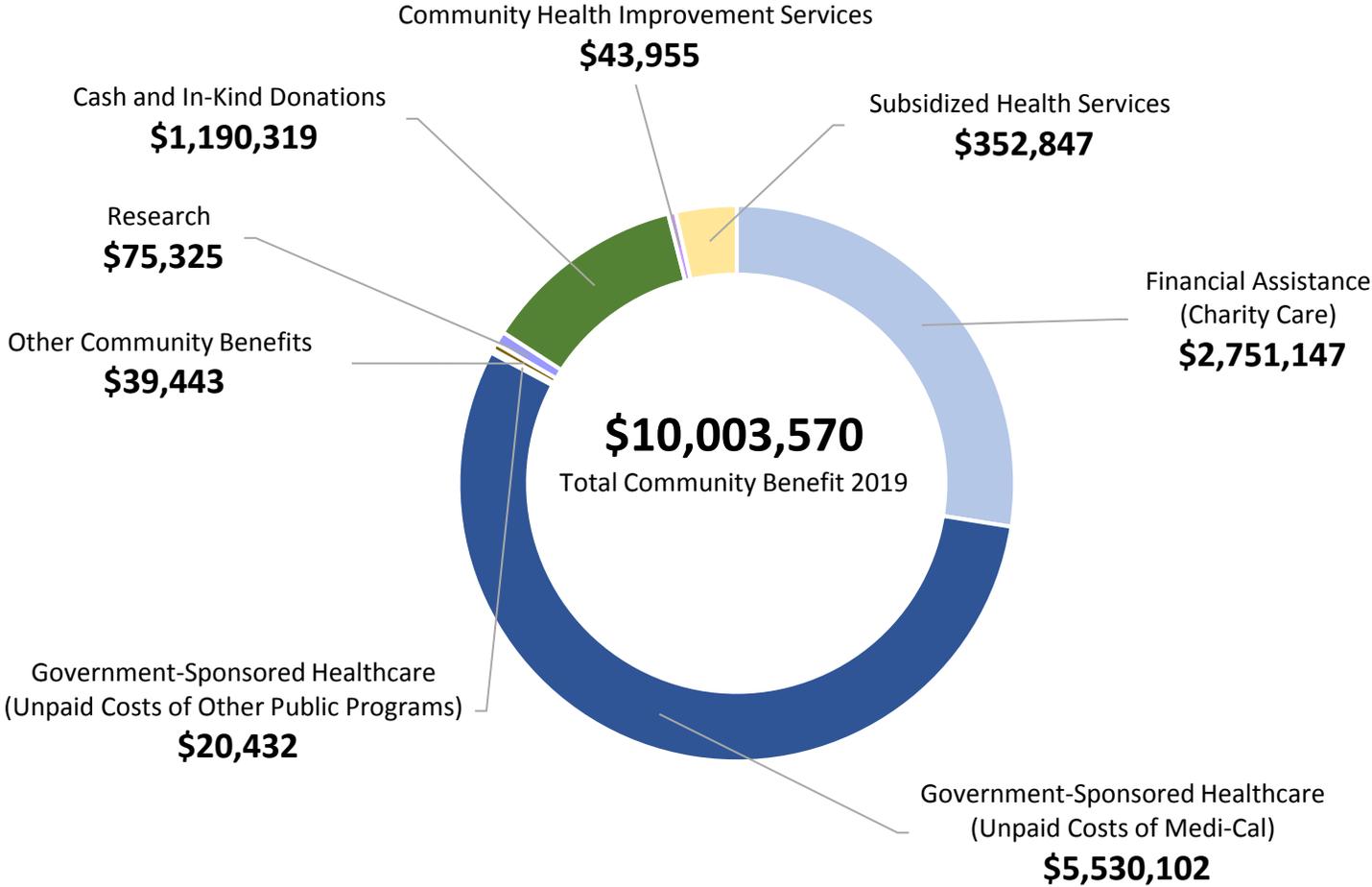
The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Health Valley Hospitals Board on November 21, 2019.

Appendix: 2019 Community Benefit Financials

Sutter Health hospitals and many other healthcare systems around the country voluntarily subscribe to a common definition of community benefit developed by the Catholic Health Association. Community benefits are programs or activities that provide treatment and/or promote health and healing as a response to community needs.

Community benefit programs include traditional charity care which covers healthcare services provided to persons who meet certain criteria and cannot afford to pay, as well as the unpaid costs of public programs treating Medi-Cal and indigent beneficiaries. Costs are computed based on a relationship of costs to charges. Additional community benefit programs include the cost of other services provided to persons who cannot afford healthcare because of inadequate resources and are uninsured or underinsured, cash donations on behalf of the poor and needy as well as contributions made to community agencies to fund charitable activities, training health professionals, the cost of performing medical research, and other services including health screenings and educating the community with various seminars and classes, and the costs associated with providing free clinics and community services. Sutter Health affiliates provide some or all of these community benefit activities.

Sutter Auburn Faith Hospital 2019 Total Community Benefit & Unpaid Costs of Medicare



2019 unpaid costs of Medicare were \$16,741,971