Sutter Health
Sutter Coast Hospital

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

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Crescent City, CA. 95531
State of California Department of Health Facility License Number: 110000067
www.sutterhealth.org

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Introduction

The implementation strategy describes how Sutter Coast Hospital, 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 Coast Hospital 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 800 East Washington Blvd., Crescent City, CA. 95531 Attention: Hospital Administrator; and
- In-person at the hospital's Information Desk.

About Sutter Health

Sutter Coast Hospital 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 "We enhance the well-being of the 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 Coast Hospital, visit www.sutterhealth.org.

2016 Community Health Needs Assessment Summary

This report documents the processes, methods, and findings of a CHNA conducted on behalf of Sutter Coast Hospital (SCH), a Sutter Health affiliate hospital located in Crescent City, California. SCH contracted with an independent consulting firm which specializes in preparing CHNA. This report was prepared by the consulting firm, Community Health Insights, with the specific authors being Heather Diaz, DrPH, MPH; Dale Ainsworth, PhD, and Matt Schmidtlein, PhD. The CHNA was conducted over a period of five months, beginning in March 2016, and concluding in July 2016. Specifically, the objective of the 2016 CHNA was:

> *Building on the 2013 CHNA, identify and prioritize the requisites (or basic provisions and conditions needed) for the improvement and/or maintenance of health status within a defined hospital service area (HSA), and in particular within neighborhoods and/or populations in the service area experiencing health disparities.*

The data used to conduct the CHNA were both identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model (for a detailed data dictionary see Appendix A of the full report). This model of population health includes the many factors that impact and account for individual health and wellbeing. Further, to guide the overall process of conducting the assessment, a defined set of data collection and analytic stages were developed. These served as the roadmap for the research team as they went about the work of the CHNA (for a detailed description of the processes followed in conducting the CHNA see Appendix B of the full report).

Data collected and analyzed included both primary or qualitative data, and secondary or quantitative data. Primary data included 15 interviews with 22 community health experts as well as eight focus groups conducted with 99 community residents (see Appendices F and G of the full report). Secondary data included health outcome and health factor indicators. Health outcome indicators included a variety of measures of both mortality and morbidity. Health factor indicators included measures of 1) health behaviors such as diet and exercise, tobacco, alcohol, and drug use; 2) clinical care including measures of access to and quality of care; 3) social and economic factors such as race/ethnicity, income, educational attainment, employment, and similar; and 4) the physical environment measures such as air and water quality, housing characteristics and more. Following federal requirements, primary and secondary data were analyzed to identify locations and populations within the HSA that experience a greater burden of poor health outcomes, as well as to identify and prioritize the significant health needs within the HSA as a whole.

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

Definition of the Community Served by the Hospital

SCH is located in Crescent City, California, a coastal community located in Del Norte County, which sits on the northwest California/Oregon border. The community served by SCH, or the hospital service area (HSA), was defined by five ZIP codes 95531, 95543, 95548, 95567, and 97415. This area was identified as the HSA because most of SCH's patients resided in these ZIP codes. All ZIP codes are located in California (Del Norte County) except 97415, which covers the communities of Brookings and Harbor, located in southern Curry County, OR (Curry County). The SCH HSA was home to 42,503 community residents in 2013.

ZIP Code	Community Area	Population	Median Age	Median Income ($)	Percent Minority	Percent Native American (Alone or in Combination with Some Other Race)
95531	Crescent City	24,687	37.9	$39,486	34.4	9.3
95543	Gasquet	549	54.5	$29,038	27.3	4.6
95548	Klamath	1,398	40.9	$27,243	61.4	35.8
95567	Smith River	1,723	47.1	$43,125	37.7	12.7
97415	Brookings, OR	14,146	53.6	$42,045	12.7	5.2
Del Norte County	*County*	*28,357*	*39.1*	*$37,909*	*35.8*	*10.7*
Curry County	*County*	*22,361*	*53.8*	*$39,516*	*11.9*	*4.2*
CA State	*State*	*37,659,181*	*35.4*	*$61,094*	*60.3*	*1.8*
OR State	*State*	*3,868,721*	*38.7*	*$50,229*	*22.0*	*2.9*

Within the SCH service area, there are communities who are very vulnerable and hence prone to experiencing health disparities. Venerable populations are closely tied to social economic indicators.

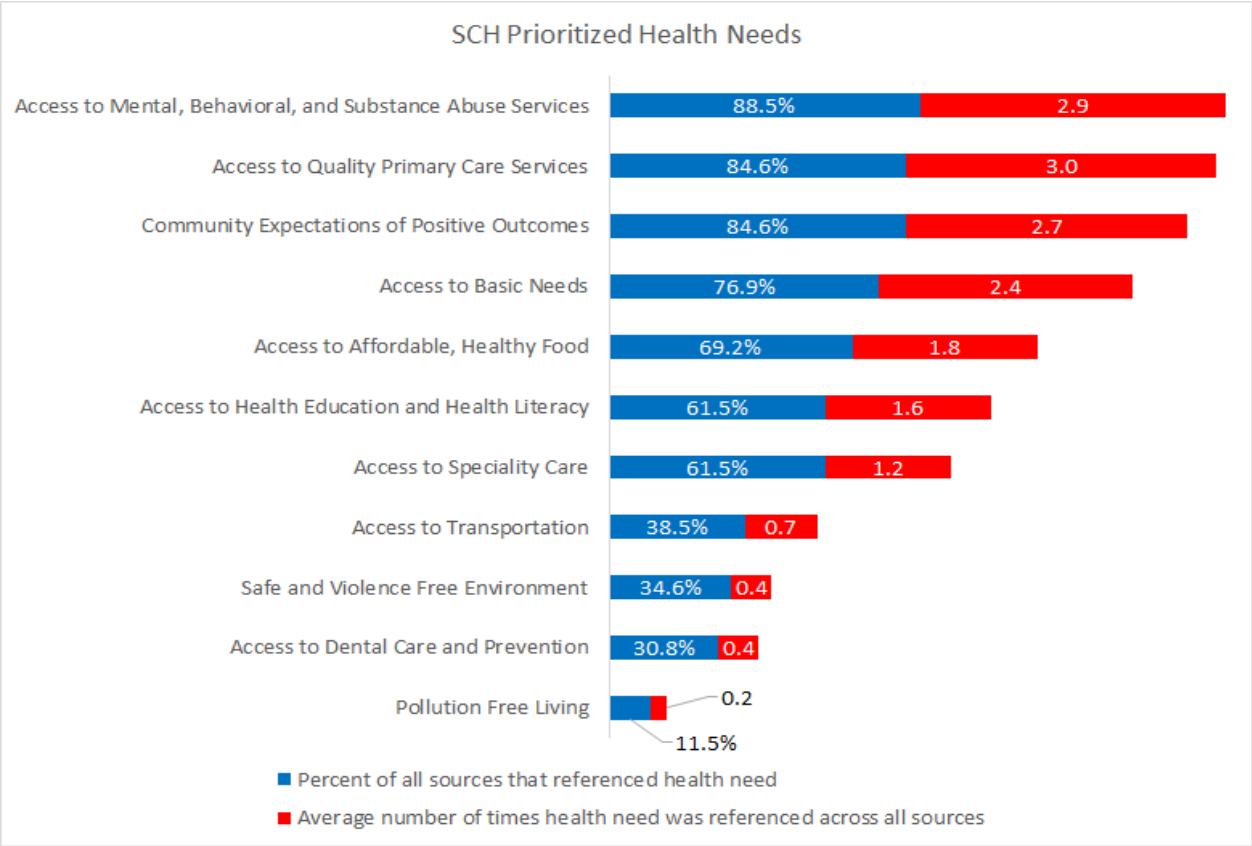
Geographic Area	Percent Adults with No High School Diploma	Percent Living in Poverty (Below 100%FPL)	Median Income	Percent Receiving Public Assistance	Percent Unemployed
95531	21.0	21.1	$39,486	23.2	12.2
95543	0.5	38.6	$29,038	20.1	8.9
95548	25.3	34.6	$27,243	25.8	23.7
95567	22.6	17.8	$43,125	8.5	7.2
97415	7.6	11.4	$42,045	16.8	17.3
Del Norte County	*20.9*	*21.8*	*$37,909*	*22.1*	*12.3*
Curry County	*8.7*	*15.0*	*$39,516*	*22.3*	*15.1*
CA State	*18.8*	*15.9*	*$61,094*	*12.1*	*11.5*
OR State	*10.6*	*16.2*	*$50,229*	*22.0*	*11.3*

Significant Health Needs Identified in the 2016 CHNA

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

1. Access to Mental, Behavioral, and Substance Abuse Services
2. Access to Quality Primary Care Health Services
3. Community Expectations of Positive Outcomes
4. Access to Basic Needs, such as Housing and Employment
5. Access to Affordable, Healthy Food
6. Access to Health Education and Health Literacy
7. Access to Specialty Care
8. Access to Transportation
9. Safe and Violence Free Environment
10. Access to Dental Care and Prevention
11. Pollution Free Living

Primary and secondary data were analyzed to identify and prioritize the significant health needs for the SCH HSA. This analysis began by identifying 10 potential health needs (PHNs) common across many previously conducted CHNAs that could be identified in these communities. Data were analyzed to discover which, if any, of these PHNs were present in the SCH HSA. All of the 10 PHNs were identified as significant health needs with one additional health need added as a result of qualitative data findings. This resulted in a total of 11 significant health needs. These 11 needs were prioritized based on an analysis of primary data sources. The results of this prioritization are shown in the figure below. The length of the bar denotes prioritization, with longer lengths corresponding to higher priorities. In the figure, the blue portion of the bar notes the percent of all primary data sources that referenced the PHN as a current, significant health need. This was combined with the average number of times that each potential health need was referenced among all primary sources and is displayed in the red portion of the bar.



2016 – 2018 Implementation Strategy

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

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

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

1. Access to Mental, Behavioral, and Substance Abuse Services
2. Access to Quality Primary Care Health Services
3. Access to Specialty Care
4. Access to Transportation

Access to Mental, Behavioral, and Substance Abuse Services

Name of program/activity/initiative	Access to Psychiatric Services
Description	In collaboration with other community agencies, revitalize the effort to recruit a psychiatrist to the SCH Service Area.
Goals	For the measurement period, actual performance will be better than the baseline data. Data being the population per mental health provider for Del Norte County. Baseline is 1101 Del Norte residents per 1 mental health worker.
Anticipated Outcomes	A collaborative effort among community leaders to successfully recruit a full time psychiatrist to the SCH Service area. With success, some patients will experience local access to psychiatric services resulting in improved mental health outcomes. For physicians and mid-level providers to have a local resource to refer patients to and to have local access to physician colleague to coordinate patient mental health needs. For the community, to have an additional mental health professional to collaborate with relative to the local mental health delivery system (operations & design).
Plan to Evaluate	Evaluation will occur within two months of public release of population per mental health provider data.
Metrics Used to Evaluate the program/activity/initiative	Ratio of population to 1 mental health worker. Del Norte baseline is 1101 Del Norte residents per 1 mental health worker.

Name of program/activity/initiative	Crisis Stabilization
Description	In the SCH service delivery area, there is a void in the mental health delivery system - absence of a local crisis stabilization facility and service.
Goals	If a crisis stabilization unit is established, ED visits due to mental health issues should be less than baseline at 18 months post opening of a crisis stabilization unit for zip code 95531 (Crescent City). And/or hospitalizations due to mental health issues will be less than baseline at 18 months post opening of a crisis stabilization unit for zip code 95531 (Crescent City).
Anticipated Outcomes	Patients in an acute mental health crisis, will receive appropriate, timely, and coordinated medical care and mental health care – better than the current circumstance.
Plan to Evaluate	If implemented, the evaluative period and process will occur at the 18th month or as soon as the annual data is available.
Metrics Used to Evaluate the program/activity/initiative	Decline in ED visits due to mental illness for zip code 95531 (Crescent City) with the baseline being 366.9 visits per 10,000 population. And/or a decline in Hospitalizations due to mental illness for zip code 95531 (Crescent City) with the baseline being 147.9 hospitalizations per 10,000.

Access to Quality Primary Care Health Services

Name of program/activity/initiative	Retention.
Description	Access to primary care services is directly tied to retention and recruitment. Frequently, the importance of retention is overlooked. Will utilize various data sources to discern and identify tactics which increase the likelihood of retaining primary care providers; e.g., increasing connection of the school district for providers with children; connecting new providers (and current) with the Chamber/Visitors Bureau to get more ingrained into the community; looking at social capital and the opportunities for spouses of providers to have enhanced opportunities in the local job market. Plan to review exit surveys of providers leaving the community to develop an appropriate retention plan.
Goals	For 2017 and 2018, the ratio of total population to I primary care provider will be equal to the baseline.
Anticipated Outcomes	Retaining community providers will improve access to Primary Care Services. When a provider departs, there is a gap in coverage until the person is replaced. If turnover can be avoided, then the gab in coverage will be avoided and thereby, there will be greater access to primary care services.
Plan to Evaluate	The Hospital will evaluate success by tracking the ratio of Total Population to 1 Primary Care Provider.
Metrics Used to Evaluate the program/activity/initiative	Population per Primary Care Provider: Ratio of Total Population to 1 Primary Care Provider. Baseline is Del Norte County 1364. Curry County 1596.

Name of program/activity/initiative	Recruitment
Description	Sutter Coast Hospital (SCH), United Health Indian Services, and Open Door Community Health Center are the three main constituents who recruit new providers into the SCH service area. In 2014, there was a collaborative effort across the respective organizations to increase the number of primary care providers. Will attempt to resurrect the collaborative effort.
Goals	For 2017 the ratio of total population to I primary care provider will be equal to the baseline. For 2018, the ratio of total population to 1 primary care provider will be 3% better than baseline.
Anticipated Outcomes	The community will experience improved access to primary care services.
Plan to Evaluate	The Hospital will evaluate success by tracking the ratio of Total Population to 1 Primary Care Provider.
Metrics Used to Evaluate the program/activity/initiative	Population per Primary Care Provider: Ratio of Total Population to 1 Primary Care Provider. Del Norte County baseline is 1364. Curry County baseline is 1596.

Access to Specialty Care

Name of program/activity/initiative	Recruitment
Description	While retaining current physicians, continue to recruit into the following specialty disciplines: Obstetrics, Orthopedics, Pulmonology, G.I., and ENT.
Goals	For 2017 and 2018, the rate of preventable hospital stays per 1,000 Medicare enrollees will be less than the baseline of 51 stays per 1,000 Del Norte County Medicare enrollees.
Anticipated Outcomes	With increased access to Specialty Care, the number of preventable hospital stays should decline – with the assistance of specialist, patients are avoiding medical crisis which result in hospitalizations.
Plan to Evaluate	Within two months of the data being publically released, the evaluation will occur.
Metrics Used to Evaluate the program/activity/initiative	Preventable Hospitalizations per 1,000 Medicare Enrollees.

Access to Transportation

Name of program/activity/initiative	Transportation Assistance Program
Description	Provide funds to off-set the transportation expense when a specific set of circumstances exits. The circumstances being the post-discharge transportation of patients back to residence in SCH's service area when such patients are transferred out of the area for specialty care or emergency services not available at SCH. The purpose of the Transportation Assistance Program is to assist eligible patients in returning to the area after being discharged from the receiving facility/hospital and not for transporting patients back to SCH. Patients eligible for the program must meet the circumstances described plus meet income eligibility requirements. This initiative is collaborative effort among several community agencies. The program will be administered by SCH. The following table identifies the cash contributions from the various involved agencies:

Sutter Coast Hospital	$27,000
Del Norte Local Transportation Commission	Up to $27,000 (Per CA statute, based on 5% of the State TDA fund estimate)
Del Norte Healthcare District	$13,500
Open Door Community Health Centers	Services
Del Norte County Department of Health & Human Services	Services up to $5,000

Goals	For eligible patients, to expend roughly $70,000 starting 12/01/2016 through 12/31/18 on transporting and returning patients to the SCH service area.
Anticipated Outcomes	For eligible patients, to lessen the financial burden associated with returning to their homes.
Plan to Evaluate	Since SCH will administer the program, SCH will track the project utilization and expense data. Project data will include pertinent patient demographic information, transportation from location, transportation to location, name of transport provider, and fee paid to the transporting service provider. This information will be compiled and reviewed quarterly. The data will be shared with the respective funding agencies. An annual report will be compiled and at a minimum, be shared with the project funding agencies.
Metrics Used to Evaluate the program/activity/initiative	For eligible patients, to expend roughly $70,000 starting 12/01/2016 through 12/31/18 on transporting and returning patients to the SCH service area.

Needs Sutter Coast Hospital Plans Not to Address

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

1. Community Expectations of Positive Outcomes
2. Access to Basic Needs, such as Housing and Employment
3. Access to Affordable, Health Food
4. Access to Health Education and Health Literacy
5. Safe and Violence Free Environment
6. Access to Dental Care and Prevention
7. Pollution Free Living

Approval by Governing Board The implementation strategy was approved by the Sutter Coast Hospital Board on the 8th. of December, 2016.