

Sutter Health

Sutter Coast 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 Coast 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 Coast 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 800 E Washington Blvd, Crescent City, CA 95531, 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 quality primary healthcare services
2. Access to mental/behavioral/substance abuse services
3. Access to basic needs such as housing, jobs, and food
4. Access to meeting functional needs (transportation and physical mobility)
5. Injury and disease prevention and management
6. Access to specialty and extended care
7. Access to active living and healthy eating
8. Safe and violence-free environment
9. Access to dental care and preventative services
10. Pollution-free living environment

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

2019 Community Health Needs Assessment Summary

Community Health Insights (www.communityhealthinsights.com) conducted the 2019 assessment on behalf of Sutter Coast 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 interviews with 19 community health experts, social-service providers, and medical personnel in one-on-one and group interviews, as well as four community member focus groups with 37 community residents in Del Norte and Curry Counties.

Using a social determinants focus to identify and organize secondary data, datasets included measures to described mortality and morbidity and social and economic factors such as income, educational attainment, and employment. Further, measures also included indicators to describe health behaviors, clinical care (both quality and access), and data to describe 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 area. After these were identified, PHNs were prioritized based on an analysis of primary data sources that described the PHN as a significant health need. 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 Coast Hospital is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

Sutter Coast Hospital’s hospital service area (HSA) includes Del Norte County, California, and the Brookings Harbor area of Curry County, Oregon, which are both coastal communities. The HSA was defined by five ZIP Codes, noted below:

ZIP Code	Total Population	% Minority	Median Age	Median Income	% Poverty	% Unemployed	% Uninsured	% No HS Graduation	% Living in High Housing Costs	% with Disability
95531	23,500	36.5	37.5	\$43,841	20.7	10.2	11.1	18.4	37.4	22.0
95543	792	23.0	50.7	\$32,500	24.6	0.0	1.4	8.3	39.6	25.0
95548	1,288	39.0	44.4	\$31,848	34.5	20.9	14.3	21.9	31.9	33.3
95567	2,048	45.6	38.7	\$44,572	23.7	10.3	9.5	12.0	24.9	20.1
<i>Del Norte County</i>	27,628	36.9	38.1	\$42,363	21.7	10.4	10.8	17.8	36.3	22.5
<i>California</i>	38,654,206	61.6	36.0	\$63,783	15.8	8.7	12.6	17.9	42.9	10.6
97415	13,816	15.1	55.1	\$37,672	14.1	11.1	9.8	10.6	41.1	25.3
<i>Curry County</i>	22,364	12.7	55.1	\$38,661	15.2	11.0	10.0	10.3	38.2	25.5
<i>Oregon</i>	3,982,267	23.0	39.1	\$53,270	15.7	8.1	10.4	10.0	36.1	14.7

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** – Two health needs tied as the highest-priority significant health needs for the SCH service area. The first was 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.
1. **Access to Mental/Behavioral/Substance Abuse Services** – Access to mental, behavioral, and substance abuse services was tied as the highest-priority significant health need for the SCH service area. 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 also occur. Adequate access to mental, behavioral, and substance abuse services helps community members obtain additional support when needed.
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 health maintenance are vital for survival. Maslow's Hierarchy of Needs says that only when members of a society have their basic physiological and safety needs met can they then become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health.
3. **Access and Functional Needs – Transportation and Disability That Prevents Access through Movement** – Having access to transportation services to support individual mobility is a necessity of daily life. Without transportation, individuals struggle to attain 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 assure that all community members have access to necessities for a high quality of life.
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, infectious disease control (e.g., STI prevention, influenza shots), and intensive strategies around the management of chronic diseases (e.g., diabetes, hypertension, obesity, and heart disease). These are important for community health improvement.
5. **Access to Specialty and Extended Care** – Specialty care services are those devoted to a particular branch of medicine and focusing on the treatment of a particular 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 such as diabetes and high blood pressure on their own. In addition to specialty care, extended care refers to care needed in the community that supports overall physical health and wellness and that extends beyond primary care services such as skilled nursing facilities and hospice and in-home care.
6. **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 often are overloaded with fast food and other establishments where unhealthy food is sold.

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 often are overloaded with fast food and other establishments where unhealthy food is sold.
8. **Access to Dental Care and Prevention** – Oral health is important for overall quality of life. When individuals have dental pain, it is difficult to eat, concentrate, and fully engage in life. Poor oral health impacts the health of the entire body, especially the heart, digestive, and endocrine systems.
9. **Pollution-Free Living Environment** – Living in a pollution-free environment is essential for health. Individual health is determined by a number of factors, and some models show that one’s living environment, including the physical (natural and manmade) and sociocultural environment, has more impact on individual health than one’s lifestyle, heredity, or access to medical services.

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 the 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.

Data collected and analyzed included both primary or qualitative data and secondary or quantitative data. Primary data included 11 interviews with 19 community health experts as well as 4 focus groups conducted with a total of 37 community residents.

Secondary data included four datasets selected for use in the various stages of the analysis. In all, 64 different health outcome and factor indicators were collected for the CHNA.

Primary and secondary data were analyzed to identify and prioritize the significant health needs within the SCH service area. This included identifying 10 potential health needs (PHN) in these communities. These potential health needs 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. After these were identified, health needs were prioritized based on an analysis of primary data sources that described the PHN as a significant health need.

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.

2019 – 2021 Implementation Strategy Plan

The implementation strategy plan describes how Sutter Coast 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 Coast 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 healthcare services
2. Access to mental/behavioral/substance abuse services
3. Access to basic needs such as housing, jobs, and food
4. Access to meeting functional needs (transportation and physical mobility)
5. Access to specialty and extended care

Access to quality primary healthcare services

Name of program/activity/initiative	Recruitment and Retention of Primary Care Providers
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 2020 and 2021, the ratio of total population to 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 gap in coverage will be avoided and thereby, there will be greater access to primary care services.
Metrics Used to Evaluate the program/activity/initiative	The Hospital will evaluate success by tracking the ratio of Total Population to 1 Primary Care Provider.

Access to mental/behavioral/substance abuse services

Name of program/activity/initiative	Suicide Risk Assessment
Description	Assessing patients that come to SCH to identify if they are actively at risk for suicide and connecting them to mental and behavioral health services.

Goals	To identify and connect those individuals experiencing suicidal ideations with services to assist them in staying safe.
Anticipated Outcomes	Early and ongoing assessments to identify if a patient is at high risk for suicide will help prevent suicide as well as identify patients who are in need of additional services that can then be provided.
Metrics Used to Evaluate the program/activity/initiative	The Hospital will evaluate success with A) the implementation of a Suicide Risk Assessment policy and B) # of patients identified as high risk.

Name of program/activity/initiative	Psychiatric Services
Description	In collaboration with other community agencies, revitalize the effort to recruit a psychiatrist to the SCH Service Area.
Goals	Improve access to psychiatric services locally by adding a full time equivalent psychiatric provider to the community.
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).
Metrics Used to Evaluate the program/activity/initiative	Increase access to psychiatric providers by 1 FTE to serve Del Norte County residents.

Access to basic needs such as housing, jobs, and food

Name of program/activity/initiative	Safe Patient Discharge Planning
Description	Improving discharge planning to ensure individuals experiencing homelessness connect with necessary resources and shelter post discharge.
Goals	To connect individuals experiencing homelessness with the continuum of care to improve health outcomes.
Anticipated Outcomes	Decreased utilization of emergency services by the homeless population; increased utilization of wraparound support services.
Metrics Used to Evaluate the program/activity/initiative	# of referrals to community resources; readmission rates for individuals experiencing homelessness.

Name of program/activity/initiative	Humboldt State
Description	RN to BSN bridge program in partnership with Humboldt State and University of the Redwoods.
Goals	Create greater opportunities for nurses to advance in their field and provide higher quality care.
Anticipated Outcomes	Increase the number of BSN nurses in the hospital service area.

Metrics Used to Evaluate the program/activity/initiative	# of participants in the program who obtain BSN.
Name of program/activity/initiative	No Place Like Home
Description	Partnering with local government and other non-profit agencies to identify ways to support and expand services to individuals experiencing homelessness.
Goals	Create expanded services for individuals experiencing homelessness and reduce the number of individuals experiencing homelessness in our community.
Anticipated Outcomes	Implementation of new and expanded services for community members who experience homelessness will provide expanded access to basic needs such as shelter, food, water, and hygiene options.
Metrics Used to Evaluate the program/activity/initiative	Identify and participate in the implementation of 1 new service provided in the community for individuals experiencing homelessness.

Name of program/activity/initiative	Food Banks
Description	Partner with local food banks to distribute healthy food options to low-income and underserved residents.
Goals	Our goal is to assist in providing food/meals to individuals in our community who do not have access to food.
Anticipated Outcomes	Provide access to basic needs such as food to underserved residents.
Metrics Used to Evaluate the program/activity/initiative	# of pounds of food donated as well as dollars contributed.

Access to meeting functional needs (transportation and physical mobility)

Name of program/activity/initiative	Taxi Vouchers for Low-Income Patients
Description	Provide taxi vouchers for low-income, often Medi-Cal patients who are discharged from the hospital and do not have means to obtain transportation home or to a shelter.
Goals	Our goal is to provide individuals with access to safe and reliable transportation from the hospital.
Anticipated Outcomes	We anticipate there will be a decrease in emergency department readmissions for individuals who are able to be transported to a safe location after their hospital stay.
Metrics Used to Evaluate the program/activity/initiative	Number of taxi vouchers provided.

Access to specialty and extended care

Name of program/activity/initiative	Recruitment for Specialty Providers
Description	While retaining current physicians, continue to recruit into the following specialty disciplines: Ear, Nose and Throat; Orthopedics; and, Urology.
Goals	Improve access to specialty services locally and reduce the number of patients having to obtain services outside of the community by adding a full time equivalent specialty provider to the community.
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.
Metrics Used to Evaluate the program/activity/initiative	Increase local specialty provider FTE by 1 FTE.

Name of program/activity/initiative	Oncology Patient Navigation Program
Description	Implement an oncology patient navigation program to help navigate individuals in our community who suffer from cancer through the various components of care needed.
Goals	Offer a nurse navigation program to our oncology patients.
Anticipated Outcomes	Improved outcomes and expedited care for individuals in our community suffering from cancer diagnosis.
Metrics Used to Evaluate the program/activity/initiative	Higher and implement a nurse navigator.

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 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. Injury and disease prevention and management – While SCH will not specifically address this area, we will improve access to primary and specialty care. This in turn will allow more patients to better prevent and manage their chronic conditions.
2. Access to active living and healthy eating – Due to limited capacity and resources we will not be focused on this area.
3. Safe and violence-free environment – Due to limited capacity and resources we will not be focused on this area.
4. Access to dental care and preventative services – Due to limited capacity and resources we will not be focused on this area.
5. Pollution-free living environment – Due to limited resources and ability to impact environmental policies, the hospital does not intend to directly address this health issue at this time.

Approval by Governing Board

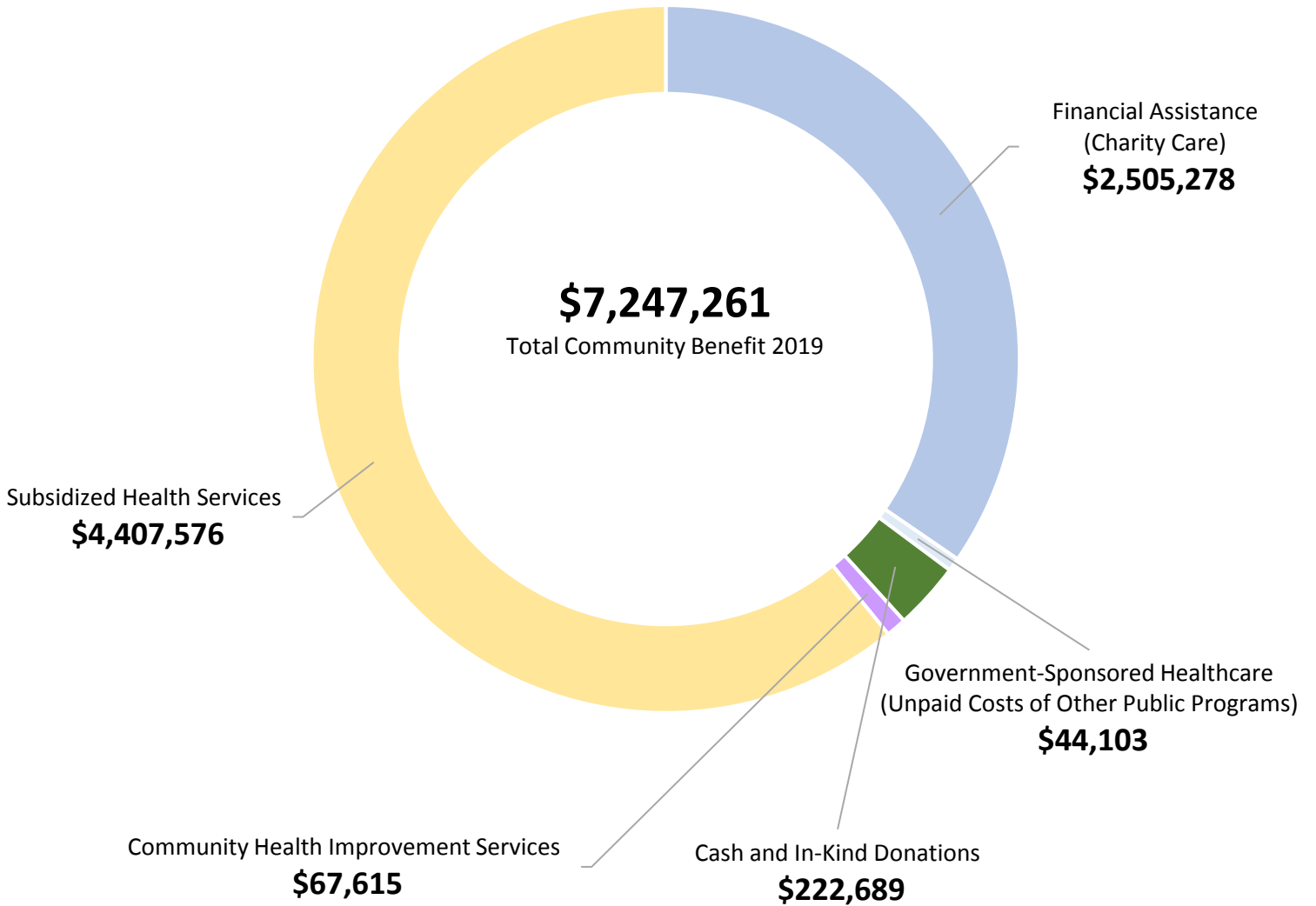
The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Health Coast Hospital Board on November 21, 2019.

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 Coast Hospital 2019 Total Community Benefit & Unpaid Costs of Medicare



2019 unpaid costs of Medicare were \$8,255,751