Sutter Health

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# Sutter Auburn Faith Hospital

2022 – 2024 Implementation Strategy Plan
Responding to the 2022 Community Health Needs Assessment

11815 Education Street, Auburn, CA 95602
FACILITY LICENSE #30000012
www.sutterhealth.org

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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 2022 Community Health Needs Assessment (CHNA). The document describes how the hospital plans to address identified needs in calendar (tax) years 2022 through 2024.

The 2022 CHNA and the 2022 - 2024 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 2022 Community Health Needs Assessment and 2022 - 2024 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 parent of not-for-profit and for-profit companies that together form an integrated healthcare system located in Northern California. The system is committed to health equity, community partnerships and innovative, high-quality patient care. Our over 65,000 employees and associated clinicians serve more than 3 million patients through our hospitals, clinics and home health services.

Learn more about how we're transforming healthcare at sutterhealth.org and vitals.sutterhealth.org

Sutter Health's total investment in community benefit in 2021 was $872 million. This amount includes traditional charity care and unreimbursed costs of providing care to Medi-Cal patients. This amount also includes 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 mission and help serve some of the most vulnerable in its communities, the Sutter Health network has implemented charity care policies to help provide access to medically necessary care for all patients, regardless of their ability to pay. In 2021, Sutter Health invested $91 million in charity care. Sutter's charity care policies for hospital services include, but are not limited to, the following:

1. Uninsured patients are eligible for full charity care for medically necessary hospital services if their family income is at or below 400% of the Federal Poverty Level ("FPL").
2. Insured patients are eligible for High Medical Cost Charity Care for medically necessary hospital services if their family income is at or below 400% of the FPL and they incurred or paid medical expenses amounting to more than 10% of their family income over the

last 12 months. (Sutter Health's Financial Assistance Policy determines the calculation of a patient's family income.)

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 2021, Sutter Health invested $557 million more than the state paid to care for Medi-Cal patients.

Through community benefit investments, Sutter helped local communities access primary, mental health and addiction care, and basic needs such as housing, jobs and food. See more about how Sutter Health reinvests into the community by visiting sutterpartners.org.

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 2022 Community Health Needs Assessment process for Sutter Auburn Faith Hospital, the following significant community health needs were identified:

1. Access to Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavioral Health and Substance Use Services
3. Access to Quality Primary Care Health Services
4. Active Living and Healthy Eating
5. Access to Specialty and Extended Care
6. Healthy Physical Environment
7. Safe and Violence-Free Environment

The 2022 Community Healthy Needs Assessment conducted by Sutter Auburn Faith Hospital is publicly available at www.sutterhealth.org.

### 2022 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. Furthermore, 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 17 community health experts, social service providers, and medical personnel. Furthermore, 20 community residents or community service provider organizations participated in 2 focus groups across the service area. Finally, 41 community service providers responded to a Community Service Provider (CSP) survey asking about health need identification and prioritization.

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. Furthermore, the measures also included indicators to describe health behaviors, clinical care (both quality and access), and the physical environment.

At the time that this CHNA was conducted, the COVID-19 pandemic was still impacting communities across the United States, including SAFH's service area. The process for conducting the CHNA remained fundamentally the same. However, there were some adjustments made during the qualitative data

collection to ensure the health and safety of those participating. Additionally, COVID-19 data were incorporated into the quantitative data analysis and COVID-19 impact was captured during qualitative data collection. These findings are reported throughout various sections of the report.

The full 2022 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 was the primary service area of SAFH. This area was 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 in northern Placer County (with ZIP Code 95949 extending into Nevada County) and includes the city of Auburn the seat of Placer County. Located at the base of the Sierra Nevada Mountains, this area provides countless recreational opportunities, as well as a relaxing natural environment and holds historical significance as an area of the Gold Rush. The total population of the service area was 98,646.

### Significant Health Needs Identified in the 2022 CHNA

Quantitative and qualitative data were analyzed to identify and prioritize significant health needs. This began by identifying 12 potential health needs (PHNs) based on a review of CHNAs previously conducted throughout Northern California.  The data associated with each PHN were then analyzed to discover which, if any, of them were significant health needs for the service area.

PHNs were selected as significant health needs if the percentage of associated quantitative indicators and qualitative themes exceeded selected thresholds. Data were also analyzed determine if there were any emerging significant health needs in the service area beyond the initial 12 PHNs.

All significant health needs were then prioritized based on 1) the percentage of key informant interviews and focus groups that indicated the health needs was present within the service area; 2) the percentage of times key informant interviews and focus groups identified the health needs as being a top priority; and, when available, 3) the percentage of service provider survey respondents who identified the health needs as being a top priority.

The following significant health needs were identified in the 2022 CHNA:

1. **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 suggests 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. Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, influence individual health as much as health behaviors and access to clinical care.

2. **Access to Mental/Behavior/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. Access to mental, behavioral, and substance use services is an essential ingredient for a healthy community where residents can obtain additional support when needed.

3. **Access to Quality Primary Healthcare Services** – Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and other similar resources. 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.

4. **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.

5. **Access to Specialty and Extended Care** – Extended care services, which include specialty care, are care provided in a particular branch of medicine and focused 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 the progression of 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.

6. **Healthy Physical 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 built) and sociocultural environment, has more impact on individual health than one's lifestyle, heredity, or access to medical services.

7. **Safe and Violence-Free Environment** – Feeling safe in one's home and community are fundamental to overall health. Next to having basic needs met (e.g., food, shelter, and clothing) is having physical safety. Feeling unsafe affects the way people act and react to everyday life occurrences. Further, research has demonstrated that individuals exposed to violence in their homes, the community, and schools are more likely to experience depression and anxiety and demonstrate more aggressive, violent behavior.

## 2022 – 2024 Implementation Strategy Plan

The implementation strategy plan describes how Sutter Auburn Faith Hospital plans to address significant health needs identified in the 2022 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 2022 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 Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavioral Health and Substance Use Services
3. Access to Quality Primary Care Health Services
4. Active Living and Healthy Eating
5. Access to Specialty and Extended Care

6. Healthy Physical Environment
7. Safe and Violence-Free Environment

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

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|---|---|
| **Name of program/activity/initiative** | Meals on Wheels |
| **Description** | Food distribution program to deliver meals to vulnerable homebound Placer County seniors (ages 60+). |
| **Goals** | Ensure low-income, Placer County seniors are food secure |
| **Anticipated Outcomes** | Provide meals to an estimated 445 homebound seniors annually. |
| **Metrics Used to Evaluate the program/activity/initiative** | Number of seniors served; number of meals delivered to homebound seniors (5 meals per week per senior) |

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| **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/Behavioral Health and Substance Use Services**

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| **Name of program/activity/initiative** | School Wellness Centers |
| **Description** | Wellness Centers are on-campus mental health resources and provider sites where students and families can access prevention, early intervention, intensive, and crisis mental health services and referrals. In addition, school staff can access the program for the purposes of training, consultation and increased mental health literacy. |
| **Goals** | Increase mental wellness in schools and connect students and families to the appropriate resources for support. |
| **Anticipated Outcomes** | Improved mental health outcomes at the individual level, school level and county level. |

| Metrics Used to Evaluate the program/activity/initiative | • Improved average daily attendance<br>• Increased academic performance<br>• Reduced suspensions and expulsions<br>• Improved student and family mental health<br>• Improved social emotional competence<br>• Reduced student psychiatric hospitalizations and crisis evaluations (5150s)<br>• Increased knowledge among county and community mental health providers of school-based supports<br>• Increased knowledge among school staff of county and community mental health services |
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**Access to Quality Primary Care Health Services**

| 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. |

| Name of program/activity/initiative | Community Care Navigator |
|---|---|
| Description | The Community Care Navigator acts as a liaison between patients, hospital care team and a local homeless shelter to establish care connections and transition plans for patients, including both in-patient and emergency department. The Community Care Navigator will facilitate warm hand-offs to shelter and respite care where client will receive case management services through those programs. In addition, the Community Care Navigator will provide unhoused clients with case management for a caseload of up to 15 clients at one time, and provide follow-up services for up to 6 months. Upon discharge, continued Case Management services and medical respite will extend support to help reduce unnecessary hospital readmission. |
| Goals | Provide stable recovery services for people experiencing homelessness, and/or those who frequent the hospital for complex medical and social needs. |

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| **Anticipated Outcomes** | Decreased hospitalization and improved care coordination to help medically complex patients who are experiencing homelessness receive the right care at the right time. |
| **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. |

**Active Living and Healthy Eating**

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| **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. |

**Safe and Violence Free Environment**

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| **Name of program/activity/initiative** | ACES Education, Prevention and Treatment Coalition |
| **Description** | The Sierra Community Medical Foundation (SCMF) will offer free education and prevention workshops, offer initial evaluations, assessments and referrals for treatment. Additionally, SCMF will offer medical education, behavioral health services, housing, basic life skills, referrals for housing, employment and training and educational aide. Mental health first aiders and navigators will be utilized to ensure coordination of screening, treatment, aftercare/follow up for additional necessities. Behavioral services will be used to include training to learn about (ACEs), toxic stress, increased confusion of life, divorce, hyperactivity, mental health screening, risk assessment, and evidence-based care to effectively intervene on toxic stress. |
| **Goals** | Develop a coalition for the community supported the education, training, business development and community agencies being better prepared to address ACE's. Secondly, ACE coalition supported agencies to utilize referral providers to assist in serving their clients with other service needs such as housing and job placement, physician encounters |
| **Anticipated Outcomes** | Improved collaboration so that hospitals, public, private and community agencies are all working together to increase education and awareness around ACEs as well as a more coordinated response. |
| **Metrics Used to Evaluate the program/activity/initiative** | Number of children/families served; number of individuals served; number and type of referrals made to medical and/or social supports. |

## 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 does not include specific plans to address the following significant health needs that were identified in the 2022 Community Health Needs Assessment:

1. **Access to Specialty and Extended Care** – Our immediate focus is on partnering to provide primary care however we will be monitoring for ways to include specialty care in our partnerships with FQHCs in Auburn.
1. **Healthy Physical Environment** – Given limited time and resources and our focus on other priority needs, we will not be addressing healthy physical environment during this implementation cycle.

## Approval by Governing Board

The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Health Valley Hospitals Board on July 21, 2022.