Sutter Health

Sutter Coast Hospital

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

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Introduction

The Implementation Strategy Plan describes how Sutter Coast 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 Coast 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 800 E. Washington Blvd. Crescent City, CA 95531; and
- In-person at the hospital's Information Desk.

Executive Summary

Sutter Coast 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 Coast Hospital, the following significant community health needs were identified:

1. Access to Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavior/Substance-Abuse Services
3. Access to Specialty and Extended Care
4. Access to Quality Primary Healthcare Services
5. Active Living and Healthy Eating
6. Access and Functional Needs
7. Injury and Disease Prevention and Management
8. Safe and Violence Free Environment
9. Increased Community Connections
10. Access to Dental Care and Preventative Services

The 2022 Community Healthy Needs Assessment conducted by Sutter Coast 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 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 one-on-one and group interviews with 14 community health

experts, social-service providers, and medical personnel. Further, 29 community residents participated in Six 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.

At the time that this CHNA was conducted, the COVID-19 pandemic was still impacting communities across the United States, including SCH'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 Coast 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 the coastal communities of Del Norte County, California and Brookings Harbor areas of Curry County, Oregon. The total population of the service area was 41,677. Del Norte County is located in the northwest corner of the state of California, along the Pacific Ocean adjacent to the Oregon Boarder. Harbor is an unincorporated community in Curry County, Oregon. It is located across the Chetco River from the city of Brookings.

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 demonstrates that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health.

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 concurrently. Adequate access to mental, behavioral, and substance-abuse services helps community members obtain additional support when needed.

3. **Access to Specialty and Extended Care** – Extended care services, including specialty care, are services provided in a branch of medicine and focused on the treatment of a specific disease. Primary and specialty care go hand in hand, and without access to specialists, such as endocrinologists, cardiologists, and gastroenterologists, community residents are often left to manage chronic diseases, including diabetes and high blood pressure, on their own. In addition to specialty care, extended care refers to care extending beyond primary care services that is needed in the community to support overall physical health and wellness, such as skilled-nursing facilities, hospice care, and in-home healthcare.

4. **Access to Quality Primary Healthcare 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.

5. **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

6. **Access and Functional Needs** – Having access to transportation services to support individual mobility is a necessity of daily life. Without transportation, individuals struggle to meet their basic needs, including those that promote and support a healthy life. Examining the number of people that have a disability is also an important indicator for community health in an effort to ensure that all community members have access to necessities for a high quality of life.

7. **Injury and Disease Prevention and Management** – Knowledge is important for individual health and well-being, and efforts aimed at prevention are powerful vehicles to improve community health. When community residents lack adequate information on how to prevent, manage, and control their health conditions, those conditions tend to worsen. Prevention efforts focused on reducing cases of injury and infectious disease control (e.g., sexually transmitted infection [STI] prevention, influenza shots) and intensive strategies for the management of chronic diseases (e.g., diabetes, hypertension, obesity, and heart disease) are important for community health improvement.

8. **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. Furthermore, 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.

9. **Increased Community Connections –** As humans are social beings, community connection is a crucial part of living a healthy life. People have a need to feel connected with a larger support network and the comfort of knowing they are accepted and loved. Research suggests "individuals who feel a sense of security, belonging, and trust in their community have better health. People who don't feel connected are less inclined to act in healthy ways or work with others to promote well-being for all." Ensuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a healthy community. Furthermore, healthcare and community support services are more effective when they are delivered in a coordinated fashion, where individual organizations collaborate with others to build a network of care.

10. **Access to Dental Care and Preventive Services –** 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. Oral health disease, including gum disease and tooth decay are preventable chronic diseases that contribute to increased risk of other chronic disease, as well as play a large role in chronic absenteeism from school in children. Poor oral health status impacts the health of the entire body, especially the heart and the digestive and endocrine systems.

2022 – 2024 Implementation Strategy Plan

The implementation strategy plan describes how Sutter Coast 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 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 Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavior/Substance-Abuse Services
3. Access to Specialty and Extended Care
4. Access to Quality Primary Healthcare Services
5. Access and Functional Needs

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

Name of program/activity/initiative	Safe Patient Discharge Collaborative
Description	Offered in partnership with a nonprofit homeless Services Organization, the Safe Patient Discharge Collaborative. The program provides for housing for up to 5 days for a patient to recuperate post discharge and an avenue for home health care follow up if needed. While housed the individual will be connected to other services that may provide permanent housing as well as nourishment. These patients are homeless individuals who otherwise would be discharged to the street or cared for in an inpatient setting only. The program is designed to offer temporary housing so that the patient can focus on recovery.
Goals	The Safe Patient Discharge Collaborative seeks to connect patients with a medical home, social support and housing.
Anticipated Outcomes	The anticipated outcome of the Safe Patient Discharge Collaborative is to help people improve their overall health by wrapping them with services and treating the whole person through linkage to appropriate health care, housing and other social support services.

Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, hospital usage post program intervention, type of resources provided, and other successful linkages.

Access to Mental/Behavior/Substance-Abuse Services

Name of program/activity/initiative	Substance Use Navigator (SUN)
Description	SCH is developing a Substance Use Navigator program designed to dedicate a care coordinator as part of the integrated ED team to improve access to medications and treatment for substance use disorders.
Goals	The goal of the SUN program is to connect patients with services and support following substance use/abuse.
Anticipated Outcomes	The anticipated outcome is a reduction in individuals who are presenting to the ED with repeat substance use disorders.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, hospital usage post program intervention, type of resources provided, and other successful linkages.

Name of program/activity/initiative	Area Wide Mental Health Strategy
Description	The need for mental health services and resources, especially for the underserved, has reached a breaking point. This is why we are focused on building a comprehensive mental health strategy that integrates key elements such as policy and advocacy, county specific investments, stigma reduction, increased awareness and education, with tangible outreach such as expanded mental health resources to professionals in the workplace and telepsych options to the underserved.
Goals	By linking these various strategies and efforts through engaging in statewide and local partnerships, replicating best practices, and securing innovation grants and award opportunities, we have the ability to create a expanded mental health care resources so desperately needed in the communities we serve.
Anticipated Outcomes	The anticipated outcome is a stronger mental/behavioral safety net and increased access to behavioral/mental health resources for our community.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, anecdotal stories, types of services/resources provided, and other successful linkages.

Access to Specialty and Extended Care

Name of program/activity/initiative	Recruitment for Specialty Providers
Description	While retaining current physicians, continue to recruit into specialty disciplines inclusive of Gastroenterology; 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 at least 1 FTE.

Access to Quality Primary Healthcare Services

Name of program/activity/initiative	Recruitment and Retention of Primary Care Providers
Description	While retaining current physicians, continue to recruit primary care providers. 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 increasethe likelihood of retaining primary care providers, e.g., increasing connection of the school district for providers with children; looking at social capital and the opportunities for spouses of providers to have enhancedopportunities in the local job market. Plan to review exit surveys of providers leaving the community to develop an appropriate retention plan.
Goals	Increase local primary care providers FTE by at least 1 FTE.
Anticipated Outcomes	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
Metrics Used to Evaluate the program/activity/initiative	Increase local specialty provider FTE by at least 1 FTE.

Name of program/activity/initiative	Family Medicine Rural Residency Program
Description	Develop an accredited Rural Family Medicine Residency Program in Del Norte County.
Goals	Our goal is to increase access to Family Medicine physician interested in practicing in rural communities specifically staying locally to care for patients post residency.
Anticipated Outcomes	Retain 20% of Residents locally post residency.
Metrics Used to Evaluate the program/activity/initiative	Program Accreditation, residency initiation and % of residents remaining in the community post residency.

Name of program/activity/initiative	Ongoing Clinic Investments
Description	With access to care, including primary, and specialty care continuing to be a major priority in the SCH health service area, we will continue to make strategic investments in our local Community Clinic to increase clinic capacity and services offered. Creative collaborations and innovative opportunities with our clinic partners will continue to evolve with the needs of the community.
Goals	The goal is to expand access to care, especially for underserved populations who have barriers to receiving proper medical care.
Anticipated Outcomes	The anticipated outcome is expanded capacity to serve the underserved population with primary care, behavioral/mental health care, and dental and other specialty services.

Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of appointments provided, types of services provided, anecdotal stories and other successful linkages.

Access and Functional Needs

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

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 2022 Community Health Needs Assessment:

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 SCH will not be focused on this area.

3. Safe and violence-free environment – Due to limited capacity and resources SCH will not be focused on this area.

4. Access to dental care and preventative services – Due to limited capacity and resources SCH will not be focused on this area.

5. Increased Community Connections – While SCH will not specifically focus on and address this area, we will continue to collaborate regarding community initiatives and where possible and appropriate, host or participate in events that connect community members with available resources.

Approval by Governing Board

The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Coast Hospital Board on September 29, 2022.