Sutter Health

Sutter Tracy Community 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 Tracy Community 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 Tracy Community 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 1420 N. Tracy Boulevard, Tracy, CA 95376; and
- In-person at the hospital's Information Desk.

Executive Summary

Sutter Tracy Community 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 Tracy Community 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. Safe and Violence-Free Environment
5. Increased Community Connections
6. Active Living and Healthy Eating
7. Access to Dental Care and Preventive Services
8. Access to Functional Needs
9. Access to Specialty and Extended Care
10. Injury and Disease Prevention and Management
11. Healthy Physical Environment

The 2022 Community Healthy Needs Assessment conducted by Sutter Tracy Community 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 Tracy Community 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 one-on-one and group interviews with 12 community health experts, social-service providers, and medical personnel. Furthermore, 41 community residents or community service provider organizations participated in 4 focus groups across the service area. Finally, 15 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. 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 STCH'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 Tracy Community 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 STCH. STCH's primary service area includes seven ZIP codes across three counties, though predominantly in San Joaquin County. The ZIP code areas are: 95330, 95376, 95377, 95391, 95385 and 95387. A portion of the service area to the West laps over into Alameda County and the southern portion of the service area crosses over into Stanislaus County.

STCH is located in Tracy, California in San Joaquin County. San Joaquin County is located in the Central Valley of California, about 58 miles south of the state capitol of Sacramento. The county was founded in 1850 includes approximately 1,426 square miles and is named after the San Joaquin River that flows through the area. The county includes the major communities of Stockton, Lodi, and Tracy.

The City of Tracy (known as Tracy) was incorporated in 1910 and is the second largest city in San Joaquin County. Tracy has served as a major hub of transport for goods up and down the state of California since its founding. Tracy has three school districts, with the largest being Tracy Unified School District. Over the last 20-30 years Tracy saw extensive growth in population due to the economic and population growth of the nearby San Francisco Bay Area, resulting in with coming to the Tracy area desiring to live in more affordable housing, while working in the Western Bay Area. This has impacted the community of Tracy in several ways, including inadvertently increasing the service area of STCH. The total population of the service area was 145,970 in 2020.

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/Behavioral Health and Substance-Use 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 Care Health 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. **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.

5. **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." Assuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a healthy community. Further, 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.

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 are often overloaded with fast food and other establishments where unhealthy food is sold.

7. **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.

8. **Access to 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.

9. **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.

10. **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.

11. **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.

2022 – 2024 Implementation Strategy Plan

The implementation strategy plan describes how Sutter Tracy Community 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 Tracy Community 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. Increased Community Connections
5. Active Living and Healthy Eating
6. Injury and Disease Prevention and Management

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

Name of program/activity/initiative	Homeless Shelters and Case Management Services
Description	Provide temporary, emergency shelter to persons experiencing homelessness or who are at risk of homelessness to connect them with permanent housing as well as services such as primary and mental health care, insurance enrollment and income assistance.

Goals	Our goal is to provide a safe emergency shelter for persons experiencing homelessness or at risk of homelessness to better connect them with mainstream shelter services, housing services and supportive services.
Anticipated Outcomes	We anticipate this program will help participants establish a medical home, obtain a source of income and obtain housing.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of referrals to support services provided, anecdotal stories, successful linkages to housing or emergency shelter, and number of individuals connected with a PCP or mental health provider.

Name of program/activity/initiative	Recuperative Care Program
Description	Provides transitional care services to patients recently discharged from the hospital. The program assists at-risk clients to return home with increased stability through support services.
Goals	The goal is to provide care management and support services to patients as they return home to help stabilize and achieve optimal recovery.
Anticipated Outcomes	Patients will have a decreased likelihood of readmission to the hospital or unnecessary emergency department visits because they will have support to properly manage their condition and recovery.
Metrics Used to Evaluate the program/activity/initiative	Number of individuals served, number of referrals to support services, number of individuals connected with a PCP or mental health provider, number of follow-up appointments scheduled, and number of times transportation was provided.

Access to Mental/Behavioral Health and Substance-Use Services

Name of program/activity/initiative	Mental Wellness for Families
Description	Sutter Tracy Community Hospital makes significant investments in programs that connect at-risk and underserved families to the mental health resources they need. Through partnerships with local shelters and resource centers, we increase access to culturally appropriate mental health care services. This includes families experiencing homelessness, under or uninsured, low-income and those with disabilities.
Goals	Goals include greater mental health awareness, prevention and early intervention, stigma reduction, increased access to resources, and suicide prevention.
Anticipated Outcomes	We anticipate these investments will serve at least 100 individuals per year and connect them to mental health support services, as well as other wraparound support as needed.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, anecdotal stories, types of services/resources provided, and number of individuals referred to a mental health provider.

Access to Quality Primary Care Health Services

Name of program/activity/initiative	Medical Care for Individuals Experiencing Homelessness
Description	This investment will deliver medical care for acute and chronic health conditions, behavioral health, dental, lab services, and pharmacy services, all at no cost to homeless patients. In addition to clinic-based services, the program will provide medical outreach services 16–20 hours

	a week at area shelters, drug treatment programs, halfway houses, and in other areas where homeless people congregate.
Goals	Connect individuals experiencing homelessness with primary health care as well as wraparound support such as mental health care, housing, and transportation.
Anticipated Outcomes	Individuals experiencing homelessness will establish a primary health care home to receive care in an appropriate setting, resulting in a decrease in unnecessary emergency department visits.
Metrics Used to Evaluate the program/activity/initiative	Number of individuals reached, number of referrals to support services, and number of follow-up appointments scheduled.

Name of program/activity/initiative	Homecoming Program
Description	This program will provide targeted and intensive case management to at-risk patients, providing them with the necessary supports and wraparound services to connect them with a health home and prevent unnecessary readmissions to the Emergency Department. Types of services provided may include: transportation to/from medical appointments; linkages to housing/shelter; establishment of a PCP or mental health care provider; assistance enrolling in income assistance/food stamps; etc. Case Managers will closely follow a small caseload of 15-20 clients for up to 6 months post discharge. This will be especially helpful in supporting those with complex medical needs to manage their care and prevent conditions from worsening.
Goals	Connect vulnerable populations with necessary medical and social supports to encourage recovery after a hospital stay.
Anticipated Outcomes	Individuals will be healthier and have better quality of life, likely reducing unnecessary hospital visits.
Metrics Used to Evaluate the program/activity/initiative	Number of clients served; types of resources offered; case management outcomes; readmission rates; number of PCP appointments scheduled.

Safe and Violence-Free Environment

Name of program/activity/initiative	Shelter and Support Services for Victims of Domestic Violence
Description	Provide free, confidential, supportive services to homeless and runaway youth and victims of domestic violence, sexual assault and human trafficking. Supportive services include, but are not limited to: food and clothing, two domestic violence shelters, two homeless youth shelters, individual peer counseling, support groups, case management, parenting classes, 24-hour helplines, Youth Drop-In Center, mentoring program for youth, referrals, etc. to help them begin healing from trauma.
Goals	The goal is to reduce and end the cycle of violence and homelessness to build healthier families and a safer community.
Anticipated Outcomes	We anticipate that families and youth will have increased access to emergency shelter to escape violence, as well as immediate and basic needs such as food and medical care. In addition, they will be connected to support services to recover such as counseling and support groups.
Metrics Used to Evaluate the program/activity/initiative	Number of youth, women and families connected to emergency shelter, number connected to support services such as counseling and crisis intervention, number of people provided transportation, and anecdotal success stories.

Increased Community Connections

Name of program/activity/initiative	Family Resource Centers
Description	Family Resource Centers help families build protective factors such as child development knowledge, parent/youth resilience, and access to concrete supports—primarily through parent skill building, resource referral, and working with other organizations to improve service access.
Goals	Provide tools, resources and connections to help families improve their quality of life. The program will seek to 1) engage parents, youth and appropriate service provider in a multi-disciplinary step-by-step approach to untangling interrelated crises and risks, while also building protective factors that help prevent future crises, 2) involve families and youth in building nurturing and thriving neighborhoods and communities, 3) connect low-income and under-served families with community resources that help prevent crisis.
Anticipated Outcomes	Low-income and/or under-served families in Tracy will access social, employment, parenting and health services which tend to decrease the risk of adverse outcomes such as chronic disease, mental health crisis, family dissolution, justice system involvement and violence.
Metrics Used to Evaluate the program/activity/initiative	Number of individuals and families served, number of referrals to support services such as income, assistance and basic needs, anecdotal stories, successful linkages to housing or emergency shelter, and number of individuals connected with a PCP or mental health provider.

Active Living and Healthy Eating

Name of program/activity/initiative	Health and Wellness Programs for Youth
Description	Afterschool and summer programs that address the health, wellness and fitness needs of the youth in the community, including those with disabilities.
Goals	Youth receive regular physical activity, access to fresh fruits/vegetables and regular healthy meals.
Anticipated Outcomes	Youth will reach the CDC recommended standards of physical activity, and have access to year-round affordable fitness programming, as well as free access to healthy meals, fruits, vegetables and clean water. They will better understand how to incorporate healthy foods and exercise into their lifestyles.
Metrics Used to Evaluate the program/activity/initiative	Number of youth served, bags of healthy food distributed per week, number of minutes of physical activity per week and number of free healthy meals.

Injury and Disease Prevention and Management

Name of program/activity/initiative	Safe at Home Seniors Program
Description	“Safe At Home” program will utilize volunteers to help seniors extend their active living in their homes, by providing outside rails, grab bars, bed rails, bath rails, stair rails, shower chairs, night lights, ramps, walkers, smoke-carbon monoxide alarms, and other safety upgrades. They also

	provide education by alerting seniors about the benefits of COVID vaccinations and advice on preventing falls.
Goals	Prevent unnecessary injury or harm to seniors' physical health by eliminating potentially dangerous factors in their homes which could lead to a fall.
Anticipated Outcomes	Seniors will be better equipped to live independently and remain mobile in their home in a safe way.
Metrics Used to Evaluate the program/activity/initiative	Number of seniors served; number of safety improvements completed; number of referrals to other resources provided.

Needs Sutter Tracy Community Hospital Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Tracy Community 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 Dental Care and Preventive Services** – While we do not plan to implement programming that directly provides dental services, we anticipate several programs we support will offer referrals to dental care for vulnerable populations.
2. **Access to Functional Needs** – Given limited time and resources and our focus on other priority needs, we will not be addressing access to functional needs during this implementation cycle.
3. **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 Tracy.
4. **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.