

## Sutter Health

### Memorial Medical Center

2019 – 2021 Implementation Strategy Plan  
Responding to the 2019 Community Health Needs Assessment

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## Introduction

The Implementation Strategy Plan describes how Memorial Medical Center, 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.

Memorial Medical Center 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 Memorial Medical Center, ATTN: Brooke Galas, 1700 Coffee Road Modesto, CA 95355; and
- In-person at the hospital's Information Desk.

## Executive Summary

Memorial Medical Center is affiliated with Sutter Health, a not-for-profit public benefit corporation that is the parent of various entities responsible for operating health care facilities and programs in Northern California, including acute care hospitals, medical foundations and home health and hospice, and other continuing care operations. Together with aligned physicians, our employees and our volunteers, we're creating a more integrated, seamless and affordable approach to caring for patients.

The hospital's mission is to enhance the well-being of people in the communities it serves through a not-for-profit commitment to compassion and excellence in healthcare services.

Over the past five years, Sutter Health and its affiliates have committed nearly \$4 billion to care for patients who couldn't afford to pay, and to support programs that improve community health. Our 2018 commitment of \$734 million includes unreimbursed costs of providing care to Medi-Cal patients, traditional charity care and investments in health education and public benefit programs. For example:

- In 2018, Sutter invested \$435 million more than the state paid to care for Medi-Cal patients. Medi-Cal accounted for nearly 19 percent of Sutter's gross patient service revenues in 2018.
- Throughout Sutter, we partner with and support community health centers to ensure that those in need have access to primary and specialty care. Sutter also supports children's health centers, food banks, youth education, job training programs and services that provide counseling to domestic violence victims.

Every three years, Sutter Health 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 2019 Community Health Needs Assessment process the following significant community health needs were identified:

1. Access to Basic Needs, Such as Housing, Jobs, and Food
2. Access to Mental, Behavioral, and Substance-Abuse Services
3. Access to Quality Primary Care Health Services
4. Safe and Violence-Free Environment
5. Injury and Disease Prevention and Management
6. Active Living and Healthy Eating
7. Access and Functional Needs – Transportation and Physical Disability
8. Access to Specialty and Extended Care
9. Pollution-Free Living Environment

The 2019 Community Healthy Needs Assessment conducted by Memorial Medical Center is publicly available at [www.sutterhealth.org](http://www.sutterhealth.org).

### **2019 Community Health Needs Assessment Summary**

Community Health Insights ([www.communityhealthinsights.com](http://www.communityhealthinsights.com)) conducted the 2019 assessment on behalf of Memorial Medical Center. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Northern California. This assessment was conducted jointly with Stanislaus Surgical Hospital, because both hospitals serve the same service area of Stanislaus County.

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 11 one-on-one and group interviews with 16 community health experts, social-service providers, and medical personnel. Further, 75 community residents participated in nine focus groups across the county.

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.

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 service area. After these were identified, PHNs were prioritized based on rankings provided by primary data sources. 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 Memorial Medical Center is available at [www.sutterhealth.org](http://www.sutterhealth.org).

### Definition of the Community Served by the Hospital

The definition of the community served was Stanislaus County. This is the designated service area because the majority of patients served by Memorial Medical Center resided in this area.

Located in California’s central valley, the county covers approximately 1,500 square miles and is home to over 530,000 residents. It is the 16th most populous among California’s 58 counties. There are nine incorporated cities in the county including Ceres, Hughson, Modesto, Newman, Oakdale, Patterson, Riverbank, Turlock, and Waterford. Of these, Modesto, the county seat, is the most populous accounting for approximately 40% of the county’s population; Turlock is the second, followed by Ceres. The two largest race/ethnic groups in the county are those of Hispanic or Latino origin (44.8%), followed by Caucasians (43.5%). Agriculture plays a significant role in the county, thus the county’s largest employers are in the agriculture and food related industries. The Robert Wood Johnson’s County Health Rankings ranked Stanislaus County the 41st most healthy among California’s 58 counties.

Population characteristics for the service area are presented below.

	Total Population	% Minority	Median Age	Median Income	% Poverty	% Unemployed	% Uninsured	% No HS Graduation	% Living in High Housing Costs	% with Disability
<i>Stanislaus</i>	530,561	55.9%	33.8	\$51,591	18.2%	13.8%	11.5%	22.4%	40.6%	13.4%
<i>California</i>	38,654,206	61.6%	36.0	\$63,783	15.8%	8.7%	12.6%	17.9%	42.9%	10.6%

### Significant Health Needs Identified in the 2019 CHNA

The following significant health needs were identified in the 2019 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 says 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, Behavioral, and 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 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.
- 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, clothing) is physical safety. Feeling unsafe affects the way people act and react to everyday life occurrences and can have significant negative impacts on physical and mental well-being.
- 5. 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.

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 and Functional Needs – Transportation and Physical Disability** – 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.
8. **Access to Specialty and Extended Care** – Extended care services, which include specialty care, are care devoted to a particular branch of medicine and focus 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, hospice care, in-home health care, and the like.
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 built) and sociocultural environment, has more impact on individual health than one’s lifestyle, heredity, or access to medical services.

Primary and secondary data were analyzed to identify and prioritize the significant health needs within the Memorial Medical Center service area. This included identifying 10 potential health needs (PHNs) in these communities. These PHNs 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.

Once identified for the area, the final set of significant health needs (SHN) 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.

First, the total percentage of all primary data sources that mentioned themes associated with a significant health need at any point was calculated. This number was taken to represent how broadly a given significant health need was recognized within the community. Next, the percentage of times a theme associated with a significant health was mentioned as one of the top three health needs in the community was calculated. Since primary data sources were asked to prioritize health needs in this question, this number was taken to represent the intensity of the need.

These two measures were next rescaled so that the SHN with the maximum value for each measure equaled one, the minimum equaled zero, and all other SHNs had values appropriately proportional to the maximum and minimum values. The rescaled values were then summed to create a combined SHN

prioritization index. SHNs were ranked in descending order based on this index value so that the SHN with the highest value was identified as the highest-priority health need, the SHN with the second highest value was identified as the second-highest-priority health need, and so on.

### 2019 – 2021 Implementation Strategy Plan

The implementation strategy plan describes how Memorial Medical Center 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 Memorial Medical Center 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, and Substance-Abuse Services
3. Access to Quality Primary Care Health Services
4. Safe and Violence-Free Environment
5. Injury and Disease Prevention and Management
6. Active Living and Healthy Eating

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

<b>Name of program/activity/initiative</b>	Emergency Shelter Programs
<b>Description</b>	Memorial Medical Center invests in various programs that provide basic needs to our homeless population. These programs provide individuals experiencing homelessness with shelter and wraparound services, including case management, meals, job training and resume assistance, and referrals to housing.
<b>Goals</b>	Our goal is to shelter individuals experiencing homelessness who would otherwise be living on the streets, and to connect them with services that will improve their overall health.
<b>Anticipated Outcomes</b>	We anticipate more individuals experiencing homelessness will be connected to primary and mental health care, which would lead to a decrease in emergency room visits and improved health outcomes. We also anticipate more individuals will be connected with housing.
<b>Metrics Used to Evaluate the program/activity/initiative</b>	Number of individuals served; number of service referrals including primary and mental health care, insurance enrollment, transportation and income assistance; case management outcomes; and number of people connected to long-term or short-term housing.

**Access to Mental, Behavioral, and Substance-Abuse Services**

<b>Name of program/activity/initiative</b>	Area Wide Mental Health Strategy
<b>Description</b>	The need for mental health services and resources, especially for the underserved, has reached a breaking point across the Sutter Health Valley Operating Unit. 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. In addition, we will identify opportunities to build and foster mental health programs and resources locally in the MMC service area.
<b>Goals</b>	By linking these various strategies and efforts through engaging in statewide partnerships, replicating best practices, and securing innovation grants and award opportunities, we have the ability to create a seamless network of mental health care resources so desperately needed in the communities we serve.
<b>Anticipated Outcomes</b>	The anticipated outcome is a stronger mental/behavioral safety net and increased access to behavioral/mental health resources for our community.
<b>Metrics Used to Evaluate the program/activity/initiative</b>	Number of people served, number of resources provided, anecdotal stories, types of services/resources provided and other successful linkages.

<b>Name of program/activity/initiative</b>	Tobacco Prevention and Education Program for Youth
<b>Description</b>	This education program promotes anti-smoking behavior by mobilizing teens to decrease tobacco use through peer-focused activities in high schools and middle schools throughout the county.
<b>Goals</b>	A large coalition of teens are trained to communicate with students the dangers and negative outcomes of smoking or tobacco use. The major objective of program is to join teens together to believe that not smoking is cool.
<b>Anticipated Outcomes</b>	An overall county wide reduction in use of tobacco products among teens.
<b>Metrics Used to Evaluate the program/activity/initiative</b>	Number of students reached; number of events held to educate youth about the risks of tobacco; and anecdotal stories.

**Access to Quality Primary Care Health Services**

<b>Name of program/activity/initiative</b>	Medical Education for Physicians
<b>Description</b>	Residency program for family care providers to train physicians in the primary care arena.
<b>Goals</b>	Our goal is to expand the number of physicians able to see underinsured patients and increase the number of family practice practitioners in our community.



<b>Anticipated Outcomes</b>	We expect to see an increase in the number of providers who will be able to take Medi-Cal and uninsured patients, which will result in lower barriers for the underserved to access primary care and better health outcomes for that population.
<b>Metrics Used to Evaluate the program/activity/initiative</b>	Number of physicians who received training; number of patients served through the program; and number of inpatient and outpatient visit by residents.

<b>Name of program/activity/initiative</b>	Street Medicine Team
<b>Description</b>	This program will deploy a team of medical professionals who can provide acute medical services and access to education through referrals to individuals who are experiencing homelessness. A Licensed Vocational Nurse (LVN) and a Community Health Worker (CHW) will connect with the homeless population by bringing medical services to them with the use of a Medical Van equipped with medical supplies to perform basic medical services such as wound care, blood pressure checks, and glucose checks.
<b>Goals</b>	Provide outreach, triage, mobile medicine, transportation, and referrals to the homeless community.
<b>Anticipated Outcomes</b>	Increased access to primary and specialty care for individuals experiencing homelessness, which will result in decreased emergency room visits because patients will be able to better manage their health.
<b>Metrics Used to Evaluate the program/activity/initiative</b>	Number of people encountered; number of patients treated; patient demographics; services provided; and number of referrals to support services.

<b>Name of program/activity/initiative</b>	Emergency Department Navigators
<b>Description</b>	Patient Service Navigators (PSNs) who are based in Memorial Medical Center will provide underserved patients from the emergency department with resources and information to ensure they receive proper follow-up care after discharge. This will include support services such as scheduling clinic appointment with their preferred Primary Care Provider (PCP), scheduling patients for dental appointments, temporary housing referrals and other community resources such as soup kitchens around the vicinity.
<b>Goals</b>	The goal of this program is to ensure patients who are under or uninsured receive appropriate and timely clinic follow up appointments after discharge from Memorial Medical Center. The program will help ensure that delivery of adequate and quality health care to those patients is achieved.
<b>Anticipated Outcomes</b>	We anticipate that by being proactive in health care planning, patients' needs are met in the primary care setting thereby preventing unnecessary ED and hospital visits.
<b>Metrics Used to Evaluate the program/activity/initiative</b>	Number of individuals served; number of individuals with a chronic condition; service referrals; primary care appoints scheduled; and number of patients who attended their follow-up appointment.

## Safe and Violence-Free Environment

<b>Name of program/activity/initiative</b>	Domestic Violence Prevention
<b>Description</b>	Partner with organizations who are committed to supporting survivors of domestic and sexual abuse or exploitation and working to end gender-based violence. Our partnership will focus on educational programming for adolescents.
<b>Goals</b>	Our goal is to educate and empower high school aged youth to reduce and prevent relationship abuse and promote healthy relationship skills and behaviors with their peers.
<b>Anticipated Outcomes</b>	High school aged youth will have greater knowledge of the signs of relationship abuse, as well as community resources that can provide support.
<b>Metrics Used to Evaluate the program/activity/initiative</b>	Number of students reached; pre-and post-intervention assessments; and anecdotal stories.

### **Injury and Disease Prevention and Management**

<b>Name of program/activity/initiative</b>	In-Patient Navigators
<b>Description</b>	Patient Service Navigators (PSNs) who are based in Memorial Medical Center will provide underserved patients from an in-patient setting with resources and information to ensure they receive proper follow-up care after discharge. This will include support services such as scheduling clinic appointment with their preferred Primary Care Provider (PCP), scheduling patients for dental appointments, temporary housing referrals and other community resources such as soup kitchens around the vicinity.
<b>Goals</b>	The goal of this program is to ensure patients who are under or uninsured receive appropriate and timely clinic follow up appointments after discharge from Memorial Medical Center. The program will help ensure that delivery of adequate and quality health care to those patients is achieved. Many of these patients have or are at-risk of having chronic disease, so another goal will be to educate them about how to better manage their health care.
<b>Anticipated Outcomes</b>	We anticipate that by being proactive in health care planning, patients' needs are met in the primary care setting and they will be able to better manage their diseases and chronic conditions. In addition, we expect that more patients will be able to prevent disease by establishing with a PCP and receiving more preventative health care services.
<b>Metrics Used to Evaluate the program/activity/initiative</b>	Number of individuals served; number of individuals with a chronic condition; service referrals; primary care appoints scheduled; and number of patients who attended their follow-up appointment.

### **Active Living and Healthy Eating**

<b>Name of program/activity/initiative</b>	After School Soccer Programs
<b>Description</b>	Provide funding for local school districts to offer free after-school soccer programs for underserved elementary aged youth who otherwise might not be able to participate in organized sports.

<b>Goals</b>	Connect youth with opportunities to participate in physical activity.
<b>Anticipated Outcomes</b>	Through after-school soccer, we expect participants to have increased physical activity, and develop an understanding of why physical activity is so important for overall mental and physical health.
<b>Metrics Used to Evaluate the program/activity/initiative</b>	Number of students reached; BMI percentile for students before and after participation; and anecdotal stories.

<b>Name of program/activity/initiative</b>	Mobile Fresh Foods Program for Youth
<b>Description</b>	Direct distribution of nutritious foods for youth and families that are struggling with food insecurity. This program is designed to bring the food out to meet the people where they live, addressing some of the barriers of the low income population.
<b>Goals</b>	Increase consumption of produce and healthy food choices for low-income youth and families.
<b>Anticipated Outcomes</b>	We anticipate this will lead to healthier choices and improved health outcomes for youth and their families, with a decreased likelihood for obesity and chronic diseases such as diabetes.
<b>Metrics Used to Evaluate the program/activity/initiative</b>	Number of clients served; number of pounds of foods distributed; and anecdotal stories.

<b>Name of program/activity/initiative</b>	Movement Videos & Games for Classroom Physical Activity
<b>Description</b>	We will invest in a suite of online movement videos and games designed to bring movement and mindfulness into elementary school classrooms and homes. The program improves classroom engagement by helping teachers channel students' natural energy to improve behavior, focus, and achievement.
<b>Goals</b>	Our goals are: to facilitate physical activity, promote classroom engagement, reinforce core subjects and social/emotional learning, and improve academic achievement.
<b>Anticipated Outcomes</b>	Increased physical activity in schools resulting in decreased obesity for youth and better health outcomes.
<b>Metrics Used to Evaluate the program/activity/initiative</b>	Number of students served, number of minutes of physical activity and anecdotal stories.

### Needs Memorial Medical Center Plans Not to Address

No hospital can address all of the health needs present in its community. Memorial Medical Center 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. Access and Functional Needs – Transportation and Physical Disability** – While our implementation plan does not directly address issues of transportation and physical disability, many of our programs will offer clients referrals to transportation services so that they can access medical appointments.

2. **Access to Specialty and Extended Care** – Our focus in Stanislaus County is primarily on expanding access to primary care through partnerships with our FQHC and community partners. However, several of these programs which increase access to primary care will also help patients become connected to specialty care once they are established with a PCP.
3. **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 Valley Hospitals Board on November 21, 2019.