Sutter Health

Sutter Auburn Faith Hospital

2019 – 2021 Community Benefit Plan
Responding to the 2019 Community Health Needs Assessment
Submitted to the Office of Statewide Health Planning and Development May 2022

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

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Note: This community benefit plan is based on the hospital's implementation strategy, which is written in accordance with Internal Revenue Service regulations pursuant to the Patient Protection and Affordable Care Act of 2010. This document format has been approved by OSHPD to satisfy the community benefit plan requirements for not-for-profit hospitals under California SB 697.

Introduction

The Implementation Strategy Plan describes how Sutter Auburn Faith Hospital, a Sutter Health affiliate, plans to address significant health needs identified in the 2019 Community Health Needs Assessment (CHNA). The document describes how the hospital plans to address identified needs in calendar (tax) years 2019 through 2021.

The 2019 CHNA and the 2019 - 2021 Implementation Strategy Plan were undertaken by the hospital to understand and address community health needs, and in accordance with state law and the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

The Implementation Strategy Plan addresses the significant community health needs described in the CHNA that the hospital plans to address in whole or in part. The hospital reserves the right to amend this Implementation Strategy Plan as circumstances warrant. For example, certain needs may become more pronounced and merit enhancements to the described strategic initiatives. Alternately, other organizations in the community may decide to address certain community health needs, and the hospital may amend its strategies and refocus on other identified significant health needs. Beyond the initiatives and programs described herein, the hospital is addressing some of these needs simply by providing health care to the community, regardless of ability to pay.

Sutter Auburn Faith Hospital welcomes comments from the public on the 2019 Community Health Needs Assessment and 2019 - 2021 Implementation Strategy Plan. Written comments can be submitted:

- By emailing the Sutter Health System Office Community Benefit department at SHCB@sutterhealth.org;
- Through the mail using the hospital's address at 11815 Education Street, Auburn, CA 95602; and
- In-person at the hospital's Information Desk.

About Sutter Health

Sutter Health is the 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.

Through the 2019 Community Health Needs Assessment process the following significant community health needs were identified:

1. Access to Quality Primary Care Health Services
2. Access to Basic Needs Such as Housing, Jobs, and Food
3. Access to Mental/Behavioral/Substance Abuse Services
4. Injury and Disease Prevention and Management
5. Access and Functional Needs
6. Access to Specialty and Extended Care
7. Active Living and Healthy Eating

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

2019 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. 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 seven one-on-one and group interviews with 15 community health experts, social service providers, and medical personnel. Further, 25 community residents participated in four 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. 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 Sutter Auburn Faith 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 as 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 predominately in Placer County (with one ZIP Code extending into Nevada County) and includes the city of Auburn. This area of Placer County is often referred to as "the foothills" of the Sierra Nevada Mountain range. The SAFH service area has a population of 96,049 residents.

Significant Health Needs Identified in the 2019 CHNA

The following significant health needs were identified in the 2019 CHNA:

1. **Access to Quality Primary Care Health Services –** 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.

2. **Access to Basic Needs Such as Housing, Jobs, and Food** – Access to affordable and clean housing, stable employment, quality education, and adequate food for 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.

3. **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.

4. **Injury and Disease Prevention and Management** – Knowledge is important for individual health and well-being, and efforts aimed at prevention are powerful vehicles to improve community health. When community residents lack adequate information on how to prevent, manage, and control their health conditions, those conditions tend to worsen. Prevention efforts focused on reducing cases of injury 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.

5. **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.

6. **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.

7. **Active Living and Healthy Eating** – Physical activity and eating a healthy diet are extremely important for one's overall health and well-being. Frequent physical activity is vital for prevention of disease and maintenance of a strong and healthy heart and mind. When access to healthy

foods is challenging for community residents, many turn to unhealthy foods that are convenient, affordable, and readily available. Communities experiencing social vulnerability and poor health outcomes are often overloaded with fast food and other establishments where unhealthy food is sold.

Primary and secondary data were analyzed to identify and prioritize the significant health needs within the Sutter Auburn Faith Hospital service area. This included identifying seven 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 (SHNs) was prioritized. To reflect the voice of the community, SHN 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 Sutter Auburn Faith Hospital plans to address significant health needs identified in the 2019 Community Health Needs Assessment and is aligned with the hospital's charitable mission. The strategy describes:

- Actions the hospital intends to take, including programs and resources it plans to commit,
- Anticipated impacts of these actions and a plan to evaluate impact, and
- Any planned collaboration between the hospital and other organizations in the community to address the significant health needs identified in the 2019 CHNA.

Prioritized Significant Health Needs the Hospital will Address: The Implementation Strategy Plan serves as a foundation for further alignment and connection of other Sutter 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 Quality Primary Care Health Services
2. Access to Basic Needs Such as Housing, Jobs, and Food
3. Access to Mental/Behavioral/Substance Abuse Services
4. Injury and Disease Prevention and Management
5. Access and Functional Needs
6. Active Living and Healthy Eating

Access to Quality Primary Healthcare Services

Name of program/activity/initiative	Promotora Program – Latino Leadership Council
Description	The Promotora program is the only program regionally that uses Promotores to help uninsured and underinsured Latinos get access to health, dental, vision and mental health services and to teach them how to effectively navigate the health care system. Promotores conduct home visits during evenings and weekends to help participants learn how to properly and effectively engage the health care system, provide them with important health information and ensure that they find a medical home or other culturally and linguistically appropriate supports such as specialty care, mental health or family wellness.
Goals	Provide access to health, dental, vision and mental health for Latino adults through Promotores.
Outcomes	• 2021: 991 total adults, youth and families served; 3,569 total services provided; 3,891 referrals made; 436 obtained basic needs.

Name of program/activity/initiative	ED Navigator/Triage, Treat, Transport (T3) Program
Description	The WellSpace Health ED Navigator/ T3 Case Manager program provides case management services for people who frequent the emergency departments for non-urgent needs. The case manager works both in the hospital and in the community providing support to enrolled individuals. The Case Manager, receives referrals from hospital staff for patients who frequently utilize the emergency department for care that can be provider at a lower level of care and social needs. Once enrolled, the case manager provides wraparound services including but not limited to establishing a primary health care home, housing assistance, insurance enrollment, substance abuse treatment, life skills, income (SSA and GA), medical and behavioral health services, transportation and other key community resources.
Goals	1. Reduce the frequency of individuals utilizing high cost systems of care 2. Coordinate and link clients to a medical and behavioral health home 3. Provide wraparound case management services to the under-served 4. Educate and assist clients with additional community resources
Outcomes	• 2021: Served 147 total clients; provided 523 direct services; made 3,604 referrals to other support services.

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

Name of program/activity/initiative	Placer County Food Bank Senior Mobile Food Distribution
Description	Program provided nutritional food boxes to income-challenged/low income seniors. Attempted to cost-effectively "customize" food boxes with food items that are easy to prepare or add to existing food and can be dietary-friendly should a senior have health-related issues

Goals	Help overcome seniors' transportation constraints through the mobile distribution model so those we are targeting don't have to worry about self-pickup.
Outcomes	• 2021: 533 seniors served; 2,250 total services provided. • The program allowed to serve 533 seniors of which 150 were added due to this funding opportunity, these reside within nine different sites. These seniors received custom built food boxes that were delivered semi-monthly, these boxes included senior friendly items as many suffer from dietary restrictions.

Name of program/activity/initiative	Seniors First Meals on Wheels Distribution
Description	Seniors First has been awarded funding to once again operate the Meals on Wheels program in Placer County. Meals on Wheels is the nation's oldest and largest community-based senior nutrition organization, and supports the more than 5,000 senior nutrition programs across the country dedicated to addressing senior hunger and isolation. This network exists in virtually every community in America and delivers the nutritious meals and friendly visits that enable America's seniors to live nourished lives with independence and dignity.
Goals	Deliver meals to homebound Placer County seniors (ages 60+).
Outcomes	• 2021: Served over 1,300 adults with food distribution. • Participation in our MOW program has continued at heightened levels; we are currently serving 190% of normal program capacity. Seniors are keenly aware of their vulnerability to the coronavirus and continue to have major concerns about public contact. All our congregate meals remain closed due to the pandemic and will remain closed until deemed safe by public health officials to re-open.

Name of program/activity/initiative	The Gathering Inn – Interim Care Program
Description	The Gathering Inn's Interim Care Program provides homeless individuals a safe place to rest and recover following hospital discharge. Its housing first model, and low barrier approach, make it a viable option to being discharged to the street and have a positive effect on health and housing outcomes. Guests of the program reside in a 5 bedroom fully furnished home and have access to showers, computers, cable television, laundry services, food, and clothes. In addition to meeting the basic needs of guests, the program provides intensive case management. Case management works with guests daily, helping to connect them to health care providers, income assistance programs, housing opportunities, and more. Since its inception in 2009, the Interim Care Program has served over 600 individuals.
Goals	1. To improve the health outcomes of homeless individuals. 2. To break the costly cycle of emergency room as first-line medical care. 3. To reduce recidivism and facilitate healing, recovery, and hope 4. To reduce health inequity by providing appropriate accommodation for recovery. 5. To transition patients to permanent supportive housing after their stay.
Outcomes	• 2021: Served 81 adults; provided 8,149 direct services; made 405 referrals to support services.

Access to Mental/Behavior/Substance-Abuse Services

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 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 tele psych options to the underserved.
Goals	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.
Outcomes	In 2021, the mental health strategy helped with the following initiatives: • Launch the 988 crisis line going live on July 26, 2022 • Pass SB803 for peer certification. • Secure funding for SB71/Bring CA Home in amount of $2 billion over two years and an unspecified amount future funding. • Advocate for funding for board and care with the County Behavioral Health Directors Association and other organizations serving people living with severe mental illness and/or substance use disorder. Resulting in securing $803 million, with program details still to be fleshed out. • Propose Children and Youth Initiative and assist Secretary Ghaly to develop what became one of the Governor's signature budget achievements: $4.5 billion over five years to meet the behavioral health needs of children.

Name of program/activity/initiative	Lighthouse Counseling and Family Resource Center Family Wellness Program
Description	Our Family Wellness Initiative provides comprehensive counseling services and a wide variety of family wellness classes for children and families who are negatively affected by trauma, anxiety and depression, family attachment issues, domestic violence, child abuse and neglect, crime, poor mental health, and other forms of familial distress. Our goals are to help families heal by establishing long-term safety, self-sufficiency and positive health outcomes. We accomplish this through an inclusive approach that incorporates case management and referral services, counseling and parental support, and a variety of educational classes.
Goals	Programs goals include the following: 1) Improve the quality of life for Placer County families and the community as a whole by providing quality evidence-based mental health counseling services (individual and/or group therapy) and educational classes for up to 150 individuals. 2) Reduce the incidences of familial violence, and child abuse and neglect in Placer County. 3) Provide intensive case management for Placer County families we serve by connecting them to critical resources such as Medi-Cal, Cal-Fresh, rent and utility assistance, diapers, bus passes, back-to-school supplies, seasonal assistance, Christmas toys, reconditioned bicycles, and gift cards for food, gas and clothing.

	4) Our primary goal is to build strong families and in turn strong communities.
Outcomes	• 2021: Served 675 adults, 491 children/youth and 872 families; provided 1,609 counseling sessions; made referrals to 1,121 support services.

Injury and Disease Prevention and Management

Name of program/activity/initiative	Telehealth Diabetes Prevention Program – Chapa De Indian Health
Description	Chapa-De's Diabetes Prevention Program (DPP) is a year-long program that helps Chapa-De patients to avoid the onset of diabetes and to live healthier. Using CDC teaching materials proven to promote weight loss and lifestyle change, Chapa-De lifestyle coaches teach participants about eating healthy, being physically active and managing stress. Participants attend weekly classes for10 weeks, then 6 bi-weekly classes, followed by optional monthly sessions to help maintain weight loss and healthy lifestyles.
Goals	Utilize a video telehealth platform to engage 40 individuals who have been identified as at-risk for type II diabetes to participate in our Diabetes Prevention Program to receive virtual instruction, support and assistance along with all necessary equipment and supplies to empower them to live healthier lives, lose weight and prevent diabetes and heart disease.
Outcomes	• 2021: 113 total adults served; 486 total services provided.

Access and Functional Needs

Name of program/activity/initiative	Health Express/ My Rides Program
Description	MyRides provides free transportation services to non-emergency medical appointments and other essential services for eligible Placer County residents. Transportation is provided by volunteer drivers who are approved and scheduled by Seniors First.
Goals	Ensure low-income, Placer County seniors have transportation to non-emergency medical care.
Outcomes	• 2021: Provided more than 1,900 rides to medical appointments

Active Living and Healthy Eating

Name of program/activity/initiative	Shady Creek Outdoor Education Foundation: FitQuest
Description	The three tenets of Fit Quest are nutrition, physical activity, and mental wellness and the students' overall health. The Fit Quest program serves students in the 5th and 6th grades (ages 9-13 years old in their respective communities) either in the classroom or, if the school permits, by interactive virtual assemblies (at least 2 site visits, if approved by the school) to accommodate current health concerns.

	In addition, Fit Quest hosts Family Camp once a year allowing the program to share its objectives, tenets, and encouraging families to eat healthier, engage in physical fitness and instill behaviors to improve their overall mental health as a family unit.
Goals	• Reduce the number of children at risk or, by definition, obese with long term effect of reducing community health care costs. • Increase mindfulness, individual uniqueness, awareness of emotional triggers and responses, tools, and resources for navigating stressors. • Empower students to effect change with inclusion of family in process. • Increase overall number of students meeting physical fitness standards; encourage physical activity. • Reach as many students as possible and their families to educate them of the tenets of Fit Quest in the counties served.
Outcomes	• 2021: 426 total adults and youth served.

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 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 to Specialty and Extended Care –** Our strategy does not directly focus on increasing access to specialty and extended care, because we feel there is a greater need for increased primary care services in this community. We are bolstering our efforts to increase access to primary care, which will in turn lead to healthier outcomes and decreased health risks for the community.

Approval by Governing Board

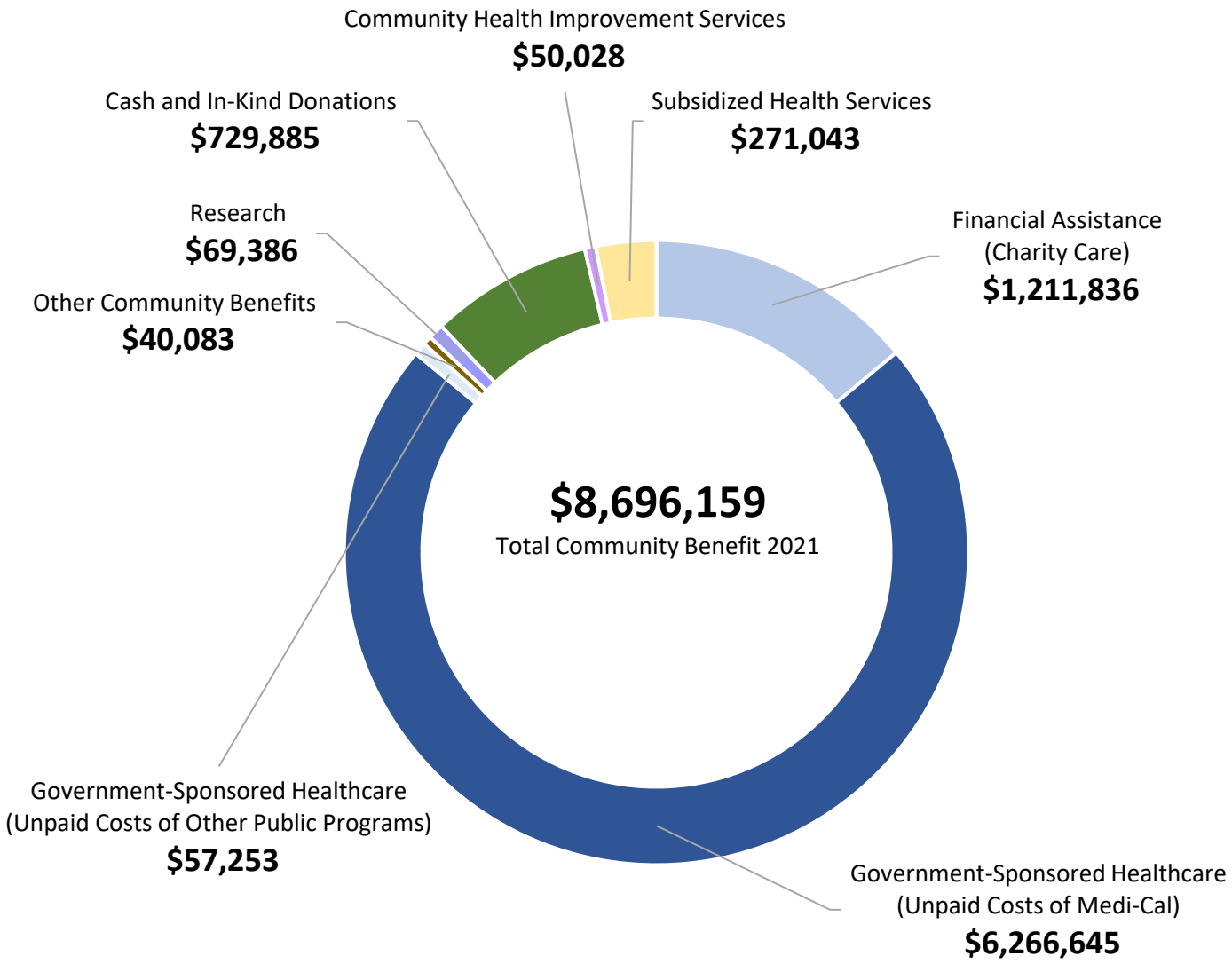
The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Health Valley Hospitals Board on November 21, 2019.

Appendix: 2021 Community Benefit Financials

Sutter Health hospitals and many other healthcare systems around the country voluntarily subscribe to a common definition of community benefit developed by the Catholic Health Association. Community benefits are programs or activities that provide treatment and/or promote health and healing as a response to community needs.

Community benefit programs include traditional charity care which covers healthcare services provided to persons who meet certain criteria and cannot afford to pay, as well as the unpaid costs of public programs treating Medi-Cal and indigent beneficiaries. Costs are computed based on a relationship of costs to charges. Additional community benefit programs include the cost of other services provided to persons who cannot afford healthcare because of inadequate resources and are uninsured or underinsured, cash donations on behalf of the poor and needy as well as contributions made to community agencies to fund charitable activities, training health professionals, the cost of performing medical research, and other services including health screenings and educating the community with various seminars and classes, and the costs associated with providing free clinics and community services. Sutter Health affiliates provide some or all of these community benefit activities.

Sutter Auburn Faith Hospital
2021 Total Community Benefit
& Unpaid Costs of Medicare



2021 unpaid costs of Medicare were $14,622,363