Sutter Health

Sutter Roseville 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 Sutter Roseville 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.

Sutter Roseville 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 1 Medical Plaza Dr, Roseville, CA 95661; and
- In-person at the hospital's Information Desk.

Executive Summary

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

The 2019 Community Healthy Needs Assessment conducted by Sutter Roseville Medical Center 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 Roseville 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.

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 12 one-on-one and group interviews with 73 community health experts, social-service providers, and medical personnel. Further, 75 community residents participated in eight 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 Roseville Medical Center 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 SRMC. The service area was defined by 21 ZIP Codes in southern Placer and northern Sacramento Counties. This service area was designated because the majority of patients served by SRMC resided in these ZIP Codes. Collectively, over 700,000 residents live in the service area.

Though located in Placer County, the hospital serves a diverse population across both Placer and Sacramento Counties. Situated in Roseville along the I-80 corridor that runs from the San Francisco Bay area to Reno, Nevada and beyond, SRMC sits near the border of these two counties. In Placer County there were 11 ZIP Codes included in the service area and included communities such as Granite Bay, Lincoln, Loomis, Penryn, Rocklin, Roseville, and Sheridan. The total population of these ZIP Codes is 287,586. In Sacramento County there were 10 ZIP Codes included in the assessment, and these encompassed communities such as Antelope, Carmichael, Citrus Heights, Folsom, North Highlands, and Orangevale. The total population of these ZIP Codes is 415,837. Collectively, the SRMC service area is home to just over 700,000 residents. The Robert Wood Johnson's County Health Rankings ranked Placer the fourth healthiest county among California's 58, while Sacramento was ranked 31st.

Significant Health Needs Identified in the 2019 CHNA

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

1. **Access to Mental/Behavior/Substance-Abuse Services** – Individual health and well-being are inseparable from individual mental and emotional outlook. Coping with daily life stressors is challenging for many people, especially when other social, familial, and economic challenges occur concurrently. Adequate access to mental, behavioral, and substance-abuse services helps community members obtain additional support when needed.

2. **Access to Quality Primary Healthcare Services** – Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and similar. Primary care services are typically the first point of contact when an individual seeks healthcare. These services are the front line in the prevention and treatment of common diseases and injuries in a community.

3. **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.

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

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. **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 Roseville Medical Center 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 SHNs 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 Sutter Roseville 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 Sutter Roseville 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 Mental/Behavior/Substance-Abuse Services
2. Access to Quality Primary Healthcare Services
3. Access to Basic Needs Such as Housing, Jobs, and Food
4. Access and Functional Needs
5. Injury and Disease Prevention and Management
6. Access to Specialty and Extended Care
7. Active Living and Healthy Eating

Access to Mental/Behavior/Substance-Abuse Services

Name of program/activity/initiative	Suicide Prevention Program
Description	The Emergency Department Suicide Prevention Follow Up Program is designed to prevent suicide during a high-risk period, and post discharge, provide emotional support, and continue evidence based risk assessment and monitoring for ongoing suicidality. That includes personalized safe plans, educational and sensitive outreach materials about surviving a suicide attempt and recovery, 24-hour access to Suicide Prevention Crisis lines, and referrals to community-based resources for ongoing treatment and support.
Goals	The goal of the Suicide Prevention program is to wrap patients with services and support following a suicide attempt or suicidal ideation.
Anticipated Outcomes	SRMC will continue to evaluate the impact of the suicide prevention program on a quarterly basis, by tracking the number of people served, number of linkages to other referrals/ services and other indicators.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, suicide attempts post program intervention, type of resources provided and other successful linkages.

Name of program/activity/initiative	Area Wide Mental Health Strategy
Description	The need for mental health services and resources, especially for the underserved, has reached a breaking point 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 SRMC service area.
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.

Anticipated Outcomes	The anticipated outcome is a stronger mental/behavioral safety net and increased access to behavioral/mental health resources for our community.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, anecdotal stories, types of services/resources provided, and other successful linkages.

Access to Quality Primary Healthcare Services

Name of program/activity/initiative	Care Transitions Team
Description	This team at SRMC will include a transitions nurse (RN) and support staff (LVN) who are employed by an FQHC but work in the hospital. The RN and LVN will work directly with SRMC care coordination staff to discuss medical appointments, specialty referrals, and special needs/timing of appointments, to help underinsured and uninsured patients access the appropriate follow-up care and resources when they leave the hospital. In addition, this team will be complemented by a peer intake staff member who will work in the community to provide patients complex case management once they are discharged. This team will not only make home visits (or for patients experiencing homelessness, visits to the parks/streets) but will also provide medical assessments, transport patient's to medical appoints, connect clients with housing and provide other services as needed.
Goals	Our goal will be to support a more successful management of underserved, complex patients post hospital discharge.
Anticipated Outcomes	We expect more patients to receive follow-up care post discharge from SRMC, and less visits to the emergency department because patients will be receiving preventative care in a primary care setting and managing their chronic conditions with appropriate specialty care.
Metrics Used to Evaluate the program/activity/initiative	Number of individuals served, number of follow-up appointments scheduled, percentage of appointments kept, number of subsequent visits to the emergency department, number of referrals to support services such as housing, transportation and insurance enrollment, and anecdotal stories.

Name of program/activity/initiative	Promotora Program
Description	The Promotora program provides culturally sensitive support to Spanish speaking patients in need of health and social services. Case management wraparound services provided by the Promotora often transcend the patient and extend to the entire family to ensure they have necessary resources. This investment provides health care access and services to the Latino community, focusing on serving recent immigrants and monolingual Spanish-speaking families who face greater challenges and barriers to receiving services.
Goals	Our goal is to increase access to primary care, preventative care, and services for the underinsured and uninsured, and ultimately help them establish a medical home.
Anticipated Outcomes	The anticipated outcome of the Promotora is reduced hospital usage, as patients will have a medical home and access to social services, in turn,

	reducing their need to come to the ED for non-urgent reasons and making the patient healthier overall.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, anecdotal stories, type of resources provided and other successful linkages.

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

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

Name of program/activity/initiative	Interim Care Program
Description	Offered in partnership with a nonprofit homeless shelter, the Placer Interim Care Program (ICP) is a respite-care shelter for homeless patients discharged from the hospital. The ICP wraps people with health and social services, while giving them a place to heal. The ICP links people in need to vital community services while giving them a place to heal. The clients who are enrolled in the ICP are homeless adult individuals who otherwise would be discharged to the street or cared for in an inpatient setting only. The program is designed to offer clients up to six weeks during which they can focus on recovery and developing a plan for their housing and care upon discharge.
Goals	The ICP seeks to connect patients with a medical home, social support and housing.
Anticipated Outcomes	The anticipated outcome of the ICP is to help people improve their overall health by wrapping them with services and treating the whole person through linkage to appropriate health care, shelter and other social support services.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, hospital usage post program intervention, type of resources provided, and other successful linkages.

Access and Functional Needs

Name of program/activity/initiative	Transportation Program for Seniors
Description	This investment will provide non-emergency medical transportation on an advance reservation, shared-ride basis for eligible residents of Placer

	County. Because we know scheduling and keeping non-emergency medical appointments is essential to preventative health this program will provide transportation to and from medical appointments for Placer County's underserved, vulnerable and elderly population, who are unable to access necessary medical care, due to transportation constraints.
Goals	Our goal is to provide transportation assistance for seniors and disabled individuals to consistently attend their medical appointments.
Anticipated Outcomes	This program will result in thousands of rides to and from medical appointments each year, for people who might not otherwise have the resources to travel to these important appointments.
Metrics Used to Evaluate the program/activity/initiative	Number of people served and number of rides provided.

Injury and Disease Prevention and Management

Name of program/activity/initiative	Pediatric Cancer Navigators
Description	Navigators provide customized supportive services to families as they navigate the complexities of their childhood cancer journey. As appropriate to each family served, these family-centered support services may include: case management, financial assistance, links to community resources, informal emotional support, meal and fuel vouchers, other travel/transportation assistance, peer support, bereavement support, and social support/outings for parents, youth, and siblings. Family Navigators provide on-going support and resources based on each family's unique needs.
Goals	The goal is to help families eliminate stressors and potential barriers so that their attention can be focused on their child.
Anticipated Outcomes	Childhood cancer families will have increased access to high-quality healthcare, social services, financial assistance and other vital resources during this life-threatening crisis.
Metrics Used to Evaluate the program/activity/initiative	Number of families served, resource referrals, services provided, case management outcomes, and anecdotal stories.

Access to Specialty and Extended Care

Name of program/activity/initiative	Maternal-Infant Support
Description	Working with the County Department of Public Health, we a public health nurse (PHN) will work cooperatively with the maternal-infant units at Sutter Roseville Medical Center (SRMC), including Labor and Delivery, Neonatal Intensive Care, Pediatrics and Postpartum. The PHN is on campus 2-3 days per week, attends NICU rounds once a week, and visits all units at least twice a week to retrieve referrals from the unit binders and conference with staff as appropriate. Referrals are sent to all counties represented by patient families. If referred families accept services offered, they will receive community support as they transition home.
Goals	The goal is to improve the health of prenatal and postpartum women and infants born at SRMC through childhood immunization education,

	outreach and promotion of breastfeeding, and improving family transition to home by connecting families to community resources and services.
Anticipated Outcomes	We will provide at-risk families who are pregnant, postpartum, or have high risk infants with outreach to help them transition at discharge to a supporting community.
Metrics Used to Evaluate the program/activity/initiative	Number of families served, resource referrals, services provided, case management outcomes, and anecdotal stories.

Active Living and Healthy Eating

Name of program/activity/initiative	Senior Recreation Program
Description	This program is designed to offer a change of pace and sense of independence to seniors with physical or memory impairments, as well as support for their caregivers. This includes planned program of activities designed to promote well-being through social and health related services. Participants take part in physical activities, mentally stimulating activities (arts and crafts), and social interaction and are fed nutritious meals.
Goals	The goal is to provide a social, physical and mentally stimulated environment for seniors with physical or memory impairments.
Anticipated Outcomes	The outcome of this successful program is hundreds of seniors and their caregivers participating in the Recreation and Respite program every year, which improves their quality of life.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, anecdotal stories and other successful program impacts.

Name of program/activity/initiative	Health Education and Physical Fitness Program for Youth
Description	We will invest in a comprehensive children's wellness program focusing on nutrition, fitness, and mental wellness. The on-site school program, geared toward 5th and 6th grade students, will teach students easy ways to incorporate healthy choices into daily living. The curriculum is designed to improve overall health in a fun and meaningful way.
Goals	To teach children and their families healthy lessons about fitness, physical activity and the importance of nutritious eating.
Anticipated Outcomes	The anticipated outcome of this program is teaching children and their families how to live a healthier and more active lifestyle, creating lifelong habits.
Metrics Used to Evaluate the program/activity/initiative	Number of children/families served, active schools, anecdotal stories and other successful program impacts.

Name of program/activity/initiative	Movement Videos & Games for Classroom Physical Activity
Description	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.

Goals	Our goals are: to facilitate physical activity, promote classroom engagement, reinforce core subjects and social/emotional learning, and improve academic achievement.
Anticipated Outcomes	Increased physical activity in schools resulting in decreased obesity for youth and better health outcomes.
Metrics Used to Evaluate the program/activity/initiative	Number of students served, number of minutes of physical activity and anecdotal stories.

Needs Sutter Roseville Medical Center Plans Not to Address

N/A

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.