Sutter Health

Sutter Solano Medical Center

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

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Table of Contents

Introduction

The Implementation Strategy Plan describes how Sutter Solano Medical Center (SSMC), 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 Solano Medical Center (SSMC) 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 2700 Gateway Oaks, Suite 2200, Sacramento, CA 95833 ATTN: Community Benefit; and

- In-person at the hospital's Information Desk.

Executive Summary

Sutter Solano Medical Center (SSMC) 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 we serve through a not-for-profit commitment to compassion and excellence in health care 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/substance-abuse services

3. Injury and disease prevention and management

4. Access to quality primary care health services

5. Increasing community connection

6. Active living and healthy eating

7. Access and functional needs

8. Safe and violence-free environment

9. Pollution-free living environment

The 2019 Community Healthy Needs Assessment conducted by Sutter Solano Medical Center (SSMC) is publicly available at www.sutterhealth.org.

2019 Community Health Needs Assessment Summary

The purpose of this community health needs assessment (CHNA) was to identify and prioritize significant health needs of the Sutter Solano Medical Center (SSMC) service area. The priorities identified in this report help to guide nonprofit hospitals' community health improvement programs and community benefit activities as well as their collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets the requirements of the Patient Protection and Affordable Care Act (and in California, Senate Bill 697) that nonprofit hospitals conduct a community health needs assessment at least once every three years. The CHNA was conducted by Community Health Insights (www.communityhealthinsights.com), and part of the assessment was conducted in collaboration with Harder+Company, a consulting firm conducting another CHNA on behalf of Kaiser Permanente in portions of the same service area.

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model. This model of population health includes many factors that impact and account for individual health and well-being. Further, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included one-on-one and group interviews with 28 community health experts, social-service providers, and medical personnel. Further, 90 community residents participated in seven 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.

The full 2019 Community Health Needs Assessment conducted by Sutter Solano Medical Center (SSMC) 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, the City of Vallejo, California, and surrounding communities as defined by six ZIP Codes—94503, 94510, 94589, 94590, 94591, and 94592. This is the designated service area because the majority of patients served by SSMC resided in these ZIP Codes. Considered a North San Francisco Bay community, Vallejo is an incorporated city in Solano County. The service area included one ZIP Code, 94503 (American Canyon), located in Napa County. The total population of the service area was 170,925.

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

2. Access to mental/behavioral/substance-abuse services

3. Injury and disease prevention and management

4. Access to quality primary care health services

5. Increasing community connection

6. Active living and healthy eating

7. Access and functional needs

8. Safe and violence-free environment

9. Pollution-free living 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. In all, 217 resources were identified in the service area that were potentially available to meet the identified significant health needs. The identification method included starting with the list of resources from the 2016 CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2019 CHNA report.

2019 – 2021 Implementation Strategy Plan

The implementation strategy plan describes how Sutter Solano Medical Center (SSMC) 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 Solano Medical Center (SSMC) 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/behavioral/substance-abuse services

2. Injury and disease prevention and management

3. Access to quality primary care health services

4. Access to basic needs, such as housing, jobs, and food

5. Active living and healthy eating

ACCESS TO MENTAL/BEHAVIORAL/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 telepysch 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.
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	We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories, types of services/resources provided and other successful linkages.

INJURY AND DISEASE PREVENTION AND MANAGEMENT

Name of program/activity/initiative	Mobile Diabetes Education
Description	The Mobile Diabetes Education Center will deliver care to the most vulnerable residents of Solano County and provide direct diabetes prevention programs and diabetes education services. The mobile diabetes clinic will provide not only diabetes screening for members of the community who may not otherwise have adequate access to healthcare but also education to the public about their risk factors, thus aiming to prevent diabetes and prediabetes in their lives.

Goals	Delivering primary health services to the underserved and connecting them to resources for ongoing care, as well as providing diabetes testing and education.
Anticipated Outcomes	The anticipated outcome of the mobile clinic is that hundreds of underserved individuals will have access to diabetes education and resources, helping them identify, manage and treat their diabetes
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of services/resources provided, anecdotal stories from staff and patients, type of services/resources provided and other successful linkages.

Name of program/activity/initiative	Pharmacist-Led Post Hospitalization Surveillance Initiative
Description	Extend health professional reach into the daily lives where health behaviors drive disease management by providing pharmacist-based interventions to improve safety, improve adherence, reduce utilization of rescue therapies and services, and better inform public on chronic disease and treatment.
Goals	Delivering primary health services to the underserved and connecting them to resources for ongoing care.
Anticipated Outcomes	Anticipated outcomes include addressing components of social determinants of health, reduce hypoglycemic and hyperglycemic crises and improve processes of care.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of services/resources provided, anecdotal stories from staff and patients, type of services/resources provided and other successful linkages.

ACCESS TO QUALITY PRIMARY CARE HEALTH SERVICES

Name of program/activity/initiative	Emergency Department Navigator (ED Navigator)
Description	The ED Navigator serves as a visible ED-based staff member. Upon referral from a Sutter employee (and after patient agreement), ED Navigators attend to patients in the ED and determines the type of resources and support this patient needs. Upon assessment, the ED Navigator identifies patient needs for community based resources and/or case-management services, such as providing a patient linkage to a primary care provider and establishing a medical home.
Goals	The goal of the ED Navigator is to connect patients with health and social services, and ultimately a medical home, as well as other community programs when appropriate.
Anticipated Outcomes	The anticipated outcome of the ED Navigator is reduced ED visits, 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	The ED Navigator program has proven to be effective in improving access to care for the underserved community. SSMC will continue to evaluate the impact of the ED Navigator on a quarterly basis, by tracking the number of people served, recidivism rates, number of linkages to other referrals/ services and other indicators. We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories, type of resources provided and other successful linkages.

Name of program/activity/initiative	Triage, Treatment, and Transport Plus (T3+)
Description	T3+ patients are identified in an inpatient setting and are often battle complex health and social issues. The T3+ navigator follows patients after discharge and works with Sutter Health staff to provide a follow-up health plan, tele-health, pain management, etc. All of this occurs while the T3+ navigators address the patient's other needs (including housing, insurance enrollment, etc) and ensure a connection is made to primary and preventive care to reduce further hospitalization.
Goals	The goal of T3+ is to wrap patients with health and social services, and ultimately a medical home.
Anticipated Outcomes	The anticipated outcome of T3+ is to successfully connect patients with a medical home and social services, in turn, managing any long term health ailments and making the patient healthier overall.
Metrics Used to Evaluate the program/activity/initiative	The T3+ program has proven to be effective in improving access to care for the underserved community in Solano County. SSMC is currently implementing this best practice and once implemented will evaluate the impact on a quarterly basis, by tracking the number of people served, recidivism rates, number of linkages to other referrals/ services and other indicators. We will look at metrics including (but not limited to) number of people served, number of resources provided, hospital usage post program intervention, type of resources provided and other successful linkages.

Name of program/activity/initiative	Transitional Care Program (TCP)
Description	The Transitional Care Program (TCP) provides a place to discharge and connect homeless patients, who are traditionally underserved residents, with resources and support. SSMC, along with other local health providers, provide this program to some of Solano County's most vulnerable residents. This program links homeless adults to vital community services while giving them a place to heal, as well as medical follow up and case management. The clients who are enrolled in the TCP are individuals who otherwise would be discharged to the street or cared for in an inpatient setting only. In addition, the TCP allows patients to focus on recovery and developing a long-term plan to get off the streets, all while being linked to vital community and medical services. The TCP has produced impressive client outcomes by providing "wraparound" services including connection to a medical home, enrollment in eligible programs and support services for clients.
Goals	The TCP seeks to connect patients with a medical home, social support and housing.
Anticipated Outcomes	The anticipated outcome of the TCP is to help people improve their overall health by wrapping them with services and treating the whole 10 person through linkage to appropriate health care, shelter and other social support services.
Metrics Used to Evaluate the program/activity/initiative	The TCP program has proven to be effective in improving access to care for the underserved community. SSMC will continue to evaluate the impact of TCP on a quarterly basis, by tracking the number of people served, recidivism rates, number of linkages to other referrals/ services and other indicators. We will look at metrics including (but not limited to) number of people served, number of resources provided, hospital usage

	post program intervention, type of resources provided and other successful linkages.

Name of program/activity/initiative	Operation Access
Description	Operation Access (OA) enables care providers to donate vital surgical and specialty care to people in need.
Goals	The overall goal of the program is to provide uninsured patients with outpatient surgeries they otherwise couldn't afford.
Anticipated Outcomes	Patients will live happier, healthier and more productive lives.
Metrics Used to Evaluate the program/activity/initiative	The plan to evaluate will follow the same process as many of our other community benefit program with bi-annual reporting and partner meetings to discuss/track effectiveness of each program within this strategy. We will look at metrics including (but not limited to) number of people served, type of surgeries provided, anecdotal stories and other successful linkages.

ACCESS TO BASIC NEEDS, SUCH AS HOUSING, JOBS, AND FOOD

Name of program/activity/initiative	Solano Economic Development Corporation
Description	The Solano Economic Development Corporation (EDC) is a public-private, nonprofit, dedicated to the economic growth of Solano County – scaling local traded sector industries, attracting new jobs and investment and maintaining competitive advantages for both existing and new businesses. The EDC provides confidential site location assistance to new businesses seeking to locate in Solano County. Pulling from the large and diverse portfolio of buildings and sites throughout the county, the EDC will prepare a comprehensive package of space opportunities, workforce and other resources that will assist the business in their decision process. The EDC will connect businesses to key contacts at the cities. The cities will facilitate location and permitting assistance, workforce development and education, financing, and incentive programs, such as energy savings.
Goals	Solano EDC's positively impact the economic growth of Solano County by maintaining and enhancing a competitive location for businesses to expand and locate, providing direct service to scale local traded sector industries, attracting new jobs and investment, and connecting businesses with resources to meet their needs. The EDC collaborates with the cities, county, workforce development, utilities, and education to deliver all resources.
Anticipated Outcomes	The anticipated outcome of the Solano EDC efforts is to revitalize the Solano County community, in turn, bringing economic development to an economically depressed area and bolstering the educational offerings and support for business, education, and workforce development.
Metrics Used to Evaluate the program/activity/initiative	As a resource hub, the EDC provides demographic reports for special areas of interest, including information on available workforce, water rates, major employers, and occupations. We will look at metrics including (but not limited to) number of people served, economic impact information (if available), anecdotal stories, type of resources provided to the local community and other successful linkages.

Name of program/activity/initiative	Homeless Navigation Center
Description	This center will be a temporary stay for people looking to find a permanent place to live. The "Path to Dignity" navigation shelter will be developed using a sustainable model where basic services are provided to people working to find housing and overcome issues contributing to their homelessness. This homeless navigation shelter will be the first in the region to provide the homeless with short term shelter (up to 3 months that can be extended based on a person's lease start date). The shelter will make use of referrals for intake of homeless individuals, couples, and military veterans who will complete an orientation, sign a shelter agreement and immediately exit the street, receive access to a bed, access three meals per day, receive mental health support, case management, and other services.
Goals	To support low-barrier housing programs to help reduce the root causes and effects of homelessness.
Anticipated Outcomes	The anticipated outcome 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	We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories, types of services/resources provided and other successful linkages. In addition, measure progress quantitatively and qualitatively by recording and tracking data by using the Homeless Information Management System (HMIS), an integrated county-wide database that tracks homeless housing and service outcomes in the region.

ACTIVE LIVING AND HEALTHY EATING

Name of program/activity/initiative	Healthy Food Access Programs
Description	Work with organizations to provide a collective effort to promote healthy eating and active living to low-income Solano County residents through advocacy, environmental change, collaboration, resource sharing, and education.
Goals	Increase access to fresh fruits and vegetables and improves beverage choices in Solano County to promote food security and equity by marketing and promoting healthier living.
Anticipated Outcomes	The anticipated outcome is to improve Solano County resident's knowledge toward healthy food to improve their attitude and develop the habit of eating healthy.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories, types of services/resources provided and other successful linkages.

Needs Sutter Solano Medical Center (SSMC) Plans Not to Address
No hospital can address all of the health needs present in its community. Sutter Solano Medical Center (SSMC) 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. Increasing community connection: While there are currently no increasing community connection SSMC community benefit programs in the SSMC HSA, we do fund programs/organizations and efforts that address this need through our sponsorship program.

2. Access and functional needs: SSMC plans to identify partnerships and strengthen relationships with organizations in the near future to collaborate on initiatives to access and functional needs in Solano County.

3. Safe and violence-free environment: This is primarily a law enforcement issue and not something that SAFH has the expertise to effectively address.

4. Pollution-free living environment: While this is an important issue, this is not something that we are able to greatly affect through community benefit; therefore, we are focusing our resources elsewhere, especially given that regional community partners and local jurisdictions are working on these vital issues.

Approval by Governing Board

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