

Sutter Health

Sutter Santa Rosa Regional Hospital (SSRRH)

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 Santa Rosa Regional Hospital (SSRRH), 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.

SSRRH 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 30 Mark West Springs Rd, Santa Rosa, CA 95403, ATTN TO: Andrea Garfia; and
- In-person at the hospital's Information Desk.

Executive Summary

Sutter Santa Rosa Regional Hospital 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: We enhance the well-being of people in the communities we serve 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:

Housing and Homelessness

Education

Economic Security

Access to care

Mental Health and Substance Use

Maternal and Child health

HEAL: Obesity and Diabetes

CVD/Stroke and Tobacco Use

Violence and Injury Prevention

The 2019 Community Healthy Needs Assessment conducted by Sutter Santa Rosa Regional Hospital is publicly available at www.sutterhealth.org.

2019 Community Health Needs Assessment Summary

Sutter Santa Rosa Regional Hospital participates in a collective needs assessment process with other health care partners, called the Sonoma CHNA Collaborative. Members of the Sonoma Collaborative includes all three nonprofit hospitals in Sonoma County which collaborated on this project in partnership with Sonoma County Department of Health Services. The Sonoma Collaborative completes a CHNA every three years, which uses primary and secondary data to help identify priority issues affecting the health of Sonoma County residents. The 2019-2021 Sonoma County Community Health Needs Assessment was conducted over a 9 month period from June, 2018 through March of 2019. Harder and Company, a consulting firm based in San Diego, was contracted to manage the project.

The full 2019 Community Health Needs Assessment conducted by Sutter Santa Rosa Regional Hospital is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

The Sutter Health – Santa Rosa Regional service area includes Sonoma County. Care centers located throughout various cities include Healdsburg, Santa Rosa, Rohnert Park, Sebastopol and Petaluma serve residents from all over Sonoma County. While the county has slightly less economic inequality than California as a whole, significant economic disparities along ethnic and regional lines affect access to resources. With a growing Latino population and a median income of \$21,695 for a Latino household, affordable housing is difficult for families. Child poverty is especially high among Latino, Black, and Native American families in the Santa Rosa area. Twenty-two percent of the growing senior population have incomes less than 200% of the Federal Poverty Level.

Significant Health Needs Identified in the 2019 CHNA

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

1. Housing and Homelessness

2. Education
3. Economic Security
4. Access to Care
5. Mental Health and Substance Abuse
6. Maternal and Child Health
7. HEAL
8. Cardiovascular Disease, Stroke and Tobacco Use
9. Violence and Injury Prevention

CRITERIA USED TO IDENTIFY HEALTH NEEDS AND DESCRIPTION OF THE PRIORITIZATION PROCESS.

The SC CHNA Collaborative developed a set of criteria to determine what constituted a health need in their community. Once all of the community health needs were identified, they were all prioritized based on identified criteria. This process resulted in a complete list of prioritized community health needs. Extensive secondary quantitative data (from the CHNA Data Platform and other publically available data), as well as primary qualitative data collected from key informant interviews, provider focus groups, and group interviews, were synthesized and analyzed to identify the community health needs.

2019 – 2021 Implementation Strategy Plan

The implementation strategy plan describes how Sutter Santa Rosa Regional 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 Santa Rosa Regional 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. Housing and Homelessness
2. Education
3. Economic Security
4. Access to Care
5. Cardiovascular Disease, Stroke and Tobacco Use

Housing and Homelessness

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| Name of program/activity/initiative | Catholic Charities - Nightingale Project |
| Description | The Project Nightingale – Respite Care Expansion Pilot Program provides post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets, but are not ill enough to be in a hospital or skilled-nursing facility (SNF). This recuperative care model is short-term residential care that allows homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. This project is a significant collaboration between Catholic Charities, Sutter Health, Kaiser Permanente, Providence St Joseph Health and the Sonoma County Department of Health Services. Each partner commits annual grant funding to operate the program and provides consultation around the referral process, home-health services and services needed to reduce the occurrence of re-admission and/or unnecessary emergency department visits |
| Goals | The goals of the Nightingale Project are: 1) Provide a safe discharge plan for hospitalized homeless patients with appropriate after care 2) Reduce unnecessary/inappropriate use of valuable hospital resources to ensure that hospital beds are available for people who require that level of care |
| Anticipated Outcomes | <ul style="list-style-type: none"> • Clients will be linked to a primary care home and enrolled in available enabling services to ensure that basic needs are met (especially around housing). • Improved (and measured) short- and long-term health outcomes for clients as defined by number of clients served and connected to a PCP |
| Metrics Used to Evaluate the program/activity/initiative | <ol style="list-style-type: none"> 1. Number of visits to PCP after admission 2. Number of clients linked to social services (cash aid, food and insurance benefits) 3. Tracking of hospital re-admission data 4. Tracking of hospital ER visits |
| Name of program/activity/initiative | Grants and Sponsorships addressing Housing & Homelessness |
| Description | Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year end. |
| Goals | Support access to housing resources and services for individuals and families that are experiencing homelessness; support for services and programs that prevent homelessness |
| Anticipated Outcomes | <ul style="list-style-type: none"> • Increase access to urgent housing needs such as emergency shelters, winter shelters and shelters that accept families or focus on at-risk youth • Increase access to housing resources, such as vouchers, rental assistance and subsidized housing for low-income families and individuals |

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| | <ul style="list-style-type: none"> • Increase support to families in need of resources, such as employment training, parent education classes and child care. • Increase support to families that are transitioning in and/or out of homelessness including, counseling and substance abuse treatment services |
| Metrics Used to Evaluate the program/activity/initiative | Possible metrics include: <ul style="list-style-type: none"> • Number of persons served (including demographics if available/applicable) • Number of encounters • Number of persons connected to mental health services or social services |

Education

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| Name of program/activity/initiative | Family Medicine Residency Program |
| Description | During their three years of training, the residents (under the supervision of Sutter attending physicians) provide all of the primary care to the patients at Santa Rosa Community Health (SRCH), the largest FQHC in our community. |
| Goals | Residents will gain world class training and graduate with the highest standard of educating and training to prepare them to practice as family physicians |
| Anticipated Outcomes | Resident physicians will gain hands-on experience in a variety of specialties by receiving training from SSRRH attending physicians |
| Metrics Used to Evaluate the program/activity/initiative | Number of staff that are supervising resident physicians by specialty Value of attending physicians training resident physicians |

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| Name of program/activity/initiative | Grants and Sponsorships addressing Education |
| Description | Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year end. |
| Goals | Promote access to education programs and resources for children at various ages and grade levels Promote access to integrated support services on school campuses including education around healthy eating habits, personal safety and mental health and well-being Increase access to college-readiness resources for high school students including scholarships, job-based learning opportunities and pre-college programs |
| Anticipated Outcomes | Increase number of college resources for high school graduates Increase healthy eating habits for elementary school students |
| Metrics Used to Evaluate the program/activity/initiative | Possible metrics include: Number of students served Number of classes/workshops provided Number of referrals to social and mental health services |

Economic Security

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| Name of program/activity/initiative | Workforce Training of students from local college programs. |
| Description | In an effort to partner with local educational institutions and further learning opportunities for students SSRRH precepts and/or train students in a variety of health care programs. One of our partnerships with a local community college and universities, provides student nurses to train and precept with a senior level staff nurse. Other students from educational programs include, respiratory therapy, physical therapy and physician assistant fellows. In total various supervising staff are training over 300 students a year aside from attending physicians that are training and supervising the resident physicians. |
| Goals | Continue to build relationships with local educational programs for students studying careers in health care. |
| Anticipated Outcomes | Effectively train and educate the future workforce, by providing the highest level of education and competent staff. |
| Metrics Used to Evaluate the program/activity/initiative | Number of family medicine residents and allied health program interns and fellows trained Number of staff supervising and training students |

Access to Care

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| Name of program/activity/initiative | Family Medicine Residency Program |
| Description | The Santa Rosa Family Medicine Residency Program has been the sole local contributor to the primary care provider pipeline in Sonoma County for more than 45 years. In affiliation with the UCSF School of Medicine, this training program for family physicians is one of the most renowned training program for family doctors in the United States. Graduates of the program represent about 50% of the current practicing family doctors in Sonoma County and about 2/3 of the medical staff at our local FQHC's are graduates. FQHC's care for about 25% our county's population. During their three years of training, the residents (under the supervision of Sutter attending physicians) provide all of the primary care to the patients at the largest FQHC in our community. This represents about 25,000 patient visits, provided at no charge to the clinic. Sutter covers all the costs related to this program that are not covered through Medicare IME reimbursement. |
| Goals | In addition to providing high quality training to family medicine residents, the program provides greater access to care by addressing the shortage of primary care providers. Having a highly-skilled primary care workforce also can reduce health care costs. |
| Anticipated Outcomes | Increase number of well-trained physicians and the availability of these services in the future. |
| Metrics Used to Evaluate the program/activity/initiative | Number of family medicine residents trained Number of patient visits per year at SSRRH Number of patient visits per year at our local FQHC |
| Name of program/activity/initiative | Advanced Illness Management (AIM) |

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| Description | Sutter Health's Advanced Illness Management (AIM) program provides customized support for patients with advanced chronic illnesses in order to manage their health/illness symptoms, manage their medications, coordinate their care, plan for the future, and live the kind of life they want. Once the AIM team understands the patient's health issues, lifestyle, and personal preferences, they work with the patient to tailor a care plan, ease the transition from hospital to home, and provide continuing over-the-phone support and in-person visits in the home or at the doctor's office as needed. If the patient returns to the hospital, AIM staff continues to support the patient there. The AIM team also provides support for the patient's family and helps them understand anything about the patient's condition that the patient wants them to know. |
| Goals | Help chronically ill patients better manage their health/illness through skilled respectful coaching and care tailored to their needs. |
| Anticipated Outcomes | Increase coaching services and support for patients who need help in self-managing advanced chronic illness. |
| Metrics Used to Evaluate the program/activity/initiative | Number of persons enrolled in the program (including demographics if available) Number of persons transitioned to home from hospital Number of persons assisted with self-managing their medications |

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| Name of program/activity/initiative | Operation Access |
| Description | Since 2001, Operation Access has enabled physicians and medical centers in Sonoma County to donate vital surgical and specialty care to people in need. Sutter Health has partnered with OA to provide free time in the operating room, staffing and surgical supplies to facilitate surgeries for people without insurance or for whom public health coverage will not authorize an elective, but important restorative or corrective surgical procedure. Surgeries provided through OA often restore functionality so as to allow a previously disabled patients to return to work. OA is also able to facilitate surgical intervention of conditions before they become emergent which increases morbidity, mortality and cost to the healthcare system. SSRRH will provide free OR time (which includes staffing and supplies) each year. |
| Goals | Provide every person not eligible for services through traditional insurance pathways to access needed surgical services, regardless of their ability to pay |
| Anticipated Outcomes | 1. Increase in the number of high volume specialty volunteer providers 2. Improved patient outcomes through timely surgical procedures 3. Provision of free surgical and specialty services to all eligible uninsured people |
| Metrics Used to Evaluate the program/activity/initiative | Number of persons served Number of services provided (surgeries, procedures, etc.) Number of SSRRH medical volunteers |

Cardiovascular Disease, Stroke and Tobacco Use

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| Name of program/activity/initiative | Northern California Center for Well-Being (NCCWB) |
| Description | The Northern California Center for Well-Being (NCCWB) is a not-for-profit community –based organization with a mission to improve the health of the community through prevention-oriented education and intervention to address obesity, diabetes and heart disease. They offer a myriad of |

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| | classes and health education materials that are free or sliding-scale fee-based for low-income families. The specific program that SSRRH supports is the Heart Works program. Heart Works focuses on cardiac rehabilitation for patients that are suffering from cardiac disease. Heart Works also is a preventative intervention for individuals with cardiac disease. With a fully equipped fitness center and licensed medical staff, patients successfully recover in a tiered program beginning with Phase II, fully supervised, to Phase III, supervised in a group setting. NCCWB serves everyone, but also some of the most at risk in the community. If it were not for the organization structure that accepted multiple types of insurance and sliding scale fees, resources for cardiac rehabilitation would not exist. |
| Goals | Patients accessing the Heart Works will reduce their risk of another cardiac episode and/or reduce severity of existing cardiac disease. |
| Anticipated Outcomes | Whether recovery or prevention, Heart Works patients will improve health outcomes by obtaining necessary tools to successfully manage heart disease. |
| Metrics Used to Evaluate the program/activity/initiative | Number of patients served Number of classes provided |

Mental Health & Substance Abuse

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| Name of program/activity/initiative | Grants and Sponsorships addressing Mental Health |
| Description | Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year end. |
| Goals | Promote mental health and the healthy development of children and families in both the broader community and at-risk communities; prevent adverse childhood experiences |
| Anticipated Outcomes | Examples: <ul style="list-style-type: none"> • Increase access to acute mental health and psychiatric services • Increase support to families in need of resources, such as parent education classes, housing, child care, and shelters. • Increase intensive assessment, counseling, and referral services to help families and individuals avert homelessness. • Increase mental health services to homeless and at-risk youth. • Increase linguistically and culturally appropriate support groups and counseling. • Increase early childhood education for at-risk families. • Increase integration of behavioral health services into existing primary care settings for at-risk Sonoma County residents. |
| Metrics Used to Evaluate the program/activity/initiative | Possible metrics include: <ul style="list-style-type: none"> Number of persons served (including demographics if available/applicable) Number of encounters Number of persons connected to mental health services or social services |

Needs Sutter Santa Rosa Regional Hospital Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Santa Rosa Regional 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:

Maternal and Child Health, HEAL, Violence and Injury Prevention - although significant issues facing the community, it is not within the scope of services for a hospital to address. Though not major priorities for SSRRH, we have and will continue to respond to modest requests for funding to support programs that address these issues.

Approval by Governing Board

The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Health Bay Hospitals Board of Directors on November 20, 2019.