

## **Sutter Health**

### **Sutter Auburn Faith Hospital**

#### **2014 Community Benefit Plan Update**

Based on the 2013 – 2015 Community Benefit Plan

Responding to the 2013 Community Health Needs Assessment

Submitted to the Office of Statewide Health Planning and Development May 2015

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This document serves as an annual update to the 2013 – 2015 community benefit plan for Sutter Auburn Faith Hospital. The update describes impact from community benefit programs/initiatives/activities conducted in the reporting year, along with the economic values of community benefits for fiscal year 2014.

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The implementation strategy is written in accordance with proposed Internal Revenue Service regulations pursuant to the Patient Protection and Affordable Care Act of 2010. This document has also been approved by OSHPD to satisfy the community benefit plan requirements for not-for-profit hospitals under California SB 697.

## Introduction

This implementation strategy describes how Sutter Auburn Faith Hospital, a Sutter Health affiliate, plans to address significant needs identified in the Community Health Needs Assessment (CHNA) published by the hospital on October 5, 2013. The document describes how the hospital plans to address identified needs in calendar (tax) years 2013 through 2015.

The 2013 CHNA and this implementation strategy were undertaken by the hospital to understand and address community health needs, and in accordance with proposed Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

This implementation strategy 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 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.

## About Sutter Health

Sutter Auburn Faith Hospital is affiliated with Sutter Health, a not-for-profit network of hospitals, physicians, employees and volunteers who care for more than 100 Northern California towns and cities. Together, we're creating a more integrated, seamless and affordable approach to caring for patients.

The hospital's mission is to enhance the health and well-being of people in the communities we serve, through a not-for-profit commitment to compassion and excellence in health care services.

### Vision

Sutter Health leads the transformation of health care to achieve the highest levels of quality, access and affordability.

### Values

Excellence and Quality  
Caring and Compassion  
Honesty and Integrity  
Teamwork  
Community

Over the past five years, Sutter Health has committed nearly \$4 billion to care for patients who couldn't afford to pay, and to support programs that improve community health. Our 2014 commitment of \$767 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:

- To provide care to Medi-Cal patients in 2014, Sutter Health invested \$535 million more than the state paid. Sutter Health hospitals proudly serve more Medi-Cal patients in our Northern California service area than any other health care provider.
- In 2014, Sutter Health's commitment to delivering charity care to patients was \$91 million. Our charity care investment represented an average of nearly \$1.8 million per week.
- Throughout our health care system, we partner with and support community health centers to ensure that those in need have access to primary and specialty care. We also support 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 hospitals participate in a comprehensive and collaborative Community Health Needs Assessment, which identifies local health care priorities and guides our community benefit strategies. The assessments help ensure that we invest our community benefit dollars in a way that targets and addresses real community needs.

For more facts and information about Sutter Auburn Faith Hospital, please visit [www.sutterauburnfaith.org](http://www.sutterauburnfaith.org).

## 2013 Community Health Needs Assessment Summary

Every three years nonprofit hospitals are required to conduct community health needs assessments (CHNA) and use the results of these to develop community health improvement implementation plans. These requirements are imposed on virtually all nonprofit hospitals by both state and federal laws.

Beginning in early 2012 through February 2013, Valley Vision, Inc. conducts an assessment of the health needs of residents living in the Sutter Auburn Faith Hospital (SAFH) service area was completed by Valley Vision, Inc. For the purposes of the assessment, a health need was defined as, “a poor health outcome and its associated driver.” A health driver was defined as, “a behavioral, environmental, and/or clinic factor, as well as more upstream social economic factors, that impact health.”

The objective of the CHNA was to provide necessary information for the SAFH's community health improvement plan, identify communities and specific groups within these communities experiencing health disparities, especially as these disparities relate to chronic disease, and further identify contributing factors that create both barriers and opportunities for these populations to live healthier lives.

The full 2013 Community Health Needs Assessment report conducted by Sutter Auburn Faith Hospital is available at <http://www.sutterhealth.org/communitybenefit/community-needs-assessment.html>.

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### Definition of Community Served by the Hospital

The study area of the assessment included the Sutter Auburn Faith Hospital HSA. A key focus was to show specific communities (defined geographically) experiencing disparities as they relate to chronic disease and mental health. To this end, ZIP code boundaries were selected as the unit of analysis for most indicators. This level of analysis allowed for examination of health outcomes at the community level that are often hidden when aggregated at the county level. Some indicators (demographic, behavioral, and environmental in nature) were included in the assessment at the census tract, census block, or point prevalence level, which allowed for deeper community level examination.

Sutter Auburn Faith's HSA was determined by analysis of patient discharge data. Collection and analysis of the ZIP codes of patients discharged from the hospital over a six-month period allowed for identification of the primary geographic area served by the hospital. The HSA identified as the focus of the needs assessment is depicted in Figure 2 in the full CHNA.

The Sutter Auburn Faith Hospital HSA Communities of Concern are home to just over 90,000 residents. The ZIP code communities consist of the suburban City of Lincoln, the foothill town of Auburn, and the small, unincorporated community of Applegate. Each ZIP code, except for the two in Auburn, is unique from others. Applegate is a small community tucked into the foothills and is home to less than 1,000 residents, while Lincoln has realized major growth over the past decade and now boasts a population of over 45,000.

Quantitative data at the ZIP code level does not necessarily point to deep disparities in regards to poverty, unemployment, or educational attainment. However, a closer look at census tract level data coupled with analysis of qualitative data revealed areas within these ZIP codes with large populations of Hispanics, individuals living under the federal poverty level, and female-headed households. For example, a census

tract within 95602 had Hispanics as 22% of its population and 23% of its residents living 200% below the federal poverty level. In contrast, an adjacent census tract within the 95602 ZIP code had only 6% Hispanics and had only 6% living 200% below FPL. Table 4 and Figure 3 provide information about the socio-demographic characteristic of the HSA at the ZIP code level and the census tract level, respectively.

**Significant Health Needs Identified**

The following significant health needs were identified by the 2013 CHNA.

<b>Significant Community Health Need</b>	<b>Intends to Address</b>
<b>Lack of health care providers/access to primary care and physicians that take Medi-Cal</b> Lack of primary care physicians in the area and lack of those who take Medi-Cal	Yes
<b>Lack of affordable health care and preventive services</b> Cost of visits, routine check-ups, cost of seeing a primary care physician	Yes
<b>Lack of health care coverage</b> No health insurance	Yes
<b>Lack of dental care</b> Lack of dental care providers and dental coverage, costly to pay out-of-pocket	Yes
<b>Difficulty qualifying for Medi-Cal</b> Income qualification standards are too low; the process can be confusing and time consuming	No
<b>Transportation issues</b> Proximity to services is an with or without a car in the area, public transit is limited	Yes
<b>Lack of access to medications</b> Cost of prescriptions; need to see a physician before refills are approved	Yes
<b>Lack of culturally competent care</b> Understanding in how Latino communities view health and access health care	Yes
<b>Lack of nutrition and health food classes</b> Classes that discuss caloric intake, foods to eat or avoid based on chronic health diseases, diet for youth	Yes
<b>Lack of active living opportunities</b> Opportunities to exercise, soccer, football, volleyball field in parks, affordable youth sports programs	Yes

To identify Communities of Concern, input from the CHNA team and primary data from key informant interviews and focus groups, along with detailed analysis of secondary data, health outcome indicators, and socio-demographics were examined. ZIP codes with rates that consistently exceeded county, state, or Healthy People 2020 benchmarks for ED utilization, hospitalization, and mortality were considered. ZIP codes that consistently fell in the top 20% were noted and were then triangulated with primary and socio-demographic data to identify specific Communities of Concern.

Data on socio-demographics of residents living in these communities was examined and included socio-economic status, race and ethnicity, educational attainment, housing status, employment, and health insurance status. Area health needs were determined via in depth analysis of qualitative and quantitative data, and then confirmed with socio-demographic data. As noted earlier, a health need was defined as a poor health outcome and its associated driver. A health need was included as a priority if it was

represented by rates worse than the established quantitative benchmarks or was consistently mentioned in the qualitative data.

The health needs identified through analysis of both quantitative and qualitative data are listed below. All needs are noted as a “health driver,” or a condition or situation that contributed to a poor health outcome. Health outcome results follow the list below. Please see Appendix G for a complete list of the identified health needs within the Sutter Auburn Faith Hospital HSA.

## 2013 – 2015 Implementation Strategy

This implementation strategy describes how Sutter Auburn Faith Hospital plans to address significant health needs identified in its 2013 Community Health Needs Assessment and consistent with its 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.

## Lack of health care providers/access to primary care and physicians that take Medi-Cal & Lack of affordable health care and preventive services

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**Name of Program, Initiative or Activity**     **T3 Foothills (Triage, Transport and Treatment)**

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### **Description**

T3 (Triage, Transport and Treatment) connects patients to the services they need at the easiest level of care and right intensity of support. T3 provides services to patients who seek emergency department care for needs that are best addressed through preventive measures and by primary care providers. This program is a model for the kind of change being called for in various health care reform plans.

A huge obstacle for healthcare providers, including Sutter Auburn Faith Hospital, is the inappropriate use of the Emergency Department. This issue is not only problematic for the healthcare provider, but also for the patients who are not receiving the appropriate care in the appropriate place, at the appropriate time. Programs like T3 seek to connect people who frequently and inappropriately use the Emergency Department to the correct resources, including primary care, insurance, housing and mental health services, which is vital to the population who utilizes T3.

Moving these patients from the emergency department improves the patients' health by providing them with the appropriate care in the right setting, while reducing the wait for those seeking care for real medical emergencies, and dramatically reducing costs to our health care system

SAFH and SRMC partners with and provides funding to WellSpace Health, the greater Sacramento region's largest Federally Qualified Health Clinic, to offer this program to some of the most vulnerable patients in our service area.

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### **Anticipated Impact and Plan to Evaluate**

The T3 program has proven to be effective in improving access to care for uninsured, medically indigent people residing in the community. SAFH will continue to evaluate the impact of T3 quarterly, by tracking the number of people served, recidivism rates, number of linkages to other referrals/ services and other indicators, and by assessing the community's access to care needs in its next Community Health Needs Assessment.

**In addition to addressing the lack of access to primary and preventative services, the T3 program also expands access to mental health services, and addresses lack of access to medications, and lack of health insurance, among other things.**

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### **2014 Impact**

140 new patients were enrolled in T3 Foothills in 2014, with 138 active clients at the end of 2014. Patients showed an 88% reduction in

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inpatient stays post-T3 Foothills and a 38% reduction in non-urgent ED visits post-T3 Foothills. Between the Placer and Sacramento T3 programs, 12,411 referrals to various health and behavioral health appointments, housing, transportation and community resources were provided in 2014.

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**Mechanism(s) Used to Measure Impact**

We track and measure the outcomes of our T3 program very carefully. WellSpace tracks the number of patients served, intake and discharge data, number and type of referrals provided, programmatic successes and challenges, as well as various other pieces of information, which are reported on a quarterly basis. We also work with the Sutter finance department to look at patient level data, which shows the actual hospital usage of patients served through the T3 program including recidivism rates, ED visit levels, length of stay for inpatients and other hospital usage data. Our tracking and reporting continues to be an evolution, as we're always looking to improve the impact of our programming.

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**Community Benefit Contribution/Expense**

\$130,000

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**Program, Initiative, or Activity Refinement**

We meet and have constant communications with our community partners to examine everything from hospital data, program data, staff input and everything else related to the needs of our community and patients, as we are on a constant quest to improve, change and grow our programming as needed. We are currently in the process of closely examining many of our Community Benefit programs to look for areas of improvement to ultimately make program and process improvement recommendations to ensure these programs can be even more effective in 2015 and the years ahead.

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**Name of Program, Initiative or Activity**

**Interim Care Program (ICP)**

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**Description**

In partnership with the Gathering Inn, Kaiser Permanente, Sutter Roseville Medical Center and Sutter Auburn Faith Hospital provide the Interim Care Program (ICP), a temporary respite program for homeless patients who are discharged from one of the participating hospitals

When a patient is ready for appropriate discharge, but does not have a place to otherwise heal, they can be referred to the Interim Care Program. Upon discharge, the Gathering Inn provides on-site nursing and social services to support clients in their recuperation and help them move out of homelessness. A WellSpace case manager links clients with services, like mental health services, substance abuse recovery, housing workshops and provides disability application assistance. The Gathering Inn works with Advocates for Mentally Ill (AMI) to provide beds

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where clients have three meals a day and a safe, clean place to recover from their hospitalizations.

The program is designed to give patients without housing alternatives, a clean and safe place to heal for up to six weeks and comprehensive wrap around services like substance abuse treatment, permanent housing and medical care.

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**Anticipated Impact and Plan to Evaluate**

The ICP consistently demonstrated that they improve access to care for uninsured, medically indigent people residing in the community. SAFH will continue to evaluate the impact of these programs on a quarterly basis, by tracking the number of people served, number of linkages to other referrals/services and other indicators, and by assessing the community's access to care needs in its next Community Health Needs Assessment.

**In addition to addressing the lack of access to primary and preventative services, the ICP also expands access to mental health services, and addresses lack of access to medications, and lack of health insurance.**

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**2014 Impact**

The ICP served a total of 34 patients in 2014. Patients show a 67% reduction in inpatient stays and a 57% reduction in ED visits, post ICP. Total hospital bed days decreased by 83%, post ICP.

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**Mechanism(s) Used to Measure Impact**

We track and measure the outcomes of our ICP program very carefully. The Gathering Inn tracks the number of patients served, intake and discharge data, number and type of referrals provided, programmatic successes and challenges, as well as various other pieces of information, which are reported on a quarterly basis. We also work with the Sutter finance department to look at patient level data, which shows the actual hospital usage of patients served through the ICP program including recidivism rates, ED visit levels, length of stay for inpatients and other hospital usage data. Our tracking and reporting continues to be an evolution, as we're always looking to improve the impact of our programming.

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**Community Benefit Contribution/Expense**

\$50,000

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**Program, Initiative, or Activity Refinement**

We meet and have constant communications with our community partners to examine everything from hospital data, program data, staff input and everything else related to the needs of our community and patients, as we are on a constant quest to improve, change and grow our programming as needed.

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<b>Name of Program, Initiative or Activity</b>	<b>ED Navigator Program</b>
<b>Description</b>	<p>The highly successful ED Navigator program can be found in various SHSSR affiliates, including SSMC, SAFH and SMCS and we are in the process of implementing this same program at SAFH to meet the need of the growing number of people seeking care in the ED for primary care purposes.</p> <p>ED Navigators attend to patients in the Emergency Department (upon referral from a Sutter employee and after patient agreement) to provide assistance in identifying primary care providers and to determine other client needs. SHSSR affiliates provide funding to WellSpace to offer this important program to the underserved in our community.</p> <p>ED Navigator is an employee of WellSpace health and serves as a visible ED-based staff member who is able to provide referrals to treatment for those who are seeking care in the ED for non-urgent matters. The ED Navigator will connect with patients and provide referrals to primary care appointments, the T3 program for persons who are frequent non-urgent users, WellSpace and other clinics for those who need a medical home and other important community resources, such as insurance and housing. The ED Navigators are critical in directing those who need medical homes or access to services, to the right care in the right place at the right time.</p> <p>The ED Navigator program is another example of the collaborative and innovative relationship shared between SAFH and WellSpace Health; however, in Auburn, we plan to use Chapa De as the primary Health Center for referrals.</p>
<b>Anticipated Impact and Plan to Evaluate</b>	<p>The ED Navigator program has shown that it improves access to care for the underinsured, medically indigent people residing in the community. Once implemented, SAFH will evaluate the impact of ED Navigator quarterly, by tracking the number of people served, number of linkages to other referrals and services and other indicators, and by assessing the community's access to care needs in its next Community Health Needs Assessment.</p> <p><b>In addition to addressing the lack of access to primary and preventative services, the ED Navigator would also address lack of access to medications, and lack of health insurance.</b></p>
<b>2014 Impact</b>	<p>An ED Navigator program at SAFH was slated to begin in early 2015; however, implementation has been slower than anticipated and the program has not yet launched in Auburn.</p>
<b>Mechanism(s) Used to Measure Impact</b>	<p>N/A until program is implemented, hopefully in 2015.</p>

<b>Community Benefit Contribution/Expense</b>	N/A until program is implemented, hopefully in 2015.
<b>Program, Initiative, or Activity Refinement</b>	N/A until program is implemented, hopefully in 2015.
<b>Name of Program, Initiative or Activity</b>	<b>Free Mammography Screenings</b>
<b>Description</b>	<p>Working with Sutter Diagnostic Imaging Centers throughout the Sutter Health Sacramento Sierra Region, we offer the opportunity for uninsured women to receive free digital mammograms. In 2012, as a result of all of the collaborative events throughout the region, we were able to provide a total of 670 free and low-cost mammograms. At many of our mammography events, we have waiting lists and long lines, demonstrating that access to primary and preventative care continues to be a major issue in our region.</p> <p>Our goal is not only to screen uninsured women, but we also use these events as a connection point for the underserved members of our community, to link them with a primary care provider, follow up resources if needed, insurance enrollment information and other key services. We will have to examine the current model of this program in 2014, as under the Affordable Care Act, all women (with the exception of undocumented immigrants) will have insurance; therefore, we will reassess our process moving forward, as these events have typically targeted the uninsured only.</p> <p>New in 2013, we are integrating our ED Navigators into some of the screening events, as a pilot project, to provide onsite primary care referrals and other community resources to the women. Also, we integrated insurance enrollment specialists from Covered California to provide insurance education, outreach and enrollment to the women who need it most.</p>
<b>Anticipated Impact and Plan to Evaluate</b>	<p>SAFH will continue evaluate the impact of our Free Mammography screenings on an annual basis, by tracking the number of people served, number of linkages to other referrals and insurance enrollment, and by assessing the community's access to care needs in its next Community Health Needs Assessment. We will also reexamine this program with a critical eye in 2014, to ensure it evolves with the needs of the community after the implementation of the ACA.</p> <p><b>This program also addresses lack of health insurance.</b></p>

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**2014 Impact**

Throughout the month of October, Sutter Diagnostic Imaging centers across the region provided uninsured/underinsured women the opportunity to receive free digital mammograms. As a result of these collaborative events, we were able to screen more than 400 uninsured women.

In 2014, we had Insurance Enrollment Specialists from Covered California attend some of the screening events to educate, connect and enroll patients who need it, in health insurance. As a result, the Covered CA team made many great connections with hundreds of women and will be following up with many of the women to help enroll them in insurance. In addition, we are integrated our ED Navigators into some of the screening events, to provide onsite primary and mental health care referrals and other community resources to the women. Connecting the un- and underinsured population to insurance and a medical home is more critical than ever, as we adapt to the implementation of the Affordable Care Act.

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**Mechanism(s) Used to Measure Impact**

We track the number of women who attend the free mammo events and receive a screening.

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**Community Benefit Contribution/Expense**

In-kind donations are contributed to this effort, including staff time, cost of screening, non-profit organization participation and staff follow up time, if screening is abnormal" instead of a hard number.

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**Program, Initiative, or Activity Refinement**

A major program refinement in 2013 and 2014 was integrating the Insurance Enrollment specialists and the ED Navigators. We continue to look at the model of this program, as it was designed to meet the needs of the uninsured only. With the implementation of the ACA, we see the number of uninsured shrinking, which is making us reconsider the model of this effort, as we want to ensure that we're meeting the needs of as many underserved women as possible.

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**Name of Program, Initiative or Activity****Investment in Health Clinics**

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**Description**

As SAFH prepares for the implementation of the Affordable Care Act, we understand that nothing is more important than expanding access to care and building capacity for the underserved. Currently, limited access to care remains the top priority in the greater Sacramento region, and while SAFH funds and supports many initiatives and organizations that do amazing work in our community, the investments we provide to local Health Clinics to expand capacity remain paramount. In Auburn, SAFH has provided support to new health clinics like the Auburn Renewal Center and is looking for creative ways to partner with

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Chapa De. Chapa-De's services to include comprehensive primary medical care, dental and orthodontics, behavioral health and substance abuse counseling, nutrition and health education, women's health, pharmacy, and optometry.

By investing in vital health clinics like ARC and Chapa De, we are able to address multiple priority needs in effective and impactful ways.

**In addition to addressing the lack of access to primary and preventative services, investing in Health Clinics in the Auburn area also addresses lack of dental care and lack of access to medications.**

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**Anticipated Impact and Plan to Evaluate**

SAFH will evaluate the impact of ARC and Chapa De, by tracking the number of people served, number of linkages to other referrals and services and other indicators, and by assessing the community's access to care needs in its next Community Health Needs Assessment.

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**2014 Impact**

In 2014, with despite only seeing patients two days a week, the Auburn Renewal Center served 247 separate patients and provided more than 900 appointments. ARC provided primary care, behavioral health, optometry, chiropractic and counseling services/appointments, serving primarily homeless and undocumented clients.

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**Mechanism(s) Used to Measure Impact**

ARC staff tracks their number of appointments, types of services provided, successes and challenges and reports back on a quarterly basis.

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**Community Benefit Contribution/Expense**

\$12,500

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**Program, Initiative, or Activity Refinement**

We recently held a meeting with ARC and SAFH staff to discuss future partnership opportunities and ways we can strengthen the existing relationship between our organizations, and other community organizations, who can help tighten the continuum of care in the Auburn community.

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**Name of Program, Initiative or Activity**

**Senior Recreation and Respite Program**

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**Description**

Senior Recreation and Respite Program (R & R) connects the senior population in Placer County, who might otherwise be isolated, with important social and educational activities.

The Senior Recreation and Respite Program (R & R) is designed to meet

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the needs of older adults with memory or physical impairment. The program provides recreational, social and educational activities for the participants and respite for caregivers to enjoy some free time to themselves.

The staff is supported by its valuable team of volunteers and completed by personal care aides. R & R meets in various locations throughout Roseville, Auburn and Lincoln to reach the maximum amount of seniors in need. In 2010, the R&R program expanded and transportation is now offered through Health Express to ensure those who benefit the most from the program will continue to access.

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**Anticipated Impact and Plan to Evaluate**

R&R has proven successful at connecting what might be an otherwise isolated and disconnected segment of our population, to interaction, education and enrichment. SAFH will continue to evaluate the impact of R&R, by tracking the number of people served

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**2014 Impact**

In 2014, Recreation and Respite served an average of 30 to 40 people each day (split between two locations) 5 days a week.

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**Mechanism(s) Used to Measure Impact**

We track the number of clients who attend R&R each day.

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**Community Benefit Contribution/Expense**

\$92,365

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**Program, Initiative, or Activity Refinement**

We are in the process of transiting this program to become a partnership of Seniors First and Sutter Health, to reach more seniors in Placer County with this service.

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## Lack of culturally competent care

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### Name of Program, Initiative or Activity

### Promotoras

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### Description

The Promotora program is the result of a partnership between Sutter Auburn Faith Hospital, Sutter Roseville Medical Center and the Latino Leadership Council. As the bridge between the hospital and the patients, Promotoras serve the dual role of advocating for the patient while at the same time ensuring that the patient fully understands and complies with the health care provider's recommendations.

Promotoras help bridge the cultural and linguistic gap between the health care provider and the patient. As the bridge, they serve the dual role of advocating for the patient while at the same time ensuring that the patient fully understands and complies with the health care provider's recommendations. They ask the questions that the patients aren't aware they should be asking or are culturally dissuaded from asking, since it is culturally inappropriate to question authority figures such as physicians or nurses. Promotoras help ensure that patients truly understand what is at stake and what is being asked of them, and can provide follow up services to help ensure that patients receive the resources they need.

Sutter nurses and other medical staff are trained to provide Spanish speaking patients with information on the Promotora program, as well as provide referrals for patients who might benefit from making a connection of this nature. Promotoras are experts in the culture, language and community of Latino patients in that area as well as a connector to community resources and programs that can help patients continue their path to wellness. They also understand cultural nuances, particularly as they relate to health care. When a patient is in need of care, it is a time of crisis for them and those cultural nuances become very important. Promotoras are quickly becoming a much-needed resource and partner in our efforts to provide the best medical care possible to patients, as they help to extend a continuum of care beyond the four walls of the hospital.

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### Anticipated Impact and Plan to Evaluate

The Promotoras program continues to improve SAFH's cultural competence and provides a critical resource to many Spanish speaking patients. As a result, we continue to look for ways to expand our partnership with the Latino Leadership Council. SAFH will continue to evaluate the impact of this program on a quarterly basis, by tracking the number of people served, number of linkages to other referrals/services and other indicators, and by assessing SAFH's cultural competence in its next Community Health Needs Assessment.

In addition to addressing the lack of access to primary and preventative services, the Promotoras also expand access to mental health services, lack of access to dental, lack of coordination of care among providers and provide a linkage to primary care and preventative services.

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<b>2014 Impact</b>	In 2014, the Promotoras served 34 Spanish speaking patients with case management, by providing them with culturally sensitive care and connecting them to needed health and community resources. In addition, the LLC provided local health screenings that served nearly 300 Latinos in Placer County.
<b>Mechanism(s) Used to Measure Impact</b>	We track and measure the outcomes of our Promotoras program very carefully. The Latino Leadership Council tracks the number of patients served, intake and discharge data, number and type of referrals provided, programmatic successes and challenges, as well as various other pieces of information, which are reported on a quarterly basis. Our tracking and reporting continues to be an evolution, as we're always looking to improve the impact of our programming.
<b>Community Benefit Contribution/Expense</b>	\$50,000
<b>Program, Initiative, or Activity Refinement</b>	We meet and have constant communications with our community partners to examine everything from hospital data, program data, staff input and everything else related to the needs of our community and patients, as we are on a constant quest to improve, change and grow our programming as needed. We are currently in the process of looking at our partnership with the Latino Leadership Council and if there are other collaborative opportunities for expanded programming with this organization.

## Transportation

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### Name of Program, Initiative or Activity

**Health Express**

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### Description

Health Express seeks to provide transportation to and from medical appointments for Placer County's most vulnerable populations, including senior residents.

One of the key issues often identified during Community Health Needs Assessments are gaps in basic transportation services for seniors and the underserved population, who often site lack of transportation as a key barrier to accessing appropriate primary care and health-related appointments. Health Express seeks to bridge this gap, to ensure that the Placer County citizens who would otherwise not have access to transportation, necessary to obtain appropriate medical care.

SAFH provides funding to Health Express and partners with Seniors First, Placer County Transportation Planning Agency and Kaiser Permanente.

The Health Express partnership provides 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. This program is publicized throughout Placer County to encourage use.

In order to increase access to health care services for Placer County seniors, disabled, and underserved populations, the Health Express was expanded in 2007 to include a larger population and provide last resort medically related transportation services within most of Placer county.

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### Anticipated Impact and Plan to Evaluate

Health Express is an extremely successful partnership that continues to provide hundreds of rides per month, in turn, allowing Placer's most vulnerable citizens to access primary and preventative medical services. SAFH will continue to evaluate the impact of Health Express, by tracking the number of people served and the impact on lack of access to care, as identified by the CHNA.

**In addition to addressing transportation needs in Placer County, Health Express helps improve of access to primary and preventative services.**

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### 2014 Impact

Health Express provides more than 700 rides each month, for a total of approximately 9,000 rides in 2014.

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### Mechanism(s) Used to Measure Impact

Health Express tracks the number of clients it serves on a monthly and annual basis.

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<b>Community Benefit Contribution/Expense</b>	\$75,000
<b>Program, Initiative, or Activity Refinement</b>	At this point, no program improvements are underway, as this program is highly efficient and effective.
<b>Name of Program, Initiative or Activity</b>	Connectivity Study of Demand-Response and Supplemental Transportation Services to Improve Health Care Access across the SACOG Region
<b>Description</b>	<p>In this project, the Sacramento Area Council of Governments (SACOG) will undertake a study to address greater connectivity and seamlessness for demand-response transit and supplemental service users needing to make cross-jurisdictional trips, particularly for health care services. The project includes significant opportunities for community and stakeholder involvement in the planning process, and seeks especially to address transportation barriers in the Sacramento region for senior, disabled, low-income, youth, and minority residents to reach health-care related services.</p> <p>SACOG will lead this project, with significant participation and input from transit agencies, supplemental transportation providers, health care providers, and community stakeholders. SHSSR community benefit staff members have already begun discussions with SACOG staff and will play a role in the overall plan, to ensure transportation needs outlined in the CHNA are addressed.</p> <p>This project has 3 overall goals: first to complete a public involvement process, feasibility/financial analysis, and final study for the Sacramento Region providing recommendations and implementation steps to improve connectivity for residents needing to make cross-jurisdictional trips, particularly to reach health care. Second, to create engagement opportunities for stakeholders and the community to inform, review, and prioritize potential improvements, and support implementation of recommendations. And finally, to facilitate discussion and longer term relationships between health care providers and transportation providers to better link planning efforts and foster partnerships to improve transportation access to health care-related services.</p>
<b>Anticipated Impact and Plan to Evaluate</b>	While this project is just getting underway, SAFH will evaluate the progress and projected impact of this program as we move forward throughout the planning cycle.
<b>2014 Impact</b>	There is no impact to report because SAFH did not implement the program in 2014.
<b>Mechanism(s) Used to</b>	No mechanisms were used because SAFH did not implement the

<b>Measure Impact</b>	program in 2014.
<b>Community Benefit Contribution/Expense</b>	N/A
<b>Program, Initiative, or Activity Refinement</b>	At the time this implementation plan was created, this program was in early planning stages and still conceptual. Given the incredible need for expanded access to primary and behavioral health services, building capacity remained the top priority in the SAFH health service area.

## Lack of active living opportunities/ Lack of nutrition and health food classes

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**Name of Program, Initiative or Activity**      **Health Teacher**

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### Description

Health Teacher was originally developed in 1999 by health educators and health professionals with the goal of providing a comprehensive online resource that would make it easy to teach good health habits to children.

Today HealthTeacher is used in all 50 states and 14 foreign countries. In Placer County, SAFH provides funding to allow Health Teacher staff to work with various schools throughout the Placer County School Districts to share this curriculum with school nurses, physical education teachers, classroom teachers, community organizers and parents. Through SAFH's support of Health Teacher, we are able to provide this free of charge to all Placer county schools, K-12.

The goal of Health Teacher curriculum is to increase the health literacy of all teachers; enable teachers to overcome constraints that limit health education in the classroom; provide the knowledge, skills and tools that increase the health literacy of all students and engage parents and other key community stakeholders to reinforce healthy behaviors among children.

By spreading the lessons of Health Teacher to as many schools and school districts as possible, it is believed that we can drastically improve childhood health. By implementing smart nutrition, health and exercise lessons early, we can stop bad habits before they start and ensure that the children in Placer County stay healthy.

Given the dire state of our school budgets, many schools find themselves without a dedicated school nurse and/or physical education teacher, as well as many key programs and athletic programs focusing on nutrition, health education and physical activity which have been carved out of curriculum. Additionally, the SAFH CHNA cites the fact that the cost of participating in sports is too expensive for some parents, so providing a program of this nature in the schools is extremely important to the health and wellbeing of the many children it reaches.

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### Anticipated Impact and Plan to Evaluate

SAFH will continue to evaluate the impact of this program on a quarterly basis, by tracking the number of children served and other indicators, and by assessing healthy living and exercise in the SAFH HSA in its next Community Health Needs Assessment.

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### 2014 Impact

In 2014, we had 66 participating schools, more than 420 participating teachers and nearly 10,000 students reached.

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<b>Mechanism(s) Used to Measure Impact</b>	We track and measure the outcomes of our Health Teacher program very carefully. Health Teacher/Go Noodle tracks the number of schools, teachers and students that use the Go Noodle lessons, the number of active minutes, etc. Our tracking and reporting continues to be an evolution, as we're always looking to improve the impact of our programming.
<b>Community Benefit Contribution/Expense</b>	\$70,000
<b>Program, Initiative, or Activity Refinement</b>	Health Teacher changed to Go Noodle in 2014, which has proven to be very successful. Teachers and schools are more inclined to use the Go Noodle programs, as they are better designed to fit into a teacher's busy day and meet the needs of the kids in school, simply needing a quick physical and mental health break during a long day of studying.

## 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. This implementation strategy does not include specific plans to address the following significant health needs that were identified in the 2013 Community Health Needs Assessment:

Difficulty qualifying for Medi-Cal: While SAFH currently, and will continue, to provide resources to support insurance enrollment and help people connect to the right insurance resources, we don't have the ability to affect the income qualifications or the difficult application process.

## Approval by Governing Board

This implementation strategy was approved by the Governing Board of Sutter Auburn Faith Hospital on November 11, 2013.

## Appendix: 2014 Community Benefit Financials

Sutter Health hospitals and many other health care 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.

The community benefit values for Sutter Health Sacramento Sierra Region are calculated in two categories: **Services for the Poor and Underserved** and **Benefits for the Broader Community**.

Services for the poor and underserved include traditional charity care which covers health care 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. Services for the poor and underserved also include the cost of other services provided to persons who cannot afford health care because of inadequate resources and are uninsured or underinsured, and cash donations on behalf of the poor and needy.

Benefits for the broader community includes costs of providing the following services: health screenings and other non-related services, training health professionals, educating the community with various seminars and classes, the cost of performing medical research and the costs associated with providing free clinics and community services. Benefits for the broader community also include contributions Sutter Health makes to community agencies to fund charitable activities.

2014 Community Benefit Value	Sutter Health Sacramento Sierra Region
<b>Services for the Poor and Underserved</b>	\$172,994,189
<b>Benefits for the Broader Community</b>	\$7,016,259
<b>Total Quantifiable Community Benefit</b>	\$180,010,448

*This reflects the community benefit values for Sutter Health Sacramento Sierra Region (SHSSR), the legal entity that includes Sutter Auburn Faith Hospital, Sutter Amador Hospital, Sutter Davis Hospital, Sutter Medical Center, Sacramento, Sutter Roseville Medical Center and Sutter Solano Medical Center. For details regarding the community benefit values specifically for SAFH, please contact Kelly Brenk at (916) 541-0519 or BrenkKM@sutterhealth.org.*

**2014 Community Benefit Financials**  
**Sutter Health Sacramento Sierra Region**

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<b>Services for the Poor and Underserved</b>	
Traditional charity care	\$35,785,331
Unpaid costs of public programs:	
Medi-Cal	\$127,853,320
Other public programs	\$4,368,320
Other benefits	\$4,987,218
<b>Total services for the poor and underserved</b>	<b>\$172,994,189</b>

<b>Benefits for the Broader Community</b>	
Education and research	\$2,850,696
Cash and in-kind donations	\$3,793,322
Other community benefits	\$372,241
<b>Total benefits for the broader community</b>	<b>\$7,016,259</b>

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*This reflects the community benefit values for Sutter Health Sacramento Sierra Region (SHSSR), the legal entity that includes Sutter Auburn Faith Hospital, Sutter Amador Hospital, Sutter Davis Hospital, Sutter Medical Center, Sacramento, Sutter Roseville Medical Center and Sutter Solano Medical Center. For details regarding the community benefit values specifically for SAFH, please contact Kelly Brenk at (916) 541-0519 or BrenkKM@sutterhealth.org.*