

Sutter Health

Sutter Medical Center, Sacramento

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 Medical Center, Sacramento. 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 Medical Center, Sacramento, a Sutter Health affiliate, plans to address significant needs identified in the Community Health Needs Assessment (CHNA) published by the hospital on December 1, 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 Medical Center, Sacramento 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 Medical Center, Sacramento, please visit www.suttermedicalcenter.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. conducted an assessment of the health needs of residents living in the service area of Sutter Medical Center, Sacramento (SMCS). 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 clinical factor, as well as more upstream social economic factors, that impact health.”

The objective of the CHNA was to provide necessary information for the Sutter Medical Center, Sacramento’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 Medical Center, Sacramento is available at <http://www.sutterhealth.org/communitybenefit/community-needs-assessment.html>

Definition of Community Served by the Hospital

The assessment study area included the SMCS HSA. A key focus was to show specific communities (defined geographically) experiencing disparities as they related 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 data are 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.

The HSA was determined by analyzing patient discharge data from two of the three facilities that make up SMCS. Collection and analysis of the ZIP codes of patients discharged from the hospitals over a six-month period allowed the primary geographic area served by the hospitals to be identified. The HSA identified as the focus of the needs assessment is depicted in Figure 2 in the final CHNA. Because the hospitals represented in SMCS (Sutter General Hospital, Sutter Memorial Hospital, and Sutter Center for Psychiatry) are close in proximity, analysis revealed that the hospitals served the same geographic areas.

To identify Communities of Concern, input from the CHNA team, 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 code communities with rates that consistently exceeded county, state, or Healthy People 2020

benchmarks for ED utilization, hospitalization, and mortality were considered. ZIP codes with rates that consistently fell in the top 20% were noted and then triangulated with primary data input and socio-demographic data to identify specific Communities of Concern.

Data on socio-demographics of residents in these communities, which included socio-economic status, race and ethnicity, educational attainment, housing arrangement, employment status, and health insurance status, were examined. 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.

Figure 5 in the full report depicts the ZIP code boundaries for the Communities of Concern for the SMCS HSA. The Communities of Concern are home to more than 200,000 residents. The areas consist of ZIP code communities occupying the northern, downtown, and southern portions of the Sacramento County area. All of the ZIP code communities are densely populated, with the South Sacramento area having the highest population and the downtown area having the lowest population.

Socio-demographic conditions, or social determinants of health, help predict which communities in a broad geographic area are most susceptible to poor health outcomes. In general, the vast majority of residents living in the Communities of Concern fell into multiple categories of social determinants often associated with poor health outcomes. For example, all ZIP code communities far exceeded the national benchmarks for the percent of families in a living in poverty with children and single-female headed households with children living in poverty. All communities had high percentages of non-White or Hispanic residents, with 84% in 95823 and 83% in 95824 falling into this category. Further, all Communities of Concern had high percentages of residents without health insurance compared to state and national benchmarks.

Significant Health Needs Identified

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

| Significant Community Health Need | Intends to Address |
|---|--------------------|
| <p>Lack of access to primary and preventative services Lack of adequate County (Sacramento) safety net/health network for low income residents; Lack of chronic disease management programs; No appointments available in low cost/free clinics; Recent job losses resulting in loss of income and benefits; Navigating the complex system of social services; and Discrimination by physician towards low income/Medi-Cal insured populations</p> | Yes |
| <p>Lack of access to mental health services Inadequate mental health services; Stigmas in seeing mental health services; Difficulty navigating the system for public assistance to receive mental health services; Reduction in services offered by County and Finding private practice counselors that take Medi-Cal</p> | Yes |
| <p>Living in an unhealthy food environment Improper nutrition; Limited access to healthy foods; Difficulty in passing healthy nutrition policies; Children’s reliance on reduced price meals at school; Lack of food/nutrition education; Fewer stores carrying fresh foods in low income neighborhoods; Cost of healthier foods and Food insecurity</p> | No |
| <p>Perceived or real fear for personal safety Gang violence, Fear of walking on busy streets; and Fear of violence in public places, i.e., parks</p> | No |
| <p>Inability to exercise and be active Built environment impedes (limited sidewalks, dangerous streets, Fear for personal safety limits outdoor activities in high crime areas, Suburbs built for reliance on automobile, Costs of joining gym and Costs to participate in sports for kids is prohibitive)</p> | No |
| <p>Lack of access to dental care Limited access to dental care – all forms of oral health</p> | Yes |
| <p>Lack of access to specialty care Limited specialists that accept Medi-Cal patients</p> | Yes |
| <p>Lack of coordination of care among providers Lack of chronic disease management and care transition programs, Patient receiving care from multiple providers working independently of one another</p> | Yes |
| <p>Acculturation/limited cultural competence in health and related systems Lack of cultural competence among healthcare providers; Racism and related stress caused by; Over reliance on prescriptions by “western” doctors; and Suspicion of “western” medicine, reluctance to get vaccines, etc.</p> | No |
| <p>Lack of health literacy Not understanding the dangers of tobacco use; Cultural norms that support poor</p> | No |

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| health behaviors (tobacco) | |
| Lack of housing, basic shelter Housing instability and Fear of losing home | Yes |

Age-adjusted rates of ED visits and hospitalization due to heart disease, diabetes, stroke, and hypertension were notably higher in communities of concern when compared to others within the HSA. With a few exceptions, Blacks and Whites had the highest rates for these conditions compared to other racial and ethnic groups. Mortality data for these conditions showed high rates as well. Analysis of environmental indicators showed that many of these communities had barriers to active lifestyles, such as elevated crime rates and a traffic climate that is unfriendly to bicyclists and pedestrians. Furthermore, these communities frequently had higher percentages of residents that were obese or overweight. Access to healthy food outlets was limited, while the concentration of fast food outlets and convenience stores were high. Analysis of the health behaviors of these residents also showed many behaviors that correlate to poor health, such as having a diet that is limited in fruit and vegetable consumption.

When examining these findings with those of the qualitative data (key informant interview and focus groups), a consolidated list of priority health needs of these communities was compiled, listed above.

2013 – 2015 Implementation Strategy

This implementation strategy describes how Sutter Medical Center, Sacramento 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 Access to Primary and Preventative Services

Name of Program, Initiative or Activity

Interim Care Program (ICP) and ICP Plus

Description

The Interim Care Program (ICP) and ICP Plus helps Sutter Medical Center, Sacramento fulfill its mission to provide access to care for vulnerable and traditionally underserved residents. A collaborative of the four health care systems, community based organizations and the county government came together in Sacramento to create a respite care shelter for homeless patients discharged from hospitals, establishing an 18-bed shelter for homeless men and women to recuperate from medical conditions. Started in 2004, the Interim Care Program links people in need to vital community services while giving them a place to heal. The clients who are enrolled in the ICP are homeless adult individuals who otherwise would be discharged to the street or cared for in an inpatient setting only. The program is designed to offer clients up to six weeks during which they can focus on recovery and developing a plan for their housing and care upon discharge. This innovative community partnership provides temporary respite housing in Sacramento that offer homeless men and women a place to recuperate from their medical conditions, link them to vital community services, and provide them a place to heal. ICP Plus is a program designed for homeless patients discharging from SMCS, and is an enhanced version of the ICP, with patients needing a greater level of support and special resources.

SMCS and the other health systems provide financial support for this program. WellSpace Health, Sacramento's Federally Qualified Health Center, provides on-site nursing and social services to support clients in their recuperation and help them move out of homelessness. The WellSpace case manager links clients with mental health services, substance abuse recovery, housing workshops and provides disability application assistance. The Salvation Army provides 18 beds in a designated wing of the shelter where clients have three meals a day and a safe, clean place to recover from their hospitalizations.

Anticipated Impact and Plan to Evaluate

ICP and ICP+ have consistently demonstrated that they improve access to care for uninsured, medically indigent people residing in the community. SMCS 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 and ICP+ also tackle lack of access to mental health services, lack of coordination of care among providers and lack of housing/basic shelter.

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| 2014 Impact | <p>In 2014: 31 Sutter Patients Served 141 Patients Served Overall Average length of stay in the program was 21 days ICP patients showed a 64% reduction in inpatient stays, post-ICP and an 80% reduction in inpatient bed days post-ICP ICP patients showed a 62% reduction in ED usage post-ICP & a 75% reduction in non-urgent visits to ED ICP patients showed a 63% reduction in overall hospital usage post-ICP</p> <p>The ICP+ program has been discontinued.</p> |
| Mechanism(s) Used to Measure Impact | <p>We track and measure the outcomes of our ICP 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 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.</p> |
| Community Benefit Contribution/Expense | \$79,117.58 |
| Program, Initiative, or Activity Refinement | <p>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.</p> |
| Name of Program, Initiative or Activity | Triage, Transport and Treat |
| Description | <p>Sutter Medical Center, Sacramento is a founding partner of T3, a program launched in 2006 that 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 Medical Center, Sacramento, 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</p> |

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 housing and mental health services, which is key 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.

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

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. SMCS 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 addresses lack of access to mental health services, lack of coordination of care among providers and lack of housing/basic shelter.

2014 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.

Mechanism(s) Used to Measure Impact

Numbers of T3 patients enrolled in 2014: 155 new patients were enrolled in T3 Sacramento, with 206 active clients at the end of 2014. Patients showed a 38% reduction in inpatient visits post-T3 and a 43% in hospital bed days post-T3. Between the SRMC and SMCS T3 program 12,411 referrals were provided to patients. Patients showed a 49% reduction in overall ED useage, post-T3.

Community Benefit Contribution/Expense

\$ 876,000

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.

Name of Program, Initiative or Activity

ED Navigator Program

Description

ED Navigators attend to patients in the Emergency Department (upon referral from a SMCS employee and after patient agreement) to provide assistance in identifying primary care providers and to determine other client needs. SMCS provides funding to WellSpace to offer this important program to the underserved in our community.

The 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.

The ED Navigator program is another example of the collaborative and innovative relationship shared between SMCS and WellSpace Health.

Anticipated Impact and Plan to Evaluate

The ED Navigator program has shown that it improves access to care for the underinsured, medically indigent people residing in the community. SMCS will continue 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.

In addition to addressing the lack of access to primary and preventative services, the ED Navigator program also tackles lack of access to mental health services, lack of coordination of care among providers and lack of housing/basic shelter.

2014 Impact

In 2014, SMCS Navigators connected with 337 patients, providing all of

them with various health and community related services. Between the SRMC and SMCS ED Navigators, 651 patients were assisted in 2014, with 3,828 referrals provided.

Mechanism(s) Used to Measure Impact

We track and measure the outcomes of our ED Navigator program very carefully. WellSpace tracks the number of patients served, 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.

Community Benefit Contribution/Expense

\$192,000 for SRMC and SSMC ED Navigator programs.

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.

Name of Program, Initiative or Activity

Free Mammography Screenings

Description

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.

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.

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.

Anticipated Impact and Plan to Evaluate

SMCS 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.

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.

Mechanism(s) Used to Measure Impact

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

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.

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 | Inpatient Navigation/T3+ |
| Description | <p>In conjunction with WellSpace Health, SMCS is examining the possibility of implementing an inpatient navigation program. The vision for this service is where ED Navigators, T3 and the Interim Care Program intersect. We are referring to this program as T3+, as patients would receive case management services like in the regular T3 program, but for more intensive issues and needs.</p> <p>We continue to see patients stay in the hospital longer than necessary, due to health, substance, mental health and other issues. This service will help connect with patients who would be better served if they had a safe place to go, or follow up case management upon discharge.</p> <p>Using FQHC staff as navigators/T3+ case managers within the walls of our hospitals, we can integrate our case management with theirs and ensure seamless transition for patients who need to be discharged to another care environment.</p> <p>These T3+ navigators would follow the patients after discharge and work with staff to provide a follow-up health plan, tele-health, pain management, etc. All of this is while the T3+ navigators ensure the success of the patient's other needs (e.g. housing, insurance enrollment, etc.) and ensure preventive future care.</p> <p>In addition to addressing the lack of access to primary and preventative services, the T3+ program would also tackle lack of access to mental health services and lack of housing/basic shelter.</p> |
| Anticipated Impact and Plan to Evaluate | <p>As with our other Community Benefit programming, we would track not only how many patients the inpatient navigator connected with, but also how many patients are touched by the T3+ program, how many are connected to insurance enrollment services, a medical home and income, reduced recidivism rates and other critical resources.</p> |
| 2014 Impact | <p>T3+ served 27 patients in 2014 and provided 421 referrals to health and community resources, for an average of 16 referrals per patient. Patients showed a 23% reduction in inpatient visits post-T3+ and a 28% decrease in hospital bed days.</p> |
| Mechanism(s) Used to Measure Impact | <p>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.</p> |

| | |
|--|---|
| Community Benefit Contribution/Expense | \$126,000 |
| 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. |
| Name of Program, Initiative or Activity | Investment in WellSpace Health |
| Description | <p>As we prepare 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 Sacramento region, and while SMCS funds and supports many initiatives and organizations that do amazing work in our community, the investments we provide to WellSpace to expand capacity remain paramount.</p> <p>SMCS has been a longtime partner with WellSpace Health and will continue to make strategic investments and provide support to this critically important network, as WellSpace expands throughout the greater Sacramento Region.</p> <p>WellSpace provides care to some of the most vulnerable populations in our region. By continuing to invest in this important health center, we are ensuring the underserved have access to care and a medical home. Established in 1953, WellSpace is a Federally Qualified Health Center (FQHC) offering primary care, pediatric dental care and specialty and integrated behavioral health services. The Sacramento-based non-profit has earned a strong reputation locally that has been built on providing quality, innovative, reliable and affordable healthcare.</p> <p>WellSpace has six full service health centers in Oak Park, North Highlands, midtown Sacramento, Roseville, South Sacramento and now Rancho Cordova, 8 part-time satellites and three pending full scope health centers. WellSpace also operates a wide array of prevention and intervention programs throughout the region.</p> <p>WellSpace Health is also a leader in integrated care, blending physical health services with addiction and mental health treatment, and has a “No Wrong Door” belief. This means that each service site seeks to connect community members to everything WellSpace Health has to offer.</p> <p>WellSpace offers the following services to the underserved population in the greater Sacramento region: Adult & Geriatric, Pediatrics, Dental Care, Women’s Health, Birth and Family Health, Prenatal Care,</p> |

Immunizations, Mental Health & Counseling, Suicide Prevention, Child Abuse Prevention, Psychiatry, Addictions Counseling and serves as a partner to all of the health systems in our region, as well as many non-profit and community based organizations. By investing in WellSpace and supporting this tremendous organization's growth and innovative efforts, 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, WellSpace Health also tackles lack of access to mental health services, lack of access to dental care and lack of access to specialty care.

Anticipated Impact and Plan to Evaluate

We work closely with the staff and leadership of WellSpace to measure the impact of this important FQHC's work. The WellSpace programs and expansion efforts have proven to expand access to care for the underinsured, medically indigent people residing in the greater Sacramento community. SMCS will continue evaluate the impact of WellSpace, 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.

2014 Impact

WellSpace Health saw about 32,000 patients in 2014, with nearly 7,500 of those visits at the Roseville Health Clinic located at MOB 5. This is approximately an 84% increase in patients served at WellSpace Health clinics since 2011.

Mechanism(s) Used to Measure Impact

WellSpace tracks the number of patients making appointments at their facilities, as well as using the Open Access hours and report this information to Sutter Health.

Community Benefit Contribution/Expense

\$150,000

Program, Initiative, or Activity Refinement

The \$150,000 helped implement Open Access hours at the Midtown and Roseville WellSpace Health locations. This innovation allows patients to walk into these Health Clinic locations for primary care needs, without an appointment, Monday through Friday, from 8:00 am – 3:00 pm. The Open Access hours have been an incredible tool in increasing access to care for the underserved by allowing WellSpace to see hundreds more patients each year.

Name of Program, Initiative or Activity

Healthy Access

Description

Healthy Access is a grassroots, community engagement effort intended to influence individual behaviors to ensure people have better access to primary care services.

We've been actively working to identify and engage community members and organizations that fit the general profile of non-urgent ED users. Engagement has focused on two general populations moving forward: The Faith and Community Based Organizations (FCBO's) serving the individual profile we seek to engage. Organizations agreed to participate by providing access to their stakeholders and collecting data from them to inform our education and outreach.

Healthy Access, a program supported by funding from SMCS, has connected with various Faith and Community Based Organizations and associations to help increase and strengthen their outreach the greater community around health care related issues. This linkage allows us to utilize our community partners to encourage and direct their patients to appropriate clinics, such as WellSpace and Elica Health Center, for primary care needs, rather than local Emergency Departments. In 2013, Healthy Access focused on supporting health ministries in local African American churches. At St. John Missionary Baptist Church, Healthy Access provided support to their food pantry where they serve about 200 people each week. Information was also provided about healthy eating, exercise, diabetic screenings and referrals to local health clinics. Also, needed resources were identified and shared with their clients. The Northern District Baptist Association disseminated information among their 26 Sacramento County congregations in support of health ministries or, where they didn't exist, their women's, young men's and youth programs. T

The primary target audience has been adults and seniors, promoting health coverage, access to primary care available to them vs emergency department visits and healthier lifestyle activities such as food choices, exercise and health screenings. Healthy Access also held a large Health Fair with a "Back to School" theme, aimed to support school readiness for children grades K-12. Nearly 40 different community resources were on site, including free dental screenings, counseling, primary care connections, suicide prevention, CalFresh information, a food bank, job development, support services and fun events for kids, like bike giveaways.

In addition to addressing the lack of access to primary and preventative services, Healthy Access also tackles access to mental health, access to dental and improved health literacy.

Anticipated Impact and Plan to Evaluate

Work is now underway, focused on linking the health fair resources with the residents at the three largest public housing sites for more consistent, ongoing access to assistance. From support groups to CalFresh and Covered CA enrollment assistance, Healthy Access will continue to measure effectiveness and impact, by tracking how many people in need are connected with and helped through this program

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| | throughout 2014. |
| 2014 Impact | This program was discontinued in 2014. No outcomes to report. |
| Mechanism(s) Used to Measure Impact | N/A, as this program was discontinued in 2014. |
| Community Benefit Contribution/Expense | N/A, as this program was discontinued in 2014. |
| Program, Initiative, or Activity Refinement | N/A, as this program was discontinued in 2014. |
| Name of Program, Initiative or Activity | Connectivity Study of Demand-Response and Supplemental Transportation Services to Improve Health Care Access across the SACOG Region |
| Description | <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. By expanding transportation services to the underserved population, we can break down one of the major impediments to people seeking preventative and primary care – lack of transportation. As a result, this 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</p> |

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.

Anticipated Impact and Plan to Evaluate

While this project is just getting underway, SMCS will evaluate the progress and projected impact of this program as we move forward throughout the planning cycle.

2014 Impact

While this project is just getting underway, SMCS will evaluate the progress and projected impact of this program as we move forward throughout the planning cycle.

Mechanism(s) Used to Measure Impact

There is no impact to report because SMCS did not implement the program in 2014.

Community Benefit Contribution/Expense

No mechanisms were used because SMCS did not implement the program in 2014.

Program, Initiative, or Activity Refinement

N/A

Lack of Access to Specialty Care

Name of Program, Initiative or Activity **SMCS and SPIRIT**

Description

In 1994 a collaborative between Mercy Healthcare of Sacramento, Sutter Community Hospitals of Sacramento, UC Davis School of Medicine, Kaiser Permanente Medical Group, The Sacramento County Department of Health and Human Services and the Sierra Sacramento Valley Medical Society is established to increase and enhance physician response to the medical needs of the targeted population through volunteerism. The collaborators name the project the Sacramento Physicians' Initiative to Reach out, Innovate and Teach (SPIRIT). SPIRIT currently provides donated services to over 1,400 patients per year, including 60+ free outpatient surgeries. To date SPIRIT volunteers have donated \$8.4 million in care to nearly 40,000 patients. SPIRIT, the organization that provides all of the case management services, works closely with SMCS and the Sutter Ambulatory Surgery Centers to provide charity surgical and specialty care at Sutter affiliated Ambulatory Surgery Centers for eligible, low-income patients. Referrals are generated by a local federally qualified health centers (FQHC) and by participating surgeons. Eligible patients have no insurance, below 250% of the Federal Poverty Level, and can be treated as a surgical outpatient. Some of the surgeries provided are cataract, other ophthalmologic surgeries, OB-GYN, ENT, orthopedics and general Surgery. As we approach implementation of the ACA we strive to provide access for those patients who fall through the cracks of our healthcare system. The lack of access to healthcare often results in frequent and costly visits to the emergency department, as well as these patients not being able to be productive members of our communities.

Anticipated Impact and Plan to Evaluate

Sutter and SPIRIT meet on a monthly basis to discuss needed surgeries and on a quarterly basis, review number of surgeries provided, success stories, etc. This service we provide gives the uninsured the opportunity to receive surgeries they couldn't otherwise pay for. SMCS will continue evaluate the impact of WellSpace, 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.

2014 Impact

Sutter ASCs donated 22 surgeries, 55 hours of doctor's time and nearly \$70,000 worth of surgery.

Mechanism(s) Used to Measure Impact

The Sacramento Valley Medical Society manages this program and tracks the number of patients, surgeries, surgery types and any other pertinent details of this program, and reports to the SPIRIT partners on a quarterly basis.

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| Community Benefit Contribution/Expense | \$15,000 |
| Program, Initiative, or Activity Refinement | We meet with the SPIRIT partners on a quarterly basis to discuss program improvements, as well as internally on a monthly call with the SVMS and Sutter staff. This monthly call has helped us work through any wait list issues, need for new surgeons, etc and has overall made the Sutter/SPIRIT partnership even stronger. |
| Name of Program, Initiative or Activity | Philanthropic Plan for Specialty Care |
| Description | <p>Our Philanthropic Foundation and our Community Benefits Department have worked to develop like-minded strategies that capitalize on individual and collaborative goals and in response, have developed a plan that establishes a case for support around specialty care services for our underinsured (County, Medi-Cal and uninsured) populations, ensuring that our fundraising efforts build upon SHSSR's current community benefit strategies that focus on increasing access to care. Historically, we have great relationships with Federally Qualified Health Centers (FQHC) and community partners that increase access to care and in this plan, we greatly expand partnerships that have proven successful.</p> <p>Specialty care continues to be an overwhelming need for our underinsured. Not only do we see this as a priority in 2013, but our 2010 CHNA cited the number two reason the underserved populations cited as a challenge for maintaining or improving health was 'the lack of access to physicians, specialists, dentists, mental/behavioral health, and other providers who accept Medi-Cal and/or work at reduced rates.' When interviewed, the four County (Sacramento, Placer, Yolo and El Dorado) Public Health Officers' cited ' increased access to specialized care, increased access to dental care and increased medical care overall with more residents relying on county care due to the economic downturn' as the biggest primary needs.</p> <p>This clear need for increased specialty care invited more research and based on our Emergency Department data and the information received from our FQHC and other community partners, orthopedic need is the greatest, as the data clearly shows a significant increase in Orthopedic visits SHSSR-wide.</p> <p>By investing in the specialty services our skilled physicians offer, we can provide seed funding for orthopedic services and offer Sutter physicians the chance to close this gap and serve those with no options for care. With seed funding, an FQHC partner could afford to employ physicians during the time they spend in the clinic. This seed funding would cease in three years, when the FQHC partner could bill at the federal Medi-Cal</p> |

rate and sustain this specialty physician employment. Ultimately, this strengthens our FQHC partners while serving some of our community's neediest patients. By negotiating a contract with one or two SMG orthopedic surgeons and an FQHC partner like WellSpace Health, we can offer our physicians the opportunity to continue to support our not-for-profit mission and receive reimbursement for the services provided. More importantly, SHSSR will be serving the underinsured residents of our communities with the right care, in the right place at the right time.

Anticipated Impact and Plan to Evaluate

This plan is largely conceptual and the details are currently being worked through. As this philanthropic strategy firms up and is implemented, SMCS will undoubtedly track the number of patients served and the overall impact of the program, as well as the community's access to specialty care in its next Community Health Needs Assessment.

2014 Impact

This plan is still being developed and has not yet been implemented, so we have no outcomes to report at this time.

Mechanism(s) Used to Measure Impact

N/A, as this plan is still being developed and has not yet been implemented.

Community Benefit Contribution/Expense

N/A, as this plan is still being developed and has not yet been implemented.

Program, Initiative, or Activity Refinement

N/A, as this plan is still being developed and has not yet been implemented.

Lack of Housing/Basic Shelter

Name of Program, Initiative or Activity

Serial Inebriate Program (SIP)

Description

The Serial Inebriate Program (SIP) is a result of a partnership between Sutter Medical Center, Sacramento and the Downtown Sacramento Partnership (DSP) Navigators. Using a model with great success, the DSP Navigators reach out and build a one-on-one rapport with homeless adults living on downtown streets. The Navigators gradually develop relationships and eventually connect individuals with local community service programs. The Navigators don't move on at that point; they continue working closely with each individual, facilitating access to care and finding ways to improve their living conditions. Another SIP partner is the Sacramento district attorney's office and the downtown community prosecutor, which both work with SIP patients and homeless adults who have been arrested repeatedly for public intoxication.

Though other cities are beginning to offer similar programs, the Sacramento programs offer a unique twist. The SIP unites downtown and midtown Sacramento businesses, nonprofit organizations, government, enforcement agencies and Sutter Medical Center, Sacramento in a truly collaborative effort.

For many years, homelessness seemed to be an eternal, incurable epidemic. In recent years, however, the connection between homeless and hopeless has begun to give way. The shift has come about through an innovative idea that is appearing in a growing number of cities, including Sacramento. The approach offers chronically homeless adults an important ingredient missing in past programs—the opportunity to move into permanent housing and medical homes.

To qualify, individuals have been arrested, taken to detox centers or emergency departments more than 25 times in a 12-month period. The program consists of a partnership between Sutter Medical Center, Sacramento, Sacramento's Navigator program (sponsored by the Downtown Partnership, an organization that supports the business community), and Sacramento Self Help Housing.

The goal of the SIP is to move homeless men and women off the streets, and connect them with the medical services and housing resources they wouldn't otherwise have access to. The SIP program provides early intervention and a lasting solution, by linking the homeless to housing, primary care, substance abuse resources and mental health services. Instead of relying on police or other non-profit agencies that work to alleviate homelessness and the problems associated with it, the SIP is a partnership that helps break the cycle and help these men and women move off the streets and on with their lives.

In addition to addressing the lack of housing/basic shelter, the SIP provides access to primary and preventative services, lack of access to mental health services, lack of access to dental care and lack of health literacy by teaching the SIP clients how to cook, about nutrition, going to doctors appointments and living an overall healthier life.

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| Anticipated Impact and Plan to Evaluate | SMCS recently won the Jackson Health Care Award (a National Award) for the innovative Serial Inebriate Program. Despite this recent success, we continually evaluate the effectiveness of this program, by examining number of people served, number of people connected with long term housing and other indicators. |
| 2014 Impact | In 2014, our program helped 18 people get off the streets, improve their health and benefit from the stability of living in their own home. |
| Mechanism(s) Used to Measure Impact | DSP staff tracks the number of patients successfully served by the SIP program each year, as well as information about these patient's connection to housing, alcohol and drug treatment and other community and health resources. |
| Community Benefit Contribution/Expense | \$50,000 |
| Program, Initiative, or Activity Refinement | SIP is a nationally recognized program for its impact and effectiveness; therefore, we have no program improvements in process at this time. |

Needs Sutter Medical Center, Sacramento Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Medical Center, Sacramento 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:

Living in an unhealthy food environment: Not only is there a lack of effective interventions to address this need, this is not something that we are able to greatly affect through community benefit; therefore, we are focusing our resources elsewhere.

Perceived or real fear for personal safety: This is primarily a law enforcement issue and not something that SMCS has the expertise to effectively address.

Inability to exercise and be active: Exercise is very important; however surrounding health systems like Kaiser put great emphasis on exercise through their “Thrive” campaign and organizations like SPIRIT, who host the “Walk with a Doc” events, which allows us to dedicate our resources to meeting other needs outlined in the CHNA.

Acculturation/limited cultural competence in health and related systems: While we work hard to partner with culturally sensitive/competent staff members and attempt to meet the needs of diverse groups through our sponsorship and community investment award funding, this is not a key priority as this time, as the need is not as pressing as other problems.

Lack of health literacy: While this is important and we scratch the surface of this issue through the Healthy Access program, this need is not as our primary focus, which is expanding access to care and building the capacity we so desperately need in the Sacramento Region.

Approval by Governing Board

This implementation strategy was approved by the Governing Board of Sutter Medical Center, Sacramento 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 |
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| Services for the Poor and Underserved | \$172,994,189 |
| Benefits for the Broader Community | \$7,016,259 |
| Total Quantifiable Community Benefit | \$180,010,448 |

This reflects the community benefit values for Sutter Health Sacramento Sierra Region (SHSSR), the legal entity that includes Sutter Medical Center, Sacramento, Sutter Amador Hospital, Sutter Auburn Faith Hospital, Sutter Davis Hospital, Sutter Roseville Medical Center and Sutter Solano Medical Center. For details regarding the community benefit values specifically for SMC Sacramento, 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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| Services for the Poor and Underserved | |
| 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 |
| Total services for the poor and underserved | \$172,994,189 |
| Benefits for the Broader Community | |
| Education and research | \$2,850,696 |
| Cash and in-kind donations | \$3,793,322 |
| Other community benefits | \$372,241 |
| Total benefits for the broader community | \$7,016,259 |

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