

Sutter Health

Sutter Roseville Medical Center

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 Roseville Medical Center. 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 Roseville Medical Center, 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 Roseville Medical Center 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 Roseville Medical Center, please visit www.sutterroseville.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 Roseville Medical Center (SRMC) 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 SRMC’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 Roseville Medical Center is available at <http://www.sutterhealth.org/communitybenefit/community-needs-assessment.html>

Definition of Community Served by the Hospital

The HSA was determined by analyzing patient discharge data. Collecting and analyzing the ZIP codes of patients discharged from the hospital over a six-month period allowed the primary geographic area served by the hospital to be identified. The HSA determined to be the focus of the needs assessment is depicted in Figure 2 in the full report.

The first step in identifying vulnerable communities was to examine socio-demographics in order to identify areas of the HSA with high vulnerability to chronic disease disparities and poor mental health outcomes. Race/ethnicity, household make-up, income, and age variables were combined into a vulnerability index that described the level of vulnerability of each census tract. This index was then mapped for the entire HSA. A tract was considered more vulnerable, or more likely to have higher unwanted health outcomes than others in the HSA, if it had higher: 1) percent non-White or Hispanic population; 2) percent single parent headed households; 3) percent below 125% of the poverty level; 4) percent under five years old; and 5) percent 65 years of age or older living in the census tract. This information was used in combination with input from the CHNA workgroup to identify prioritized areas for which key informants would be sought.

To identify Communities of Concern, input from the CHNA team, primary data from key informant interviews and focus groups, and 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 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.

The SRMC Communities of Concern are home to more than 220,000

Sacramento County residents. The areas consist of ZIP codes all in the northeastern part of the Sacramento Metropolitan area, except the ZIP code 95670 (Rancho Cordova), which is located along the Highway 50 corridor in eastern Sacramento County. Several ZIP codes sit along the Interstate 80 corridor and all ZIP code Communities of Concern are contiguous, except 95670 (Rancho Cordova). All Communities of Concern are urban areas of relatively high population density.

Many communities exceeded state and national benchmarks for a number of socio-demographic conditions, with 95660 (North Highlands) leading in almost all categories. Other notable population characteristics included unemployment and uninsured rates that exceeded both national and state benchmarks in all Communities of Concern. Nearly three of every 10 residents in ZIP code 95821 (north Watt area) were uninsured, a rate that was almost double the national benchmark. Further, in 95660 (North Highlands) over four of every 10 single female headed-households lived in poverty, a strong predictor of poor health outcomes for this vulnerable population.

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; 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 Sacramento County; 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</p>	No

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	
Lack of access to dental care Limited dental care	Yes
Lack of access to specialty care Limited specialists that accept Medi-Cal patients	Yes
Lack of coordination of care among providers Lack of chronic disease management and care transition programs; and Patient receiving care from multiple providers working independently of one another	Yes
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.	Yes
Lack of health literacy Not understanding the dangers of tobacco use; Cultural norms that support poor health behaviors (tobacco)	No

To identify Communities of Concern, input from the CHNA team, primary data from key informant interviews and focus groups, and 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 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. This analytical framework is depicted in Figure 4 in the full report.

Data on socio-demographics of residents living in these communities, which included socio-economic status, race and ethnicity, educational attainment, housing status, employment status, and health insurance status, were examined. Area health needs were determined via in depth analysis of qualitative and quantitative data, and were 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 clearly above the established benchmarks in the quantitative data or was consistently mentioned in the qualitative data.

The priority health needs identified through analysis of both quantitative and qualitative data are listed below. A detailed listing of each need, its associated drivers, resulting health outcomes, and supporting data sources can be found in Appendix G. All needs are noted as a “health driver,” or a condition or situation that contributed to a poor health outcome.

2013 – 2015 Implementation Strategy

This implementation strategy describes how Sutter Roseville Medical Center 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

T3 Foothills (Triage, Transport and Treatment)

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 Roseville Medical Center, 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 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

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.

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. SRMC 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 and lack of coordination of care among providers.

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 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.

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.

Community Benefit Contribution/Expense

\$130,000

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

Interim Care Program (ICP)

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 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.

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. SRMC 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 tackle lack of access to mental health services and lack of coordination of care among providers.

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.

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.

Community Benefit Contribution/Expense

\$50,000

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.

Name of Program, Initiative or Activity

ED Navigator Program

Description	<p>ED Navigators attend to patients in the Emergency Department (upon referral from a SRMC employee and after patient agreement) to provide assistance in identifying primary care providers and to determine other client needs. SRMC provides funding to WellSpace to offer this important program to the underserved in our community.</p> <p>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.</p> <p>The ED Navigator program is another example of the collaborative and innovative relationship shared between SRMC and WellSpace Health.</p>
Anticipated Impact and Plan to Evaluate	<p>The ED Navigator program has shown that it improves access to care for the underinsured, medically indigent people residing in the community. SRMC 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.</p> <p>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 and lack of coordination of care among providers.</p>
2014 Impact	<p>In 2014, SRMC Navigators connected with 314 patients. Between the SRMC and SMCS ED Navigator programs, ED Navigators provided 3,828 health and community related referrals to the underserved population.</p>
Mechanism(s) Used to Measure Impact	<p>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.</p>
Community Benefit Contribution/Expense	<p>\$192,000 for SRMC and SSMC ED Navigator programs.</p>
Program, Initiative, or	<p>We meet and have constant communications with our community</p>

Activity Refinement

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

Health Express

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.

SRMC 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.

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. SRMC 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.

2014 Impact

Health Express provides more than 700 rides each month, for a total of

approximately 9,000 rides in 2014.

Mechanism(s) Used to Measure Impact

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

Community Benefit Contribution/Expense

\$75,000

Program, Initiative, or Activity Refinement

At this point, no program improvements are underway, as this program is highly efficient and effective.

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

SRMC 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.

Name of Program, Initiative or Activity

Investment in WellSpace Health

Description

As SRMC 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 Sacramento region, and while SRMC 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. SRMC 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.

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.

Thanks to strategic investments made by SRMC, WellSpace Health was able to open a satellite clinic on the campus of Sutter Roseville Medical Center, further strengthening the referral network between SRMC and providing a medical home for many of the patients referred from our various community benefit programming to primary and mental health services.

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.

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.

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, 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 Roseville/Placer community. SRMC 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	Senior Recreation and Respite Program
Description	<p>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.</p> <p>The Senior Recreation and Respite Program (R & R) is designed to meet 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.</p> <p>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.</p>
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. SRMC will continue to evaluate the impact of R&R, by tracking the number of people served.

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.
Mechanism(s) Used to Measure Impact	We track the number of clients who attend R&R each day.
Community Benefit Contribution/Expense	\$92,365
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.

Acculturation/limited cultural competence in health and related systems

Name of Program, Initiative or Activity **Promotoras**

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.

Anticipated Impact and Plan to Evaluate

The Promotoras program continues to improve SRMC'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. SRMC 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 SRMC'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 tackle lack of 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.

2014 Impact

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.

Mechanism(s) Used to Measure Impact

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.

Community Benefit Contribution/Expense

\$50,000

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 looking at our partnership with the Latino Leadership Council and if there are other collaborative opportunities for expanded programming with this organization.

Inability to exercise and be active

Name of Program, Initiative or Activity

Health Teacher

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, SRMC 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 SRMC'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 SRMC 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.

Anticipated Impact and Plan to Evaluate

SRMC 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 SRMC HSA in its next Community Health Needs Assessment.

2014 Impact

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

Mechanism(s) Used to Measure Impact

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.

**Community Benefit
Contribution/Expense**

\$70,000

**Program, Initiative, or
Activity Refinement**

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 Roseville Medical Center Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Roseville Medical Center 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 SRMC has the expertise to effectively address.

Lack of health literacy: While this is important, this need is not as our primary focus, which is expanding access to care and building the capacity we so desperately need in the Placer County and the Greater Sacramento Region.

Approval by Governing Board

This implementation strategy was approved by the Governing Board of Sutter Roseville Medical Center 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
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 Roseville Medical Center, Sutter Amador Hospital, Sutter Auburn Faith Hospital, Sutter Davis Hospital, Sutter Medical Center, Sacramento 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

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 Roseville Medical Center, Sutter Amador Hospital, Sutter Auburn Faith Hospital, Sutter Davis Hospital, Sutter Medical Center, Sacramento 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.