

Sutter Health

Sutter Santa Rosa Regional Hospital

2014 Community Benefit Plan Update

Based on the 2013- 2015 Community Benefit Plan

Responding to the 2013 Community Health Needs Assessment

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

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

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

Introduction

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

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

This implementation strategy addresses the significant community health needs described in the CHNA that the hospital plans to address in whole or in part. The hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and merit enhancements to the described strategic initiatives. Alternately, other organizations in the community may decide to address certain community health needs, and the hospital may amend its strategies and refocus on other identified significant health needs. Beyond the initiatives and programs described herein, the hospital is addressing some of these needs simply by providing health care to the community, regardless of ability to pay.

About Sutter Health

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

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

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 Santa Rosa Regional Hospital, please visit www.santarosa.org.

2013 Community Health Needs Assessment Summary

Sutter Santa Rosa Regional Hospital, in collaboration with local partners Kaiser Permanente, St. Joseph's Health System and the Sonoma County Department of Health Services conducted a Community Health Needs Assessment (CHNA) beginning in early 2012 and concluding in February 2013. The partners engaged BK Consultants to collect and analyze data and write the report with partner input. Secondary data were collected through multiple sources which are cited in the full report. Primary data were collected through key informant interviews, community focus groups, and a phone survey of local residents. Additionally, a stakeholders group was convened to review data and assist in identifying the health priorities.

The full 2013 Community Health Needs Assessment report conducted by Sutter Santa Rosa Regional Hospital is available at http://www.suttersantarosa.org/relations/community_benefits.html.

Definition of Community Served by the Hospital

Demographic Overview: Sonoma County is a large, urban-rural county encompassing 1,575 square miles. The county's total population is currently estimated at 487,011. According to projections from the California Department of Finance, county population is projected to grow by 8.3% to 546,204 in 2020. This rate of growth is less than that projected for California as a whole (10.1%).

Geographic Distribution of Population: Sonoma County residents inhabit nine cities and a large unincorporated area, including many geographically isolated communities. The majority of the county's population resides within its cities, the largest of which are clustered along the Highway 101 corridor. Santa Rosa is the largest city with a population of 168,841 and is the service hub for the entire county and the location of the county's three major hospitals.

Sonoma County's unincorporated areas are home to 146,739 residents, 30.1% of the total population. A significant number of these individuals live in locations that are very rural and geographically remote. Residents of these areas may experience social isolation and significant barriers in accessing basic services and supports such as transportation, health care, nutritious food and opportunities to socialize. Low-income and senior populations living in remote areas may face special challenges in maintaining health and quality of life. Of the county's total senior population, age 60 and older, 12,144 (12%) are considered "geographically isolated" as defined by the Older Americans Act.

Race and Ethnicity: White, Non-Hispanics currently represent 64.2% of the county's population while Hispanics account for 25.6%. Other ethnic groups include: Asian/Pacific Islander (5.2%), African Americans (1.7%), American Indians (1.0%), and persons reporting two or more races (2.3%). While the county's population is less diverse than that of California as a whole, this is changing. By 2020, Sonoma's Hispanic population, currently estimated at 129,057, is expected to grow to 168,290 and account for 31% of the total population. Other ethnic groups are projected to experience less dramatic growth.

While the majority of the county's ethnic populations are English-proficient, the 2010 Census estimates that 50,236 residents, age 5 and older, or 11.26% of total population, are "linguistically isolated" (i.e.

speaking a language other than English at home and speaking English less than “very well”).

Poverty: While many Sonoma County residents enjoy financial security, 10.27% of county residents reported annual incomes below Federal Poverty Level in 2010. The 2010 Federal Poverty Level (FPL) was \$10,830 in annual income for an individual or \$22,050 for a family of four. The Federal Poverty Guidelines are not scaled to reflect significant regional variations in the cost of living. Given the high cost of living in Sonoma County, it is generally accepted that an annual income under 200% of FPL (\$21,660 for an individual) is inadequate to meet basic needs for food, clothing, shelter, transportation, health care and other necessities.

Poverty rates vary significantly by ethnicity. Significant disparities exist, especially for Sonoma County Hispanics, who experience a much higher rate of poverty (21.8%) than Whites or Asians.

In some parts of Southwest Santa Rosa, the Russian River corridor, Sonoma Valley and unincorporated areas in the northwest and northeast, poverty rates for children under age 18 exceed 40%. Based on neighborhood conditions, residents in these communities may have limited access to safe places to play, safe routes to walk and bike to school, grocery stores that offer affordable, fresh fruits and vegetables or prevention-focused health and dental services.

The county’s lowest income senior populations are clustered around Santa Rosa, the Sonoma Valley and the Russian River. Similarly, low-income seniors may face barriers in accessing affordable transportation, nutritious food, safe places to exercise and opportunities to socialize with others.

Beyond the County Line: Because of Sutter Medical Center’s expertise in neonatal medicine, interventional cardiology, and cardiac surgery, we often transfer in patients from adjoining counties, particularly northern, more rurally isolated counties of Lake and Mendocino. Each of these counties has a high percentage of medically underserved people living in poverty.

Significant Health Needs Identified

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

Significant Community Health Need	Intends to Address
<p>Healthy Eating and Physical Fitness Poor nutrition and lack of physical activity are driving a national and local obesity epidemic and are contribution to increasing rates of chronic disease, disability and premature mortality in Sonoma County. Low-income children and families are especially at risk when they reside in neighborhoods that offer few options to obtain healthy, nutritious food or engage safely in physical activity. Expansion of current efforts in schools and communities to improve nutrition and fitness among youth and adults can help to reduce the growing burden of disease.</p>	Yes
<p>Gaps in Access to Primary Care Strong primary care systems are associated with improved health outcomes and reduced health care costs. While most Sonoma County residents have a regular source of care and can access health care when they need it, too many do not. Those who are uninsured, low-income, or are members of racial and ethnic minorities are less likely to have an ongoing source of care and more likely to defer needed care, medicines and diagnostics, often at the cost of unnecessary suffering and poor health outcomes. Increasing access to affordable, prevention-focused primary care can help to eliminate health disparities and promote health and well-being.</p>	Yes
<p>Access to Services for Substance Use Disorders Treatment works. Early screening, intervention and appropriate treatment for harmful substance use and addiction behaviors are critical to intervening with teens, pregnant women and others who can benefit from treatment. Unfortunately, despite increasing levels of addiction, access to substance abuse treatment in Sonoma County is severely limited for low-income individuals without health care coverage. Insuring timely access to culturally competent substance abuse treatment, tailored to the specific needs of those seeking help, can break the cycle of addiction and benefit individuals, families and the community.</p>	Yes
<p>Barriers to Health Aging People over 60 now make up a larger proportion of the population of Sonoma County than ever before. As growth in this population continues, it will challenge families and communities to provide the support seniors need to stay healthy, safe, engaged and independent. Current senior service “systems” are fragmented, under-funded and often difficult for seniors and their families to understand and utilize. Low-income seniors are especially at-risk for neglect, abuse and isolation. Lack of adequate, local supportive services often result in early institutionalization, poor health outcomes and reduced quality of life for many vulnerable seniors. Further development of community-based systems of services and supports for seniors can improve health outcomes and quality of life and significantly reduce costs for long-term institutional care.</p>	See Page 34
<p>Access to Mental Health Services Many mental health problems can be effectively treated and managed with access to assessment, early detection, and links to ongoing treatment and supports. In Sonoma County, however, many low income individuals with mental health concerns do not have access to the treatment they need. Insufficient private insurance coverage for mental health services and insufficient availability of publicly-funded treatment services are significant barriers for many. Limited integration of mental health services within the health care system also leads to missed opportunities for early problem identification and prevention.</p>	Yes

Significant Community Health Need (continued)	Intends to Address
<p>Disparities in Educational Attainment Educational attainment is the single greatest predictor of both income and employment status in later life and both factors are powerful determinants of health and well-being. In Sonoma County, Hispanics currently lag behind their White counterparts in educational attainment levels. Just over 6% of Whites do not have a high school diploma as compared with 45.9% of the Hispanic population. Among current students, 93.6% of White 9th graders graduate from high school 4 years later as compared with only 64.4% of Latino students.</p>	See Page 34
<p>Cardiovascular Disease Cardiovascular disease is the third leading cause of death for people ages 18 – 59 in Sonoma County. For residents, age 60 and older, coronary heart disease and stroke are the second and third most common cause of death, behind cancer. Major behavioral contributors to cardiovascular disease include tobacco use, physical inactivity, unhealthy diet and harmful use of alcohol. Education and prevention efforts targeting these “lifestyle” choices and behaviors should be expanded along with continued emphasis on early detection and management of chronic disease.</p>	Yes
<p>Adverse Childhood Exposure to Stress (ACES) Adverse Childhood Exposure to Stress (ACES), which include a variety of ongoing conditions or events that can be categorized as recurrent childhood trauma, have been documented to lead to health and social problems, risk-taking behaviors and a shortened lifespan for the adults who survive them. ACES has been linked to a range of adverse health outcomes in adulthood, including substance abuse, depression, cardiovascular disease, diabetes, cancer, and premature mortality. The prevalence of ACES underscores the need for additional efforts to reduce and prevent child maltreatment and associated family dysfunction and the need for further development and dissemination of trauma-focused services to treat stress-related health outcomes associated with ACES.</p>	See Page 34
<p>Access to Health Care Coverage Ensuring access to affordable, quality health care services is important to protecting both individual and population health, eliminating health disparities and promoting overall quality of life in the community. For uninsured people, the cost of both routine and emergency care can be financially devastating. Individuals without health care insurance coverage may defer needed care, diagnostics and medicines for themselves and their families and may, as a result, experience higher rates of preventable illness, suffering, disability and mortality than those who have insurance. While a significant portion of Sonoma County’s uninsured population will be eligible for more affordable health care coverage under the Affordable Care Act, financial barriers may still exist for low-wage earners who are unable to meet premium requirements. And, undocumented individuals will continue to be ineligible for publicly-funded coverage, leaving many individuals and families vulnerable.</p>	Yes

Significant Community Health Need (continued)	Intends to Address
<p>Tobacco Use Approximately one-third of all tobacco-using Americans will die prematurely from lung cancer, emphysema, cardiovascular disease and other causes related to their dependence on tobacco. Chewing tobacco is a principal contributor to oral cancers. Most smokers become addicted before the age of 19. Those who start smoking young are more likely to have difficulty quitting and more likely to develop smoking-related illness and disability. Sonoma County’s adult smoking rate does not meet the Healthy People 2020 target and is higher than the California average. Smoking rates for teens also exceeds both national and state-level benchmarks. Education programs to prevent smoking initiation among youth should be strengthened along with efforts to expand access to cessation programs for both youth and adults.</p>	See Page 34
<p>Coordination and Integration of Local Health Care System Integration of health care services may take a variety of forms, but essentially consists of the coordination of care to reduce fragmentation and unnecessary use of services, prevent avoidable conditions, and promote independence and self-care. The ability of care providers to effectively develop and use Electronic Medical Records will be critical to the coordination and integration of care. The Affordable Care Act expands health care coverage options for more Sonoma County residents. To maximize resources and provide high quality health care for newly insured patients and those already established in care, local health care services must be better coordinated and integrated with an emphasis on those most vulnerable - the aged, those living in poverty or geographic isolation and those with multiple disabilities.</p>	Yes
<p>Disparities in Oral Health Poor oral health status can threaten the health and healthy development of young children and compromise the health and well-being of adults. Low-income children suffer disproportionately from dental caries in Sonoma County. Low-income residents have few options for affordable oral health care and even those with insurance find access to preventative services severely limited. Fluoridated drinking water has proven to be an effective public health measure for prevention of tooth decay, yet only 3% of the public water supply in Sonoma County is fluoridated. Among the cities, only Healdsburg fluoridates its water. Stronger prevention initiatives and expanded access to prevention-focused oral health care are critical to protecting the health and well-being of low-income children and adults.</p>	Yes
<p>Lung, Breast and Colorectal Cancer With the exception of stomach cancer, Sonoma County’s all-cancer incidence is higher than the California rate. Research shows that routine screening for certain cancers, including breast, cervical and colorectal cancers, can increase detection at an early and often treatable stage, thereby reducing morbidity and mortality. Lung, breast, and colorectal cancer were identified as priorities because they are significant contributors to morbidity and mortality in Sonoma County and present significant opportunities for early detection through expanded education and screening.</p>	See Page 34

2013 – 2015 Implementation Strategy

This implementation strategy describes how Sutter Santa Rosa Regional Hospital plans to address significant health needs identified in its 2013 Community Health Needs Assessment and consistent with its charitable mission. The strategy describes:

- Actions the hospital intends to take, including programs and resources it plans to commit;
- Anticipated impacts of these actions and a plan to evaluate impact; and
- Any planned collaboration between the hospital and other organizations.

Many of these priorities have already been identified by health and community leaders and are being addressed through a collaborative called “Health Action” which has identified 10 goals that will help Sonoma County become the healthiest county in California by 2020. The chief executive at Sutter Medical Center sits on a board of Health Action and several health and administrative leaders sit on various work groups under the Health Action umbrella. Health Action will be cited several times in the following plan.

Healthy Eating and Physical Fitness

Name of Program, Initiative or Activity **Fighting Food Insecurity**

Description

A survey of the residents' patients at the Community Health Center partner revealed that more than 60% of their patients experience regular food insecurity and often need to make unhealthy food choices based on affordability, or don't eat at all. We have entered into a partnership with the Redwood Empire Food Bank to be a food drop-off location once a week. Each Monday, patients of the Vista Clinic are invited to come and pick up one box of healthy, fresh food for their families. Patients are also educated about other food programs and food stamp exchanges at Farmers Markets.

Anticipated Impact and Plan to Evaluate

We anticipate that when patients learn about the food resources available to them, they will report less food insecurity and will be able to focus on making healthy food choices.

2014 Impact

The year began with 70 families receiving food but increased awareness and education resulted in 120 families/patients of the residency requesting to pick up fresh food each week.

Mechanism(s) Used to Measure Impact

There has not been a follow up survey with these patients to determine if they are experiencing less food insecurity than before the food delivery service.

Community Benefit Contribution/Expense

This is a program led by the Santa Rosa Family Medicine Residency Program and does not incur any additional cost beyond what Sutter is already investing to run the residency (that contribution is listed in other activities of this report).

Program, Initiative, or Activity Refinement

"A Cook on Every Corner" is a new program that will be added and was specifically designed to train health care providers and community advocates to teach economically disadvantaged people to prepare healthy meals more affordably at home, to improve health outcomes, and to combat food insecurity.

Discussions are also in progress about repeating the food insecurity survey but it would be difficult to draw any precise conclusions about the intervention because the survey was done of current patients at the time of the initial survey. A repeat survey would likely not include all the same respondents from the initial survey.

Name of Program, Initiative or Activity	Redwood Empire Food Bank
Description	The Redwood Empire Food Bank is the regional leader in hunger relief. Their mission is to respond to immediate needs of people seeking help through the provision of healthy food and nutrition education. We pursue long-term solutions to food insecurity through public policy and the development of partnerships with civic, faith-based, corporate and government organizations and, most importantly, individuals in our community. Each month, the Food Bank feeds more than 78,000 hungry people in Sonoma, Lake and Mendocino counties. Sutter Medical Center provides annual financial donations to support this mission.
Anticipated Impact and Plan to Evaluate	Each year, the Redwood Empire Food Bank operates three strategic hunger initiatives – Every Child, Every Day, Senior Security, and Neighborhood Hunger Network. The success of each initiative is measured based on process and/or outcome measures identified each year. Having access to healthy food is one of Health Action’s primary goals and our progress is measured against the Healthy People 2020 benchmarks.
2014 Impact	Every Child Every Day served approximately 36,000 children and their families through 6 different grocery programs (4 million pounds of food) and 3 meal programs (468,204 meals served). Senior Security served 12,000 seniors through 5 different grocery programs distributing over 2,320,000 pounds of food. Neighborhood Hunger Network provided 5 million pounds of food to 178 community organizations throughout Sonoma County to fuel their hunger-relief programs. Altogether the REFB conducted 300 distributions throughout the county serving all demographics to ensure that anyone in need of healthful food has access to healthful food.
Mechanism(s) Used to Measure Impact	Sonoma County has developed the “Hunger Index” which measures the “missing meal gap” for our community’s low-income. The gap is the difference between what people can provide for themselves along with assistance from local food programs and the USDA Food Plan’s recommendations for the number of meals families need. We have closed that gap by 12% for 2013-2014 but there is still a 40% gap for our local families so there is much work to do.
Community Benefit Contribution/Expense	Sutter Health contributed \$6,000 to help fund these initiatives Sutter Santa Rosa Regional Hospital contributed \$2,500.
Program, Initiative, or Activity Refinement	The Food Bank has strengthened its partnership with Cal Fresh and will employ Cal Fresh workers to do outreach through the Food Bank programs in order to help local folks apply for Cal Fresh. Additionally, a new program that crosses all three initiatives is being piloted in 2015. The “Kitchen Collective” will provide prepared meals to folks unable to

cook due to disability.

Access to Primary Care

Name of Program, Initiative or Activity	Family Medicine Residency Program
Description	<p>Sutter Medical Center sponsors a three-year training program for medical school graduates desiring to be primary care doctors. The training is provided by Sutter physicians who are also adjunct professors with our partner, the UCSF Medical School. Residents are trained in the hospital and in the clinic setting by caring for patients under the clinical supervision of faculty. Sutter has been sponsoring the program since 1996 but it has existed in our community for more than 40 years. Fueling the primary care pipeline in Sonoma County is vital to the health and well-being of our community. The cost of living is quite high and without this program, it would be very difficult to recruit family physicians.</p>
Anticipated Impact and Plan to Evaluate	<p>Each year, the program graduates 12 new family medicine physicians. In the wake of the Affordable Care Act, we project that about 14,000 people in Sonoma County who have been uninsured, will now have insurance and access to primary care. Sonoma County is fueling our pipeline of critically needed primary care doctors. Currently, more than 50% of Sonoma County's active family physicians are graduates of the program and about 75% of the doctors who staff the local Federally Qualified Health Centers are graduates. We do not have a valid way to measure the impact of this related to meeting the expected increased demand but we know that many of the doctors who train in Sonoma County stay here to live and work so we are "growing our own."</p>
2014 Impact	<p>The impact of the Santa Rosa Family Medicine program can be measured in many multi-factorial ways but in terms of increasing access to primary care in our community, the two biggest ways of measuring impact are in the numbers of patients seen by the residents (primarily low-income) and in the number of graduates who stay and practice in Sonoma County following graduation.</p> <ol style="list-style-type: none"> 1) Numbers of 2014 graduates who are in practice in Sonoma County: 6/12 2) Number of graduates practicing locally who choose to work with low income populations exclusively at FQHCs: 4/6
Mechanism(s) Used to Measure Impact	resident self-report
Community Benefit Contribution/Expense	\$10,628,826 (Cost to run the program less Medicare GME reimbursement)
Program, Initiative, or	None planned.

Activity Refinement

Name of Program, Initiative or Activity	Partnership with Santa Rosa Community Health Centers (“free physicians”)
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Description	The Santa Rosa Family Medicine Residency program partners with Redwood Coalition for Health Care, to staff their Santa Rosa Community Health Center Vista Clinic with 36 family medicine residents, supervised by faculty physicians. This partnership essentially offers free physician staffing to a clinic that would otherwise have to hire staff physicians, providing a significantly increased capacity that the clinic would not be able to sustain on its own.
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Anticipated Impact and Plan to Evaluate	The 36 residents provide approximately 28,000 patient visits each year to a population of people who are underserved and who without this clinic, would not have a reliable medical home. The quality of care is evaluated by preceptors and patients who complete patient satisfaction surveys.
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2014 Impact	1) 21,987 patient visits in 2014. 2) \$1.4 million approximate savings to FQHC in physician salary
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Mechanism(s) Used to Measure Impact	1) Patient logs 2) Used average family medicine physician salary in Sonoma County plus 30% for benefits multiplied by the average number of patient visits per one full time physician (4,000) x 4.5 (\$200,000x 30%=\$260,000; 21,987/4,000=5.49)
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Community Benefit Contribution/Expense	\$10,628,826 (Cost to run the program less Medicare GME reimbursement)
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Program, Initiative, or Activity Refinement	None planned
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Name of Program, Initiative or Activity	Social Advocates for Youth Mobile Health Van
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Description	The Homeless Youth Mobile Van is a partnership between the Santa Rosa Family Medicine Residency, Santa Rosa Community Health Centers and Social Advocates for Youth (SAY). Once per month, two to
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three resident physicians, a volunteer community preceptor, a medical assistant and an HIV testing and outreach worker go to the shelter run by SAY in a van equipped with two treatment rooms and medical supplies. We offer basic urgent care services, such as treatment of skin infections and rashes, assessments of wounds and abrasions, general health screening, HIV testing, referrals for full STD testing, family planning services, testing and treatment of urinary tract infections, screening for diabetes, etc. When we cannot treat patients at the van we refer them to Brookwood Health Center for more comprehensive care. We also offer initial mental health consultations and have even seen patients for prenatal and postpartum visits. In addition to these services, we spend time hanging out with the youth and working to build rapport and a longer partnership. In addition, our HIV outreach team offers rapid testing and our medical assistant enrolls patients in FFACT and provides information on Medi-Cal.

Anticipated Impact and Plan to Evaluate

We hope to build a relationship with the homeless youth so that over time more and more are able to access medical care at the van and eventually through a medical home at Brookwood Health Center. In addition, we aim to teach residents about medical care in underserved and under-resourced settings, as well as specifics about teen and homeless health care.

We are conducting a needs assessment of medical care for the homeless youth at each clinic and working with SAY to assess impact and feedback. We are also seeking written and verbal feedback from resident participants. Finally we are collecting data on number of patients seen, complaints and services provided.

2014 Impact

In order to assess our impact on health care for homeless youth, the residents conducted a needs assessment to better understand their needs. Data were collected on the services we provided and follow up at the clinics.

Needs Assessment Results:

- 71% of respondents were men, reflecting an overall higher percentage of male homeless youth seeking drop in services at SAY and VOICES.
 - Respondents ranged in age from 14-28 with the two-thirds of respondents age 16-21.
 - 68% had seen some type of health care worker in the past year. Of those who had seen a provider:
 - 37% had actually been to one of the clinics in Santa Rosa Community Health Centers network
 - 42% had gone to a hospital, ER or urgent care
 - One patient sought care in jail
 - 66% reported that they had health insurance
 - 82% of those with insurance had some form of state or county public health insurance
 - 42% reported having health problems that were not treated in the past year
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- Lack of treatment was due to lack of insurance, family problems, or housing instability

The most commonly listed unmet medical needs were dental care, broken bones and mental health concerns.

Youth listed the biggest needs of other homeless youth as:

- 62% housing
- 18% love/safety/family
- 12% medical care
- Youth listed their own biggest needs as:
 - 33% housing,
 - 25% food,
 - 28% love/safety/family,
 - 5% medical care

Mobile Clinic Visits Summary:

- 40 medical visits provided
- 13 vaccines given (Tdap and influenza)

Services provided at the mobile van included:

- Family Planning/Sexual Health – 47.5%
- Mental Health – 22.5%
- Other medical – 17.5%
- Asthma/Respiratory – 15%
- Musculoskeletal – 12.5%
- Skin concerns – 10%

Follow up visits:

- 37.5% of participants were seen at the Vista Family Health Center (resident primary care clinic) or the Brookwood Clinic
- 20% of these visits were with the same resident provider
- 27% of these visits reconnected patients with their previous provider

Reasons for follow up visit:

- 33% mental health
- 33% family planning/sexual health, including treatment for STDs and birth control implant insertions
- 20% establish care

Mechanism(s) Used to Measure Impact

Informal Assessment

SAY staff have heard youth comment that they were:

- Impressed that doctors were just hanging out and answering questions
- Waiting for the next mobile van to get health care
- Hearing we had a clinic and wanted to check it out

SAY staff have also commented that they:

- Feel they can offer youth services that they did not have access to before
- Appreciate health education provided by residents

Resident Education:

The homeless youth mobile clinic has been included as part of a larger Culturally Responsive Medicine Curriculum that is being developed at the residency. We are in the process of implementing a formal assessment of skills, attitudes and knowledge for this curriculum. In addition, residents are now being asked to write a brief reflection on their mobile van experience as part of their required evaluation. This was previously only included as optional and was not completed by residents. We will also be having each resident complete a brief evaluation of the learning experience to ensure that learning objective are met and any necessary changes can be made to the program based on incoming feedback. At the end of the year we conducted a retrospective resident survey to assess our new curriculum. The mobile van was one of the most successful activities. Below is a description of our results.

Resident Curriculum Survey Results:

- 24 residents (2/3 of the total 36 residents at the residency) completed the survey, 75 % of whom had participated in the mobile van
- Equal responses were received from all three resident classes and male and female residents.
- 92% of residents found our Intro to Street Medicine and Homeless Youth lecture very effective or effective in contributing to their training in culturally responsive medicine.

In general, 89% of mobile van participants found the mobile van to be a very effective or effective learning experience for community health. We also asked residents about their experience in 4 specific areas and in all areas at least 2/3 of residents agreed that the mobile van experience provided them with a learning experience about community assessment, care of teens, population specific issues and providing care in resource poor settings.

Community Benefit Contribution/Expense

\$3.713 in grant funds from the American Academy of Family Medicine was used for supplies. The bulk of the contribution came from the resident's time, the value of which is included in an activity listed above (Family Medicine Residency Program)

Program, Initiative, or Activity Refinement

Mechanical problems and theft have been significant issues in operating the mobile van this year but recent county funding will make it possible to repair and upgrade the van.

Additionally, partnerships with other youth serving agencies have been added or strengthened which will create opportunities for increased contact with youth and more mobile van site visits in 2015 including direct outreach to locations where homeless youth live such as local

parks.

Discussions are in progress with Graton Day Laborer Center to bring the mobile van to their site. We have a tentative start day of August 2015.

Name of Program, Initiative or Activity

Home Visits

Description

The Family Medicine residents serve many medically fragile and poor seniors who cannot get into the clinic for appointments. In order to reduce access barriers and reduce unnecessary ED visits or hospitalizations, the residents make regular home visits to their homebound patients.

Anticipated Impact and Plan to Evaluate

Since the initiation of home visits, residents are noting that their elderly homebound patients, who were missing office visits, are now staying more compliant with medication and medical advice. It would be very difficult to measure the direct impact in terms of reduction of ED visits and hospitalizations as there are too many variables in this frail population. Instead, we will measure the number of home visits per doctor/per month.

2014 Impact

Residents logged 17 home visits total in 2014*

Mechanism(s) Used to Measure Impact

Resident logging of home visit hours

Community Benefit Contribution/Expense

The contribution came from the residents' time, the value of which is included in an activity listed above (Family Medicine Residency Program)

Program, Initiative, or Activity Refinement

*It was discovered that the residents are not consistently logging their home visits so the number reported above is considering lower than the actual number. Since there are too many variables impacting the integrity of this data and the ability to draw any conclusions between the activity and the impact, this activity will not be reported in future updates.

Access to Services for Behavioral Health Issues

Name of Program, Initiative or Activity	Drug Free Babies
Description	Pregnancy and childbirth are two critical windows in which women are most receptive to making positive changes around substance use. Drug-Free Babies (DFB) is our main referral source for connecting mothers/mothers-to-be with county substance recovery resources (residential and non-residential). Possible participants give consent for us to make a phone referral. We provide DFB with patient contact information and encourage DFB staff to meet with patients at the hospital to expedite entry to services. At the initial meeting, DFB staff conducts a full intake utilizing an industry standard comprehensive AOD intake tool. From there they consider client needs, possible funding stream and program openings. DFB is funded through a partnership with Sonoma County First Five Commission. The hospital's social work staff sits on a local advisory committee that helps to plan local interventions.
Anticipated Impact and Plan to Evaluate	Drug Free Babies tracks how many of the women we refer end up in services and the funding partner, Sonoma County First Five Commission, tracks outcomes.
2014 Impact	<p>Number of referrals: 41*</p> <p>Number of intakes: 23</p> <p>Number entering treatment: 16</p> <p>Number completing treatment: 9</p> <p>Number of client babies born with clean drug screen: 8**</p> <p><i>*does not include Q2 which was not reported</i></p> <p><i>**some clients still pregnant at the end of the reporting period</i></p>
Mechanism(s) Used to Measure Impact	Reports from program coordinator to primary funder, First Five
Community Benefit Contribution/Expense	Regrettably, Sutter is no longer actively participating in this program. Referrals are made when appropriate but staff is not participating in the steering group at this time.
Program, Initiative, or Activity Refinement	First Five is no longer funding this program in part due to the inconsistent and incomplete data collection. The county department of behavioral health will assume oversight and it is hoped that the data demonstrating impact will be tracked more consistently.
Name of Program, Initiative	Health Action

or Activity

Description

Health Action is a local collaborative of health and community leaders that are partnering to 'move the dial' on 10 local priorities designed to make Sonoma County the healthiest county in California by 2020. The chief executive at Sutter Medical Center sits on the steering committee and several clinical leaders serve on work groups targeting one or more of the 10 priorities. Mental Health is one of the 10 priorities.

Anticipated Impact and Plan to Evaluate

The overall goal is to meet all the statewide Healthy People 2020 benchmarks. The steering committee develops an action plan identifying short term objectives designed to move the county in that direction. The objectives for mental health are:

1) Percent of adults who report needing help for mental/emotional problems who saw a mental health professional.

2) Suicide deaths for Sonoma County youth ages 10 – 24.

The objectives for substance use are:

1) Percent of adolescents (12 – 17 years) not using alcohol or any illicit drug during the past 30 days.

2) Percent of adults binge drinking alcoholic beverages during the past 30 days.

3) Percent of adults smoking a cigarette in the past 30 days.

2014 impact

Mental Health

1) 2008 Baseline- 50%; 2012*- 59%	2020 Target: 75%
2) 2008 Baseline- 6 2013* 4	2020 Target: 0

Substance Abuse

1) 2008 Baseline-53% 2013*- 65.3%	2020 Target-90%
2) 2008 Baseline-20%* 2013- not reported	2020 Target-6%
3) 2008 Baseline-13% 2012*- 14%	2020 Target-10%

*most recent data available

Also of note is that Sonoma County was ranked as the 8th Healthiest County in California by the Robert Wood Johnson Foundation in 2014.(up from #12 in 2013) The RWJF also recognized the county as one of 15 finalists for the prestigious "Culture of Health" award.

Mechanism(s) Used to Measure Impact

Various sources of secondary data at the county and state level. Some metrics are not measured annually.

**Community Benefit
Contribution/Expense**

Two of our executives sit on workgroups for Health Action. Each group meets monthly for 1 hour and we value that at \$150/hr so the total quantifiable cost is \$3,600.

**Program, Initiative, or
Activity Refinement**

All of these metrics are progressing in the desired direction except for the adult smoking metric. The Health Action work group addressing this metric recently implemented a media campaign designed to target young adults, hoping to make an impact that will be measured next year.

Cardiovascular Disease

Name of Program, Initiative or Activity

Heart Works Cardiac Rehabilitation Program

Description

Heart Works is a Phase II and III cardiac rehabilitation program that helps patients recover from a major cardiac event and helps reduce the risk for another one. Northern California Center for Well-Being and the Northern California Medical Associates makes annual grants to assure the sustainability of this vital program.

Anticipated Impact and Plan to Evaluate

Heart Works measures the following outcomes three months into the program:

- 1) Aerobic capacity, flexibility and strength
- 2) Body fat composition
- 3) Participant satisfaction
- 4) Individualized action plans

2014 Impact

Phase II Cardiac Rehabilitation:

Phase II Cardiac Rehab is a monitored cardiac rehab program usually offered at 36 sessions.

Category	Result	Target
Participants	n= 146 (Jan-Dec) Total encounters: 3,268	130 patients 2,800 visits
Fitness measures: * MET level. Session 1 to 36 * Individual Fitness Plan	n=120 Number of Patients exceeding Met level of 5: 18 (15%) Number of Patients Doubling their Met Level: 84 (70%) Number of Patients Maintaining their Met Level: 18 (15%) Average Pre Met Level: 3 Average Post Met Level: 4 100% have an individualized plan	Target: 5 (or patient doubles starting MET level) Individualized fitness plan on file

	on file	
Clinical measures: *Body Composition *BP	Individualized body composition and goals set for each patient Blood Pressure at goal Average Resting BP at Start of Program: 126/78 Average Resting BP at End of Program: 124/72	Body composition (pre/post) Target: range varies based on need to lose or gain weight; documented in individualized plan Blood Pressure at goal. Target: less than 150/90
Program Completion Rate	68% of patients completed maximum number of sessions offered.	Target: 65%
Referrals to support services (Nutrition Counseling, Smoking Cessation)	<i>Number of RD visits pending</i>	Target: Documented referrals as appropriate

Phase III Cardiac Rehabilitation:

Patients have documented improvements in aerobic capacity; body composition; and endurance within 3 months adherence to program recommendations. HeartWorks has maintained consistent enrollment throughout the year. Seventeen (53) Of the 246 Phase III Patients were new during Jan-Nov 2014.

Category	Result	Target
Participants	n= 246 (Jan-Nov) 11 Phase III sessions per week Total encounters: 8,548	15 participants per session (165) 74% of capacity
Program satisfaction	4.6	4.5 or above
Fitness measures: *Aerobic Capacity *Endurance	All participants have an individualized fitness plan on file with a goal to double their endurance	3 months post program start: Aerobic Capacity (50% improvement) Endurance (doubled)
Clinical measures: *Body Composition	4.2% reduction in body fat	3% reduction in body fat

*BP	98% of participants have BP at goal	100% Blood Pressure at goal. Target: less than 150/90
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Mechanism(s) Used to Measure Impact	Clinical measurements as indicated above
Community Benefit Contribution/Expense	\$140,674 in grants to fund these programs
Program, Initiative, or Activity Refinement	None planned
Name of Program, Initiative or Activity	Community Access to Automated External Defibrillators (AEDs)
Description	An AED is a portable electronic device that automatically diagnoses the potentially life threatening cardiac conditions and is able to treat them through defibrillation, the application of electric therapy which stops arrhythmia, allowing the heart to reestablish an effective rhythm. Uncorrected, these cardiac conditions rapidly lead to irreversible brain damage and death. Through a partnership with St. Jude, we are receiving five AED devices to deploy in high-risk, high impact locations throughout Sonoma County.
Anticipated Impact and Plan to Evaluate	Studies demonstrate that any location with 1000 adults over the age of 35 present per day during the normal business hours (7.5 hours/day, 5 days per week, 250 days per year) can expect one incident of sudden cardiac arrest every 5 years. For every minute that a cardiac arrest victim waits for emergency response, the survival rate decreases by 7% to 10%. Combined with CPR, the use of an AED may increase the likelihood of survival by 75% or more.
2014 Impact	We had expected to receive the defibrillators early in 2014 and have them deployed during the year. Unfortunately we did not receive them until December so we don't have any 2014 impact to report.
Mechanism(s) Used to Measure Impact	n/a

Community Benefit Contribution/Expense	n/a
Program, Initiative, or Activity Refinement	Defibrillators were received in December 2014 and four of them have been deployed in early 2015.
Name of Program, Initiative or Activity	Provision of Life-Saving Medication to Rural Coastal Clinic
Description	The only FDA-approved treatment for ischemic strokes is tissue plasminogen activator (tPA). tPA is also used for acute heart attacks to open clogged arteries. This medication works by dissolving the clot and improving blood flow to the part of the brain/heart being deprived of blood flow. If administered within 3 hours (and up to 4.5 hours in certain eligible patients), tPA may improve the chances of recovering from a stroke or heart attack. Sutter Medical Center is the closest hospital (providing stroke and heart attack (STEMI) care) to a rural, coastal clinic in South Mendocino County, approximately 60 one-lane road miles away. The tPA medication is cost-prohibitive for the clinic which decreases chance of a significant recovery from an ischemic stroke or heart attack for patients in that area. Sutter Medical Center has agreed to ensure that the clinic has one dose of tPA at all times.
Anticipated Impact and Plan to Evaluate	With this medication available, this rural clinic will have life-saving medication "in the field" that would otherwise only be available in an emergency room. For this remote clinic, that could be the difference between life and death for a patient having a heart attack.
2014 Impact	One dose provided to the Gualala Clinic. It has not been used yet so we have no impact to report.
Mechanism(s) Used to Measure Impact	Once the medication is used, the clinic will request another does at which time we will request a report on the patient outcome.
Community Benefit Contribution/Expense	\$2,500. (cost of one does)
Program, Initiative, or Activity Refinement	n/a

Access to Health Care Coverage

Name of Program, Initiative or Activity	Eligibility Screening and Application Assistance
Description	Many patients come into the emergency department who are uninsured. The Affordable Care Act now requires all individuals to secure health insurance. Low-income people may be eligible for free public programs or subsidies to assist them in purchasing private health insurance. The emergency room is the “point of entry” for many into the health care system so offering assistance in determining eligibility for public programs and completing applications is an important community benefit. Sutter Medical Center has on-staff financial counselors who spend a considerable amount of time doing eligibility screening. Additionally, the hospital pays for contractual services to provide onsite application assistance.
Anticipated Impact and Plan to Evaluate	Having insurance is directly related to better health outcomes. We measure the number of patients screened and the number of patients who are assisted with applications.
2014 Impact	<ol style="list-style-type: none"> 1) \$249,000 (value of 4080 staff hours and annual contract with county for onsite eligibility worker) 2) 3,203 uninsured people served
Mechanism(s) Used to Measure Impact	Department manager tracks # of people served and number of staff hours
Community Benefit Contribution/Expense	\$249,000 (see above)
Program, Initiative, or Activity Refinement	None planned
Name of Program, Initiative or Activity	Covered Sonoma County
Description	A local program developing local partnerships and outreach strategies to educate and enroll uninsured and self-employed people about their options under the Affordable Care Act. The collaborative is working with local hospitals and health care providers, community-based organizations and other community groups to provide information and help people make the right choices for affordable health care. Senior

staff from Sutter Medical Center serves on the steering committee.

Anticipated Impact and Plan to Evaluate Each month, the steering committee is provided a report with updated enrollment and renewal statistics. The overall goal is for 100% coverage but there are intermediate goal initiatives such as the Schools 100% campaigns.

2014 Impact

# of new insurance applications:	11,332
# of renewals:	5,881
Total applications:	17,213

Mechanism(s) Used to Measure Impact Certified Application Assistants track all activity per enrollment site. In addition to enrolling previously uninsured people, there is a focus on renewing existing enrollees, particularly those on Medi-Cal for which there is a high rate of disenrollment due to lack of follow-through from members once they are initially enrolled.

Community Benefit Contribution/Expense Sutter representative sits on steering committee and attends monthly meetings. Total quantifiable contribution: \$1560

Program, Initiative, or Activity Refinement None planned

Coordination and Integration of Local Health Care System

Name of Program, Initiative or Activity	Health Care for the Homeless
Description	<p>The Sonoma County Task Force on the Homeless convened a work group in 2010 for the coordination of health care services for homeless people in our community. All of the hospitals see a high percentage of homeless people in the ED and in the hospital bed. Providing good transitions of care for this population is very challenging. The group works to develop processes and “wrap around” services with the goal of reducing unsafe discharges from the hospital to the street, and to work collaboratively to coordinate medical, mental health, and substance use disorders services for homeless patients. Sutter Medical Center supports these efforts by committing professional staff time monthly to attend meetings and participate in planning programs and services. Additionally, Sutter provides significant financial support to operate the county’s only medical respite shelter that provides a safe transition for homeless patients from hospital to community living that allows extended convalescence not typically allowed in traditional shelter settings.</p>
Anticipated Impact and Plan to Evaluate	<p>Quarterly, Sutter Medical Center is provided a statistical report that shows the number of referrals from all local hospitals to the shelter and services that were provided/referred to patients staying at the shelter. These are patients who might otherwise be readmitted to the hospital for failing to manage their health on the street.</p>
2014 Impact	<p>Total people served: 130 Total avoidable hospital days cost savings: \$4,238,000 (for all of Santa Rosa)</p>
Mechanism(s) Used to Measure Impact	<p>Catholic Charities tracks all their referrals, admissions, and number of days per patient for each participating hospital. They calculate the cost savings based on a per day cost that the hospitals provide them that reflects the cost to board a non-acute patient for which no insurance reimbursement is provided. Each patient is also provided counseling around housing and other issues impacting their homelessness.</p>
Community Benefit Contribution/Expense	\$80,000
Program, Initiative, or Activity Refinement	<p>Catholic Charities is looking to expand the program in 2015 and is seeking funding.</p>

Name of Program, Initiative or Activity	Electronic Medical Record Access
Description	Currently, hospital-based physicians and residents are able to access the EMR of patients who are receiving their primary medical care at one of the local community health centers affiliated with the Redwood Coalition for Health Care. This access allows our ED providers to check recent medical history of our shared patients so as to reduce duplication of services, increase quality of care, and provide better continuity of care post-discharge.
Anticipated Impact and Plan to Evaluate	Sutter will be tracking readmissions of all clinic patients for whose record we are able to access electronically while hospitalized. We expect that better coordination through access to health records will reduce readmissions and improve quality of care for the most at-risk patients.
2014 Impact	The impact of this activity is not able to be measured because there was a flaw in the EMR report designed to capture this data.
Mechanism(s) Used to Measure Impact	n/a
Community Benefit Contribution/Expense	none
Program, Initiative, or Activity Refinement	A workgroup is currently assessing ways to accurately track this metric. It is hoped we can report out on it accurately for 2015.

Disparities in Oral Health

Name of Program, Initiative or Activity **Sonoma County Oral Health Task Force**

Description In the previous two community health needs assessments, Sonoma County identified oral health, particularly for children, as one of our most significant community health challenges and one of our top priorities. Several local efforts emerged including the Task Force which was convened in 2011 to identify specific strategies that could be developed, implemented, and show measurable impact in three to five years. Sutter Medical Center participates by assigning senior community benefit staff to the Task Force.

Anticipated Impact and Plan to Evaluate These are the five specific strategies:

- 1) Increase Access to Basic Dental Care: Mobilize public-private partnerships to expand access to care in Santa Rosa and other high-need communities by adding new clinical capacity and/or expanding the cost-effective use of existing community-based facilities (community health centers, WIC nutrition programs, private dental offices, Santa Rosa Junior College Dental Hygiene Clinic, mobile dental clinics).
- 2) Integrate Dental & Medical Care: Adopt and implement practice changes, including education for primary care providers and staff, to strengthen oral health assessment, education and preventive care in primary care visits and fully integrate dental professionals within the medical home model.
- 3) Educate Pregnant Women About the Importance of Oral Health: Develop and integrate a comprehensive oral health promotion program, to include prevention, assessment, treatment, referral and case management, into the Comprehensive Perinatal Services Program (CPSP) for pregnant women at all CPSP service delivery sites.
- 4) Promote Promising Models of Dental Care: Expand the use of Registered Dental Hygienists in Alternative Practice (RDHAP) and other appropriate, trained personnel to deliver cost effective oral health education, assessment and preventive services in primary care, school, and community settings.
- 5) Collect Data to Measure the Oral Health Status of Sonoma County: Develop and implement an ongoing oral health surveillance program, within the Sonoma County Department of Health Services, to collect, analyze and report data on oral health status, access to prevention and care, and system capacity and identify strategies to promote oral health throughout the community, with emphasis on high-risk populations.

Each of these tasks has a work group assigned to develop tactics, measurable outcomes, and track progress. The first annual report

focused primarily on the action/activities of each work group and what the process “accomplishments” have been achieved. Health outcomes improvement directly related to these activities will be difficult to measure especially in the short term. However, it is expected that these efforts, along with other community efforts, will collectively get us closer to meeting our Healthy People 2020 goals.

2014 Impact

The Oral Health Task Force issued a final report of progress on the 5 recommendations noted above in 2013. That report showed the many activities and tactics that had been employed between 2009-2013 to “move the dial” on the state of oral health in Sonoma County. While there are many positive actions happening now in response to the increased visibility of our local dental disease epidemic, we have not seen any measurable improvement yet.

Mechanism(s) Used to Measure Impact

In 2009, Sonoma County conducted the first “Smiles Survey” that explored disparities in dental health and access to care. Several hundred local kindergarteners and third-graders were assessed for presence of decay and untreated tooth decay. It was discovered that 52% of these students had decay and 16% had untreated decay. The survey was repeated in 2014 and the figures have not changed significantly.

Community Benefit Contribution/Expense

Community Benefit staffer participates in the Sonoma County Dental Health Network, a collaborative of local stakeholders convened to continue the work of the now disbanded Oral Health Task Force. Quantifiable value of 2014 time: \$676.00

Program, Initiative, or Activity Refinement

None planned

Name of Program, Initiative or Activity

Sonoma County Fluoridation Advisory Group

Description

Healdsburg is the only city in the entire county of Sonoma that has fluoridation in their public water supply. The county board of supervisors approved the commissioning of a study to determine the engineering and economic feasibility of fluoridating the entire county’s water supply. Many studies have supported the fact that for every \$1 spent in fluoridating the water, \$38 in dental treatment is saved. Fluoridating the water is seen as the single most impactful method to prevent dental caries, particularly for poor families with little access to dental care and prevention services. Sutter Medical Center is represented on this advisory group by senior staff.

Anticipated Impact and Plan to Evaluate	It is expected that the group will recommend fluoridation to the county. It will then be up to the county to secure the funding for this project. The impact, then, is unknown at this time.
2014 Impact	There was a change of leadership in the public health department which put the work of this group on hold until fall of 2014. The group re-convened and began reviewing the engineering and aquatic assessments previously presented. It is anticipated that the group will conclude its work and decide on formal recommendations to the Board of Supervisors in early 2015.
Mechanism(s) Used to Measure Impact	N/a
Community Benefit Contribution/Expense	\$1092.00 (Time spent by Sutter Community Benefit staffer participating on committee)
Program, Initiative, or Activity Refinement	Committee expects to complete its work in 2015 and make recommendations to Board
Name of Program, Initiative or Activity	Oral Health Screenings and Prevention
Description	The Family Medicine residents are now incorporating oral health screenings, fluoride varnishes, prevention education and referrals to community dental programs into their well-child examinations. This has been a recommendation of the Sonoma County Oral Health Task Force.
Anticipated Impact and Plan to Evaluate	Since there are very few local dentists that accept Denti-Cal and fewer that will see children under the age of 1, many low-income families do not have access to early and regular dental care for their children. The American Academy of Pediatricians recommends that children have a first dental visit by the time the first tooth erupts or by age 1, whichever comes first. The Family Medicine residents see a large percentage of our community's poor children so this new practice will likely have significant impact but evaluation methodology is not yet developed.
2014 Impact	All children seen by residents for well child care are getting dental screening and referred to dental care. Santa Rosa Community Health Centers (where residents receive their clinic training) now has a dental clinic to which residents and faculty refer patients. The medical assistants are applying fluoride varnish for the age appropriate visit as part of standard well child protocols.

This is a significant step toward integrating medical and dental care and viewing dental health as an important part of overall health.

Mechanism(s) Used to Measure Impact

Regrettably, no formal tracking was done to provide numbers of children served but in the resident's clinic practice, about 10% of their visits are pediatric and about half of these are for well child visits annually. Therefore, using the # of patients seen by the residents as cited in another activity, the approximate number of children receiving dental screening, referrals and preventive care is 1,100.

Community Benefit Contribution/Expense

\$10,628,826 (Cost to run the residency program less Medicare GME reimbursement)

Program, Initiative, or Activity Refinement

Will formally track # of kids receiving dental screening, referrals and preventive treatment during well child visits with the family medicine residents.

Needs Sutter Santa Rosa Regional Hospital Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Santa Rosa Regional Hospital is committed to serving the community by adhering to its mission, using its skills and capabilities, and remaining a strong organization so that it can continue to provide a wide range of community benefits. 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:

Barriers of Healthy Aging

In recent years, Sutter Santa Rosa Regional Hospital has partnered on several initiatives to address the barriers to health aging, most notably a grant to preserve the county's only Adult Day Health Care Center and several financial and staff time commitments to develop and implement "A Matter of Balance," a falls prevention program. At this time, we do not have the bandwidth to commit significant resources to address this issue. There are many local agencies that, in partnership with each other and the county, have developed many programs and services targeting healthy aging (i.e. Aging in Place). We will continue to make modest financial commitments to support these local programs.

Disparities in Educational Attainment

Seen as one of the many social determinants of health, attaining at least a high school diploma is vital to the health and prosperity of communities but this issue is significantly outside the scope of services and expertise of our organization. The good news is that there are several local initiatives (i.e. Cradle to Career and Schools of Hope) that are aggressively addressing this disparity and have ambitious goals to improve the status of educational attainment, particularly in underserved communities. The Health Action Council is actively working to address this issue.

Adverse Childhood Exposure to Stress (ACES)

Though there are a couple of promising studies that demonstrate a link between childhood trauma and long-term health impact, there is a lack of evidence-based approach for addressing the problem. The hospital simply does not have the financial or human resources to take a leadership role in developing and piloting programs and strategies for preventing or treating childhood stress.

Tobacco Use

At this time, Sutter Santa Rosa Regional Hospital does not have the resources to develop a formal program to address tobacco addiction but there are two strategies that we have implemented that we hope will help many of our patients and employees stop smoking. First, the Family Medicine residents use motivational interviewing which is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change for their tobacco-addicted patients. Second, the hospital has recently become a smoke-free campus which has provided the opportunity for encouraging and supporting treatment service options for employees and patients who smoke.

Lung, Breast and Colorectal Cancer

Awareness and early detection are the keys to reducing the morbidity and mortality of cancer. The hospital is not addressing this issue because our affiliate partner, Sutter Pacific Medical Foundation, invests considerable resources in our community to raise awareness of cancer screening. Additionally, the foundation provides many free cancer screening services to uninsured people and does considerable outreach to our Latino community.

Approval by Governing Board

This implementation strategy was approved by the Governing Board of Sutter West Bay Hospitals on November 21, 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 West Bay Hospitals 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 West Bay Hospitals
Services for the Poor and Underserved	\$138,940,838
Benefits for the Broader Community	\$52,119,770
Total Quantifiable Community Benefit	\$191,060,608

This reflects the community benefit values for Sutter West Bay Hospitals (SWBH), the legal entity that includes Sutter Santa Rosa Regional Hospital, California Pacific Medical Center, St. Luke's Hospital, Novato Community Hospital and Sutter Lakeside Hospital. For details regarding the community benefit values specifically for SMC of Santa Rosa, please contact Penny Cleary at (707) 576-4009 or ClearyP@sutterhealth.org.

2014 Community Benefit Financials
Sutter West Bay Hospitals

Services for the Poor and Underserved	
Traditional charity care	\$14,293,651
Unpaid costs of public programs:	
Medi-Cal	\$105,805,388
Other public programs	\$178,197
Other benefits	\$18,663,602
Total services for the poor and underserved	\$138,940,838
Benefits for the Broader Community	
Nonbilled services	\$3,567,768
Education and research	\$47,975,042
Cash and in-kind donations	\$459,623
Other community benefits	\$117,337
Total benefits for the broader community	\$52,119,770

This reflects the community benefit values for Sutter West Bay Hospitals (SWBH), the legal entity that includes Sutter Santa Rosa Regional Hospital, California Pacific Medical Center, St. Luke's Hospital, Novato Community Hospital and Sutter Lakeside Hospital. For details regarding the community benefit values specifically for SMC of Santa Rosa, please contact Penny Cleary at (707) 576-4009 or ClearyP@sutterhealth.org.