Sutter Health
Memorial Medical Center

2022 – 2024 Implementation Strategy Plan
Responding to the 2022 Community Health Needs Assessment

1700 Coffee Road Modesto, CA 95355
License #030000061
www.sutterhealth.org

Table of Contents

Introduction

The Implementation Strategy Plan describes how Memorial Medical Center, a Sutter Health affiliate, plans to address significant health needs identified in the 2022 Community Health Needs Assessment (CHNA). The document describes how the hospital plans to address identified needs in calendar (tax) years 2022 through 2024.

The 2022 CHNA and the 2022 - 2024 Implementation Strategy Plan were undertaken by the hospital to understand and address community health needs, and in accordance with state law and the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

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

Memorial Medical Center welcomes comments from the public on the 2022 Community Health Needs Assessment and 2022 - 2024 Implementation Strategy Plan. Written comments can be submitted:

- By emailing the Sutter Health System Office Community Benefit department at SHCB@sutterhealth.org;
- Through the mail using the hospital's address at 1700 Coffee Road Modesto, CA 95355; and
- In-person at the hospital's Information Desk.

Executive Summary

Memorial Medical Center is affiliated with Sutter Health, a not-for-profit parent of not-for-profit and for-profit companies that together form an integrated healthcare system located in Northern California. The system is committed to health equity, community partnerships and innovative, high-quality patient care. Our over 65,000 employees and associated clinicians serve more than 3 million patients through our hospitals, clinics and home health services.

Learn more about how we're transforming healthcare at sutterhealth.org and vitals.sutterhealth.org

Sutter Health's total investment in community benefit in 2021 was $872 million. This amount includes traditional charity care and unreimbursed costs of providing care to Medi-Cal patients. This amount also includes investments in community health programs to address prioritized health needs as identified by regional community health needs assessments.

As part of Sutter Health's commitment to fulfill its not-for-profit mission and help serve some of the most vulnerable in its communities, the Sutter Health network has implemented charity care policies to help provide access to medically necessary care for all patients, regardless of their ability to pay. In 2021, Sutter Health invested $91 million in charity care. Sutter's charity care policies for hospital services include, but are not limited to, the following:

1. Uninsured patients are eligible for full charity care for medically necessary hospital services if their family income is at or below 400% of the Federal Poverty Level ("FPL").
2. Insured patients are eligible for High Medical Cost Charity Care for medically necessary hospital services if their family income is at or below 400% of the FPL and they incurred or paid medical expenses amounting to more than 10% of their family income over the

last 12 months. (Sutter Health's Financial Assistance Policy determines the calculation of a patient's family income.)

Overall, since the implementation of the Affordable Care Act, greater numbers of previously uninsured people now have more access to healthcare coverage through the Medi-Cal and Medicare programs. The payments for patients who are covered by Medi-Cal and Medicare do not cover the full costs of providing care. In 2021, Sutter Health invested $557 million more than the state paid to care for Medi-Cal patients.

Through community benefit investments, Sutter helped local communities access primary, mental health and addiction care, and basic needs such as housing, jobs and food. See more about how Sutter Health reinvests into the community by visiting sutterpartners.org.

Every three years, Sutter Health affiliated hospitals participate in a comprehensive and collaborative Community Health Needs Assessment, which identifies significant community health needs and guides our community benefit strategies. The assessments help ensure that Sutter invests its community benefit dollars in a way that targets and addresses real community needs.

Through the 2022 Community Health Needs Assessment process for Memorial Medical Center, the following significant community health needs were identified:

1. Access to Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavioral Health and Substance Use Services
3. Access to Quality Primary Care Health Services
4. Increased Community Connections
5. Access to Functional Needs
6. Injury and Disease Prevention and Management
7. Active Living and Healthy Eating
8. System Navigation
9. Safe and Violence-Free Environment

The 2022 Community Healthy Needs Assessment conducted by Memorial Medical Center is publicly available at www.sutterhealth.org.

2022 Community Health Needs Assessment Summary

Community Health Insights (www.communityhealthinsights.com) conducted the assessment on behalf of Memorial Medical Center. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Northern California.

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model. This model of population health includes many factors that impact and account for individual health and well-being. Further, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included one-on-one and group interviews with 12 community health experts, social service providers, and medical personnel. Furthermore, 17 community residents or community service provider organizations participated in 3 focus groups across the service area. Finally, 7 community service providers responded to a Community Service Provider (CSP) survey asking about health need identification and prioritization.

Focusing on social determinants of health to identify and organize secondary data, datasets included measures to describe mortality and morbidity and social and economic factors such as income, educational attainment, and employment. Further, the measures also included indicators to describe health behaviors, clinical care (both quality and access), and the physical environment.

At the time that this CHNA was conducted, the COVID-19 pandemic was still impacting communities across the United States, including MMC's service area. The process for conducting the CHNA remained fundamentally the same. However, there were some adjustments made during the qualitative data collection to ensure the health and safety of those participating. Additionally, COVID-19 data were incorporated into the quantitative data analysis and COVID-19 impact was captured during qualitative data collection. These findings are reported throughout various sections of the report.

The full 2022 Community Health Needs Assessment conducted by Memorial Medical Center is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

The definition of the community served was the county boundary of Stanislaus County. Stanislaus County includes the county hub which is the city of Modesto, California, and surrounding communities as defined by 26 ZIP codes. This is the designated service area because the majority of patients served by MMC and SSH resided in these ZIP Codes. Stanislaus County in located in the Central Valley of California and is a major agricultural producer for the state and the nation. The total population of the county was 548,679.

Significant Health Needs Identified in the 2022 CHNA

Quantitative and qualitative data were analyzed to identify and prioritize significant health needs. This began by identifying 12 potential health needs (PHNs) based on a review of CHNAs previously conducted throughout Northern California. The data associated with each PHN were then analyzed to discover which, if any, of them were significant health needs for the service area.

PHNs were selected as significant health needs if the percentage of associated quantitative indicators and qualitative themes exceeded selected thresholds. Data were also analyzed determine if there were any emerging significant health needs in the service area beyond the initial 12 PHNs.

All significant health needs were then prioritized based on 1) the percentage of key informant interviews and focus groups that indicated the health needs was present within the service area; 2) the percentage of times key informant interviews and focus groups identified the health needs as being a top priority; and, when available, 3) the percentage of service provider survey respondents who identified the health needs as being a top priority.

The following significant health needs were identified in the 2022 CHNA:

1. **Access to Basic Needs Such as Housing, Jobs, and Food** – Access to affordable and clean housing, stable employment, quality education, and adequate food for good health are vital for survival. Maslow's Hierarchy of Needs suggests that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health. Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, influence individual health as much as health behaviors and access to clinical care.

2. **Access to Mental/Behavior/Substance-Abuse Services** – Individual health and well-being are inseparable from individual mental and emotional outlook. Coping with daily life stressors is challenging for many people, especially when other social, familial, and economic challenges occur. Access to mental, behavioral, and substance use services is an essential ingredient for a healthy community where residents can obtain additional support when needed.

3. **Access to Quality Primary Healthcare Services** – Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and other similar resources. Primary care services are typically the first point of contact when an individual seeks healthcare. These services are the front line in the prevention and treatment of common diseases and injuries in a community.

4. **Increased Community Connection –** As humans are social beings, community connection is a crucial part of living a healthy life. People have a need to feel connected with a larger support network and the comfort of knowing they are accepted and loved. Research suggests "individuals who feel a sense of security, belonging, and trust in their community have better health. People who don't feel connected are less inclined to act in healthy ways or work with others to promote well-being for all." Assuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a healthy community. Further, healthcare and community support services are more effective when they are delivered in a coordinated fashion, where individual organizations collaborate with others to build a network of care.

5. **Access to Functional Needs** – Having access to transportation services to support individual mobility is a necessity of daily life. Without transportation, individuals struggle to meet their basic needs, including those that promote and support a healthy life. Examining the number of people that have a disability is also an important indicator for community health in an effort to ensure that all community members have access to necessities for a high quality of life.

6. **Injury and Disease Prevention and Management**– Knowledge is important for individual health and well-being, and efforts aimed at prevention are powerful vehicles to improve community health. When community residents lack adequate information on how to prevent, manage, and control their health conditions, those conditions tend to worsen. Prevention efforts focused on reducing cases of injury and infectious disease control (e.g., sexually transmitted infection [STI] prevention, influenza shots) and intensive strategies for the management of chronic diseases (e.g., diabetes, hypertension, obesity, and heart disease) are important for community health improvement.

7. **Active Living and Healthy Eating** – Physical activity and eating a healthy diet are extremely important for one's overall health and well-being. Frequent physical activity is vital for prevention of disease and maintenance of a strong and healthy heart and mind. When access to healthy foods is challenging for community residents, many turn to unhealthy foods that are convenient, affordable, and readily available. Communities experiencing social vulnerability and poor health outcomes are often overloaded with fast food and other establishments where unhealthy food is sold.

8. **System Navigation** – System navigation refers to an individual's ability to traverse fragmented social-services and healthcare systems in order to receive the necessary benefits and supports to improve health outcomes. Research has demonstrated that navigating the complex U.S. healthcare system is a barrier for many that results in health disparities. Further, accessing social services provided by government agencies can be an obstacle for those with limited resources such as transportation access and English proficiency.

9. **Safe and Violence-Free Environment** – Feeling safe in one's home and community are fundamental to overall health. Next to having basic needs met (e.g., food, shelter, and clothing) is having physical safety. Feeling unsafe affects the way people act and react to everyday life occurrences. Further, research has demonstrated that individuals exposed to violence in their homes, the community, and schools are more likely to experience depression and anxiety and demonstrate more aggressive, violent behavior.

2022 – 2024 Implementation Strategy Plan

The implementation strategy plan describes how Memorial Medical Center plans to address significant health needs identified in the 2022 Community Health Needs Assessment and is aligned with the hospital's charitable mission. The strategy describes:

- Actions the hospital intends to take, including programs and resources it plans to commit,
- Anticipated impacts of these actions and a plan to evaluate impact, and

- Any planned collaboration between the hospital and other organizations in the community to address the significant health needs identified in the 2022 CHNA.

Prioritized Significant Health Needs the Hospital Will Address

The implementation strategy plan serves as a foundation for further alignment and connection of other Memorial Medical Center initiatives that may not be described herein, but which together advance the hospital's commitment to improving the health of the communities it serves. Each year, programs are evaluated for effectiveness, the need for continuation, discontinuation, or the need for enhancement. Depending on these variables, programs may change to continue focus on the health needs listed below.

1. Access to Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavioral Health and Substance Use Services
3. Access to Quality Primary Care Health Services
4. Increased Community Connections
5. Access to Functional Needs
6. Injury and Disease Prevention and Management
7. Active Living and Healthy Eating
8. Safe and Violence-Free Environment

Access to Basic Needs Such as Housing Jobs, and Food

Name of program/activity/initiative	Low Barrier Shelter Programs
Description	Memorial Medical Center invests in various programs that provide basic needs to our homeless population. These programs provide individuals experiencing homelessness with shelter and wraparound services, including case management, meals, job training and resume assistance, and referrals to housing.
Goals	Our goal is to shelter individuals experiencing homelessness who would otherwise be living on the streets, and to connect them with services that will improve their overall health.
Anticipated Outcomes	We anticipate more individuals experiencing homelessness will be connected to primary and mental health care, which would lead to a decrease in emergency room visits and improved health outcomes. We also anticipate more individuals will be connected with housing.
Metrics Used to Evaluate the program/activity/initiative	Number of individuals served; number of service referrals including primary and mental health care, insurance enrollment, transportation and income assistance; case management outcomes; and number of people connected to long-term or short-term housing.

Access to Mental/Behavioral Health and Substance Use Services

Name of program/activity/initiative	Respite Care Program
Description	In partnership with other hospitals, health plans and the County, we are exploring opportunities to open a respite care program which will provide both medical and behavioral health support for individuals experiencing

	homelessness who need a safe place to recuperate and recover. The program will link clients in need to vital community services while giving them a place to heal.
Goals	Our goal is to shelter individuals experiencing homelessness who would otherwise be living on the streets, and to connect them with services that will improve their overall health.
Anticipated Outcomes	We anticipate more individuals experiencing homelessness will be connected to primary and mental health care, which would lead to a decrease in emergency room visits and improved health outcomes. We also anticipate more individuals will be connected with housing.
Metrics Used to Evaluate the program/activity/initiative	Number of individuals served; number of service referrals including primary and mental health care, insurance enrollment, transportation and income assistance; case management outcomes; and number of people connected to long-term or short-term housing.

Access to Quality Primary Care Health Services

Name of program/activity/initiative	Medical Education for Physicians
Description	Residency program for family care providers to train physicians in the primary care arena.
Goals	Our goal is to expand the number of physicians able to see underinsured patients and increase the number of family practice practitioners in our community.
Anticipated Outcomes	We expect to see an increase in the number of providers who will be able to take Medi-Cal and uninsured patients, which will result in lower barriers for the underserved to access primary care and better health outcomes for that population.
Metrics Used to Evaluate the program/activity/initiative	Number of physicians who received training; number of patients served through the program; and number of inpatient and outpatient visit by residents.

Name of program/activity/initiative	Street Medicine Team
Description	This program will deploy a team of medical professionals who can provide acute medical services and access to education through referrals to individuals who are experiencing homelessness. A Licensed Vocational Nurse (LVN) and a Community Health Worker (CHW) will connect with the homeless population by bringing medical services to them with the use of a Medical Van equipped with medical supplies to perform basic medical services such as wound care, blood pressure checks, and glucose checks.
Goals	Provide outreach, triage, mobile medicine, transportation, and referrals to the homeless community.
Anticipated Outcomes	Increased access to primary and specialty care for individuals experiencing homelessness, which will result in decreased emergency room visits because patients will be able to better manage their health.
Metrics Used to Evaluate the program/activity/initiative	Number of people encountered; number of patients treated; patient demographics; services provided; and number of referrals to support services.

	Emergency Department Navigators

Name of program/activity/initiative	
Description	Patient Service Navigators (PSNs) who are based in Memorial Medical Center will provide underserved patients from the emergency department with resources and information to ensure they receive proper follow-up care after discharge. This will include support services such as scheduling clinic appointment with their preferred Primary Care Provider (PCP), scheduling patients for dental appointments, temporary housing referrals and other community resources such as soup kitchens around the vicinity.
Goals	The goal of this program is to ensure patients who are under or uninsured receive appropriate and timely clinic follow up appointments after discharge from Memorial Medical Center. The program will help ensure that delivery of adequate and quality health care to those patients is achieved.
Anticipated Outcomes	We anticipate that by being proactive in health care planning, patients' needs are met in the primary care setting thereby preventing unnecessary ED and hospital visits.
Metrics Used to Evaluate the program/activity/initiative	Number of individuals served; number of individuals with a chronic condition; service referrals; primary care appoints scheduled; and number of patients who attended their follow-up appointment.

Name of program/activity/initiative	In-Patient Navigators
Description	Patient Service Navigators (PSNs) who are based in Memorial Medical Center will provide underserved patients from an in-patient setting with resources and information to ensure they receive proper follow-up care after discharge. This will include support services such as scheduling clinic appointment with their preferred Primary Care Provider (PCP), scheduling patients for dental appointments, temporary housing referrals and other community resources such as soup kitchens around the vicinity.
Goals	The goal of this program is to ensure patients who are under or uninsured receive appropriate and timely clinic follow up appointments after discharge from Memorial Medical Center. The program will help ensure that delivery of adequate and quality health care to those patients is achieved. Many of these patients have or are at-risk of having chronic disease, so another goal will be to educate them about how to better manage their health care.
Anticipated Outcomes	We anticipate that by being proactive in health care planning, patients' needs are met in the primary care setting and they will be able to better manage their diseases and chronic conditions. In addition, we expect that more patients will be able to prevent disease by establishing with a PCP and receiving more preventative health care services.
Metrics Used to Evaluate the program/activity/initiative	Number of individuals served; number of individuals with a chronic condition; service referrals; primary care appoints scheduled; and number of patients who attended their follow-up appointment.

Increased Community Connections

Name of program/activity/initiative	Day Program for Seniors
Description	The Senior Program will provide a daily program for seniors to participate in classes from mental health, fitness, basic senior needs, nutrition,

	healthy living, active living and healthy eating. A Senior Coordinator will implement program with assistance from Program Manager. A kitchen aide will provide daily hot cooked nutritious meals. A driver will be available to shuttle seniors to and from program and appointments as needed this includes shuttling over seniors from the homeless shelters. The program will incorporate guest speakers for senior related topics. Fitness classes will be available and the program will allow for seniors of all demographics to be treated and served quality programs and meals.
Goals	Provide at-risk seniors with resources and programing that are beneficial to them and offer a safe haven for seniors to have social interaction.
Anticipated Outcomes	The outcome is to decrease health risks and increase physical activity to improve mental and physical health.
Metrics Used to Evaluate the program/activity/initiative	Number of clients; number of referrals; case management outcomes; track healthy lifestyle eating, fitness and wellness benchmarks; referrals to homeless service resources.

Access to Functional Needs

Name of program/activity/initiative	Day Program for Seniors
Description	The Senior Program will provide a daily program for seniors to participate in classes from mental health, fitness, basic senior needs, nutrition, healthy living, active living and healthy eating. A Senior Coordinator will implement program with assistance from Program Manager. A kitchen aide will provide daily hot cooked nutritious meals. A driver will be available to shuttle seniors to and from program and appointments as needed this includes shuttling over seniors from the homeless shelters. The program will incorporate guest speakers for senior related topics. Fitness classes will be available and the program will allow for seniors of all demographics to be treated and served quality programs and meals.
Goals	Provide at-risk seniors with resources and programing that are beneficial to them and offer a safe haven for seniors to have social interaction. Also provide transportation for seniors to access health care appointments and other services.
Anticipated Outcomes	The outcome is to decrease health risks and increase physical activity to improve mental and physical health.
Metrics Used to Evaluate the program/activity/initiative	Number of clients; number of referrals; case management outcomes; track healthy lifestyle eating, fitness and wellness benchmarks; referrals to homeless service resources; number of rides provided.

Injury and Disease Prevention and Management

Name of program/activity/initiative	Tobacco Prevention and Education Program for Youth
Description	This education program promotes anti-smoking behavior by mobilizing teens to decrease tobacco use through peer-focused activities in high schools and middle schools throughout the county.
Goals	A large coalition of teens are trained to communicate with students the dangers and negative outcomes of smoking or tobacco use. The major objective of program is to join teens together to believe that not smoking is cool.

Anticipated Outcomes	An overall county wide reduction in use of tobacco products among teens.
Metrics Used to Evaluate the program/activity/initiative	Number of students reached; number of events held to educate youth about the risks of tobacco; and anecdotal stories.

Active Living and Healthy Eating

Name of program/activity/initiative	Mobile Fresh Foods Program for Youth
Description	Direct distribution of nutritious foods for youth and families that are struggling with food insecurity. This program is designed to bring the food out to meet the people where they live, addressing some of the barriers of the low income population.
Goals	Increase consumption of produce and healthy food choices for low-income youth and families.
Anticipated Outcomes	We anticipate this will lead to healthier choices and improved health outcomes for youth and their families, with a decreased likelihood for obesity and chronic diseases such as diabetes.
Metrics Used to Evaluate the program/activity/initiative	Number of clients served; number of pounds of foods distributed; and anecdotal stories.

Safe and Violence-Free Environment

Name of program/activity/initiative	Domestic Violence Prevention
Description	Partner with organizations who are committed to supporting survivors of domestic and sexual abuse or exploitation and working to end gender-based violence. Our partnership will focus on educational programming for adolescents.
Goals	Our goal is to educate and empower high school aged youth to reduce and prevent relationship abuse and promote healthy relationship skills and behaviors with their peers.
Anticipated Outcomes	High school aged youth will have greater knowledge of the signs of relationship abuse, as well as community resources that can provide support.
Metrics Used to Evaluate the program/activity/initiative	Number of students reached; pre-and post-intervention assessments; and anecdotal stories.

Needs Memorial Medical Center Plans Not to Address

No hospital can address all of the health needs present in its community. Memorial 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. The implementation strategy does not include specific plans to address the following significant health needs that were identified in the 2022 Community Health Needs Assessment:

1. **System Navigation**: Given limited time and resources and our focus on other priority needs, we will not be addressing system navigation during this implementation cycle.

Approval by Governing Board

The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Health Valley Hospitals Board on July 21, 2022.