

St. Helena Hospital Clear Lake

2017 Community Health Plan
(Implementation Strategy)
2016 Update/Annual Report



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Adventist Health Overview

St. Helena hospital Clear Lake is an affiliate of Adventist Health, a faith-based, nonprofit, integrated health system headquartered in Roseville, California. We provide compassionate care in more than 75 communities throughout California, Hawaii, Oregon and Washington.



OUR MISSION:

Living God's love by inspiring health, wholeness and hope.

OUR VISION:

Adventist Health will be a recognized leader in mission focus, quality care and fiscal strength.

Adventist Health entities include:

- 20 hospitals with more than 2,700 beds
- More than 260 clinics (hospital-based, rural health and physician clinics)
- 15 home care agencies and seven hospice agencies
- Four joint-venture retirement centers
- Workforce of 32,900 includes more than 23,600 employees; 5,000 medical staff physicians; and 4,350 volunteers

We owe much of our heritage and organizational success to the Seventh-day Adventist Church, which has long been a promoter of prevention and whole person care. Inspired by our belief in the loving and healing power of Jesus Christ, we aim to bring physical, mental and spiritual health and healing to our neighbors of all faiths. Every individual, regardless of his/her personal beliefs, is welcome in our facilities. We are also eager to partner with members of other faiths to enhance the health of the communities we serve.

Our commitment to quality health care stems from our heritage, which dates back to 1866 when the first Seventh-day Adventist health care facility opened in Battle Creek, Michigan. There, dedicated pioneers promoted the “radical” concepts of proper nutrition, exercise and sanitation. Early on, the facility was devoted to prevention as well as healing. They called it a sanitarium, a place where patients—and their families—could learn to be well.

More than a century later, the health care system sponsored by the Seventh-day Adventist Church circles the globe with more than 170 hospitals and more than 500 clinics, nursing homes and dispensaries worldwide. And the same vision to treat the whole person—mind, body and spirit—continues to provide the foundation for our progressive approach to health care.



Adventist Health's mission of healing began in 1866 and has been present in Lake County since the purchase of what was Redbud Community Hospital in 1997. At St. Helena Hospital Clear Lake, we have fully embraced living God's love by inspiring health, wholeness and hope and have set our sights on a future where our health care organization is not only a destination for medical care, but is also committed to leading innovative, results-drive initiatives that make a difference in the lives of our patients and community members.

The annual Community Health Improvement Plan provides an opportunity for our organization to think strategically and proactively about how we can best support Lake County. We have aligned our priorities with partner agencies and organizations to address challenges and overcome barriers to health and wellness for our citizens. As we become more efficient in working together, our collective impact in the community becomes more significant. Our motto, "Together Inspired," brings a unified focus to Adventist Health as an organization. Locally, this tagline beautifully describes the collaborative development of our Community Health Needs Assessment and collective response. This synergy will continue to be evident as we work together to serve Lake County.

Thank you for your interest in this important work. Contact our Community Wellness team for more information at 707-995-5884.

Sincerely,

A handwritten signature in blue ink that reads "David Santos". The signature is fluid and cursive, with a long horizontal stroke at the end.

David Santos
President and CEO

Hospital Identifying Information



St. Helena Hospital Clearlake

25-bed Critical Access hospital

15630 18th Avenue, Clearlake, CA 95422

David Santos, President, CEO

Existing healthcare facilities that can respond to the health needs of the community:

- Adventist Hospital Clear Lake, 15630 18th Avenue, Clearlake, Ca 95422
- Adventist Health Family Health Center, 15320 Lakeshore Drive, Clearlake, CA 95422
- Adventist Health Live Well, 15320 Lakeshore Drive, Clearlake, CA 95422
- Adventist Health Hidden Valley Clinic, 18990 Coyote Valley Drive, Hidden Valley Lake, Ca 95467
- Adventist Health Family Health Center, 52960 State Street, Kelseyville, CA 95451
- Adventist Health Konocti Wellness Center, 9340 C Lake Street, Lower Lake, CA 95457
- Adventist Health Family Health Center, 21337 Bush Street, Middletown, CA 95461
- Adventist Health General Surgery, 15322 Lakeshore Drive, Suite 101, Clearlake, CA 95422
- Adventist Health Rehabilitation Services, 14855 Olympic Drive, Clearlake, CA 95422
- Family Health Center Arbuckle, 900 King Street, Arbuckle, CA 95912
- Family Health Center Williams, 501 E Street, Williams, CA 95987

- Family Health Center Colusa, 151 E. Webster Street, Colusa, CA 95932
- Sutter Lakeside Hospital, 5176 Hill Road East, Lakeport, CA 95453
- Lakeview Health Center, 5335 Lakeshore Drive, Lakeport, CA 95453
- Lake County Tribal Health Consortium, 925 Bevins Street, Lakeport, Ca 95453
- Clearlake Veterans Affairs Medical Clinic, 15145 Lakeshore Drive, Clearlake, CA 95422

Community Health Development Team



David Santos

President, CEO



Marc Shapiro, MD

Chief of Staff



Shelly Mascari

Director
Community Wellness



Garin Fuhriman

Director
Outpatient Operations



Colleen Assavapisiktul

RN, BSPA, HACCP
Vice President of Patient Care



Carlton Jacobson

Regional Vice President
Finance



Brent Dupper

Administrative Director
Physician Outpatient Services



Conrad Colbrandt

Executive Director
Redbud Health Care District



Laurie Allen

Project Coordinator
Community Wellness



Marilyn Wakefield

Grants Coordinator
Community Wellness

CHNA/CHP contact:

Shelly Mascari
Director, Community Wellness
15322 Lakeshore Drive, Suite 201, Clearlake, CA 95422
email: shelly.mascari@ah.org

To request a copy, provide comments or view electronic copies of current and previous community health needs assessments:
<https://www.adventisthealth.org/pages/about-us/community-health-needs-assessments.aspx> or [AdventistHealth.org/
communitybenefit](https://www.adventisthealth.org/communitybenefit)

Invitation to a Healthier Community

Fulfilling AH 's Mission

Where and how we live is vital to our health. We recognize that health status is a product of multiple factors. To comprehensively address the needs of our community, we must take into account health behaviors and risks, the physical environment, the health system, and social determinants of health. Each component influences the next and through strategic and collective action improved health can be achieved.

The Community Health Plan marks the second phase in a collaborative effort to systematically investigate and identify our community's most pressing needs. After a thorough review of health status in our community through the Community Health Needs Assessment (CHNA), we identified areas that we could address through the use of our resources, expertise, and community partners. Through these actions and relationships, we aim to empower our community and fulfill our mission, "to share God's love by providing physical, mental and spiritual healing."

Identified Community Needs

The results of the CHNA guided the creation of this document and aided us in how we could best provide for our community and the most vulnerable among us. As a result, St. Helena Hospital Clear Lake soon to know as St. Helena Hospital Clear Lake has adopted the following priority areas for our community health investments for 2017-2019:

- Healthy Behaviors
- Clinical Care
- Social & Economic Factors
- Physical Environment

Additionally, we engage in a process of continuous quality improvement, whereby we ask the following questions for each priority area:

- Are our interventions making a difference in improving health outcomes?
- Are we providing the appropriate resources in the appropriate locations?
- What changes or collaborations within our system need to be made?
- How are we using technology to track our health improvements and provide relevant feedback at the local level?
- Do we have the resources as a region to elevate the population's health status?

Building a healthy community requires multiple stakeholders working together with a common purpose. We invite you to explore how we intend to address health challenges in our community and partner to achieve change. More importantly though, we hope you imagine a healthier region and work with us to find solutions across a broad range of sectors to create communities we all want for ourselves and our families.

Community Profile

How our community is defined

Lake County is located in Northern California just two hours by car from the San Francisco Bay Area, the Sacramento Valley, or the Pacific Coast. The county's economy is based largely on tourism and recreation, due to the accessibility and popularity of its several lakes and accompanying recreational areas. It is predominantly rural, about 100 miles long by about 50 miles wide, and includes the largest natural lake entirely within California borders. Lake County is mostly agricultural, with tourist facilities and some light industry. Major crops include pears, walnuts and, increasingly, wine grapes. Dotted with vineyards and wineries, orchards and farm stands, and small towns, the county is home to Clear Lake, California's largest natural freshwater lake, known as "The Bass Capital of the West," and Mt. Konocti, which towers over Clear Lake.

Within Lake County there are two incorporated cities, the county seat of Lakeport and the City of Clearlake, the largest city, and the communities of Blue Lakes, Clearlake Oaks, Cobb, Finley, Glenhaven, Hidden Valley Lake, Kelseyville, Loch Lomond, Lower Lake, Lucerne, Nice, Middletown, Spring Valley, Anderson Springs, Upper Lake, and Witter Springs as displayed on the map below.

Lake County is bordered by Mendocino and Sonoma Counties on the west; Glenn, Colusa and Yolo Counties on the east; and Napa County on the south. The two main transportation corridors through the county are State Routes 29 and 20. State Route 29 connects Napa County with Lakeport and State Route 20 traverses California and provides connections to Highway 101 and Interstate 5.

According to California labor market data about county-to-county commute patterns (which have not been updated since 2000), the total workers that live and work in Lake County is 15,566 persons: the total workers commuting in was 1,046; and 4,320 total workers commuted out. About 67% of people who live in Lake County also work within the county. While the population size of Lake County was estimated as 64,918 residents in January 2015, the population can swell with daytime work commuters and seasonal tourists.

Demographics of the community

Approximately 30% of all Lake County residents live in the cities of Clearlake and Lakeport while the remainder lives in unincorporated areas. The population of Lake County has increased modestly overall since the 2000 Census, with most of the growth occurring outside of the two cities (Table 3).



Table 3. Population Estimates of Lake County Cities

Area	4/1/2010	1/1/2011	1/1/2012	1/1/2013	1/1/2014	1/1/2015
Clearlake	15,250	15,186	15,104	15,087	15,036	14,977
Lakeport	4,753	4,711	4,673	4,664	4,728	4,699
Balance of County	44,662	44,486	44,527	44,753	44,995	45,242
Unincorporated	20,003	19,897	19,777	19,751	19,764	19,676
County Total	64,665	64,383	64,304	64,504	64,759	64,918

Source: State of California, Department of Finance, *E-4 Population Estimates for Cities, Counties, and the State, 2011-2015, with 2010 Census Benchmark*. Sacramento, California, May 2015.

City/county population estimates with annual percent change between January 2014 and January 2015 show slight growth for the county overall. The two cities, however, saw a slight decline in population between the two time periods.

In 2010 three-quarters of Lake County’s population identified themselves as non-Hispanic White, 17.2% as Hispanic, 3.1% as multi-race, 2.4% as American Indian, 1.9% Black, 1.1% Asian and 0.2% as Native Hawaiian/Pacific Islander; less diverse than the state as a whole.

Lake County’s population is projected to become increasingly culturally diverse in coming years with significant growth among Hispanics, Asians and multi-race individuals. The Hispanic population is projected to more than double, Asians to increase four-fold, and persons identifying as multi-race to almost double from 2010 to 2060. Conversely, the proportion of non-Hispanic Whites, African Americans, and American Indians will decline. The shift in Lake County population groups has implications for designing and delivering needed services in ways that are culturally and linguistically appropriate.

Lake County’s senior population is projected to grow at a disproportionate rate, while its proportion of young and working age people declines. The working age population (age 25-64) is expected to shrink by 10% by 2060. In 2010, 17.8% of the county’s population was 65 or older compared to 11.5% statewide. It is predicted to nearly double and comprise almost one-third of the county’s population by 2060. California’s senior population is also expected to double, but to only comprise about one-quarter of the total population. In Lake County, the proportion of people age 75- 84 is projected to double, and for people 85 and over to almost triple. The anticipated significant growth in this age group will put a larger burden on the health care system and local economy, which may not have sufficient community services or tax base to support it.

Priority Areas

Priority Area 1: Mental Health

While risk and protective factors vary, individuals, families and communities are impacted by mental disorders in endless ways—health status, income, family stability, suicide risk, to name the more important ones. People have different ways of coping with mental and emotional distress—some healthy (exercise, worship), some not (drug use)—and different extents of support systems. Social and economic determinants of mental health demand public health and population-based strategies to prevent and manage common mental disorders in the community.

Priority Area #2: Substance Use Disorders

Experts indicate that an optimal mix of prevention interventions, as well as treatment resources, are required to address substance use issues in communities, because they are among the most difficult social problems to prevent or reduce.

Priority Area #3: Access to Programs and Services

This priority area addresses a range of access concerns from inadequacies in infrastructure to lack of community awareness. It was clear from the community input to the CHNA that so many people in Lake County were unaware of the many health, educational, and social services and programs that are already available (though not always affordable or convenient).

Priority Area #4: Housing and Homelessness

The vast majority of homeless individuals and families fall into homelessness after a housing or personal crisis. These households may require only short-term assistance to find permanent housing quickly and without conditions. Others fall into homelessness after release from institutions, including jail and the foster care system. Still others come to homelessness from mental health programs and other medical care facilities. Early intervention to prevent homelessness is a critical component in treating mental illness before it can cause serious results like unemployment and chronic homelessness. Suggested strategies for Lake County could include:

- Year-round sheltering that includes families with children.
- Social programs that connect vulnerable populations with emergency services, temporary cash assistance, and case management, many of which already exist in Lake County. By and large, homeless individuals can access mainstream programs, including Temporary Assistance to Needy Families (TANF), Supplemental Security Income (SSI), Medi-Cal and other existing federal assistance programs.
- Financial and other support or assistance to achieve housing stability and individual well-being. This can also minimize the length of stay in shelters and reduce repeat homeless episodes.
- Housing locator services that include incentives to landlords to rent to homeless households, creative uses of housing vouchers and subsidies to help homeless individuals and families afford their rental unit, and links to resources to help clients maintain their housing.
- Low-demand housing that does not mandate sobriety or treatment. It is well recognized that many people living on the streets exhibit mental illness, substance addiction, and other negative behavior patterns.

Information gaps

There are several ways to present data just as there are multiple ways to identify health needs: by age group; by issue or problem; by ethnic group; by systems (hospitals, clinics). The CHNA examined the published community health indicator data commonly collected in community needs assessments (referred to as “secondary data”), added to it, and highlighted populations and issues of interest where the data already existed. Where data were available by more than one variable (for instance, age and racial/ethnic group) they are generally presented. Having baseline data from the prior assessment allowed us to add certain trend data in the current report.

Using secondary data requires collecting information from many sources. Data availability varies among different data sources; new data are continually being released. Any report of this type will soon have certain data that are not the most up-to-date. (For example, data from CHIS, the California Health Information Survey, which is a rich data source for community health needs assessments, is generally not released until about 2 years after it is collected). Also, reporting periods can vary by calendar year, frequency and fiscal year; consistency varies, especially over time and among agencies and organizations; and data are not always collected in the format that is best suited to the purposes of the report.

The CHNA relied on data that could be collected and analyzed to determine if and to what degree a problem or need existed. In some cases, data did not exist that directly applied to a certain need or condition; in other cases, no indicators were readily available to describe a potential need. The community input process (referred to as “primary data”) provided some opportunity to identify such needs and ensured that they were considered in the priority-setting process. The availability (or lack) of services can substantially influence reporting. Some data were not collected, such as the availability of services from private medical groups, and therefore could not be counted in the capacity assessment.

In some cases, statistics and information that others compiled have been included in this report. However, it was not always possible to authenticate all of that data. In some cases, expert opinion was included in the analysis regarding the state or condition of a certain issue. And, while recommendations to address unmet needs were identified by participants in the community input process, there was no attempt by the Collaborative to evaluate these suggestions for appropriateness or endorse them relative to best practices and evidence-based effectiveness.

Finally, no one data set in this report really tells the whole story about Lake County’s unmet or under met health needs; all of the data collected by this process—the statistics, feedback from the community questionnaire, focus group input and key informants’ perspectives—collectively paint the picture. It is therefore suggested that readers consider the entirety of the findings when drawing conclusions or making policy changes and funding decisions.



Community Health Needs Assessment Overview

Link to final CHNA report

St. Helena Hospital Clear Lake approved the 2016 CHNA in September 2016 and made it publicly available on the St. Helena Hospital Clear Lake website in October 2016. Click here to view the <https://www.adventisthealth.org/pages/about-us/community-health-needs-assessments.aspx>.

Methodology for CHNA

Collaborative Process

To engage community partners and maximize the efforts of this community health assessment, invitations were issued to individuals, organizations, and Tribal representatives to serve as the project’s Advisory. In addition to providing overall guidance and helpful insights, the members supported the community engagement strategies, helped to increase awareness and mobilize the community, and facilitated participation in community input activities.

Data Collection

Community needs assessments involve gathering, analyzing and applying data and other information for strategic purposes. These methods provide the necessary input to inform decision makers and funders about the challenges they face in improving community health, and the priority areas where support is most needed. The information is also useful for community organizations by having comprehensive, local data located in one document. Both quantitative and qualitative methods were used to collect the information for this assessment.

Secondary Data: Publicly Available Statistics

Existing data were collected from all applicable existing data sources including government agencies (e.g., California Department of Health Care Services, California Department of Finance, Office of Statewide Health Planning and Development, California Health Information Survey and other public and private institutions. These data included demographic, economic and health status indicators, and service capacity/ availability. Where trend data were readily available, they are presented in this report.

While data at the national and state level are generally available for community health-related indicators, local data—from counties and cities—are less accessible and sometimes less reliable. For example, small sample sizes can result in statistical “instability,” and well-meaning data collection methods without appropriate “rigor” may limit the value of the findings. Because data from publicly- available sources typically lag by at least 2 years—because it takes time for reported data to be received, reviewed, approved, analyzed, and prepared for presentation—data may not always be as current as needed. And, some data may only be reported as 3-year averages, not annually.



Document Review

A document review was undertaken that collected relevant information about the community, health status, where health services are obtained, other related services, and gaps in services. This information was found in documents and records of facilities such as data from local clinics and state government, reports from needs assessments conducted related to health, and reports about specific health programs or services.

Primary Data: Community Input

Input from the broad community was considered and taken into account when identifying and prioritizing the significant health needs of Lake County that are addressed in this assessment. This rich source of data was obtained through key informant interviews, focus groups and a community health survey.

Community Survey

A survey was developed in English and Spanish that solicited people’s opinions about most important health needs, barriers to access care, and suggestions for community health improvements. Certain questions that serve as markers for access to services were also included. The survey was distributed in hard copy by members of the Collaborative to locations where the groups of interest would best be reached, such as at branches of public libraries, laundromats, churches, nail salons, and family resource centers throughout the county, as well as promoted through efforts such as at the 2-day Valley Fire “Rebuild Expo” in Middletown and over the air on KPFZ’s “Senior Moments” show.

The survey was also available online (English only) and notices about the electronic version were posted on the County’s and various organizations’ websites and in newsletters. All of the electronic and hard-copy survey data were cleaned, coded, and entered into an Excel spreadsheet and analyzed using SPSS Version 20.0.

Community Focus Groups

Three communities—Clearlake, Lakeport and Kelseyville—ensured geographic representation at the 6 community focus groups that were conducted. Key community-based organizations and social clubs were identified by the Collaborative and invited to host a focus group. In each case, the focus groups were co-scheduled during a time the participants were already meeting there for other purposes (e.g., young mothers attending a Mother-Wise parenting meeting) to facilitate access and promote attendance. Although the participants constituted a convenience sample, there was the expectation that in the aggregate the groups would be diverse and include the populations of highest interest.

A common set of structured key questions was used for all groups (Attachment 2). The questions were generally open-ended; prompting with information or data was limited to reduce the potential for bias or leading of participants to any conclusions. Participants were not asked to “vote” or otherwise rank the items they identified as needs, problems or solutions. The focus group data were recorded on a flip chart or notebook by the facilitator during the meetings then transferred to written summary formats where the notes were then coded for analysis. A \$20 Safeway gift card was offered in most groups in appreciation for participation. The agencies and organizations that sponsored the community meetings helped to publicize the sessions and promote attendance.

Key Informant Interviews

Telephone interviews using a structured set of questions (with additional, personalized questions to obtain more in-depth information) were conducted with 12 of the 16 invited individuals who agreed to participate in



a key informant interview (Attachment 3). The interviews provided an informed perspective from those who work directly with the public and/or determine some of the policies that affect the community's health. These individuals were able to offer information about local resources and gaps in services, high-priority health needs, and suggestions for positive change. The interviews also focused the needs assessment on particular issues of concern where individuals with certain expertise could confirm or dispute patterns in the data and identify data and other studies the Collaborative might not otherwise be aware of.

Collaborative Partners

Partners

- Jennifer Dodd, Executive Director Lake Family Resource Center
- Karen Tait, MD, Health Officer Lake County Health Services
- Kimberly Tangermann, Clinic Director Lakeview Health Center
- Shelly Mascari, Director Community Wellness St. Helena Hospital Clear Lake
- Susan Jen, MPH, MA, Director Health Leadership Network
- Tiffany Ortega, MHA, Assistant Administrator Sutter Lakeside Hospital
- Todd Metcalf, Director, Lake County Department of Social Services
- Tom Jordan, Executive Director First 5 Lake County

Mendocino Community Health Clinic: Lakeview Health Center

Previously named the Lakeside Health Center, the Lakeview Health Center was opened in 1999 by Mendocino Community Health Clinic, Inc. Located in Lakeport, the health center advocated for a public transit bus stop at the clinic site and provides a van to assist patients in accessing services. Services are provided for individuals regardless of their ability to pay.

The health center provides medical, dental and counseling services. The clinic reports that almost one-third of its patients have some form of chronic illness and the overwhelming numbers of these individuals have multiple disorders. Services include: comprehensive primary care medical services including physical exams, chronic disease management services, health maintenance support, vaccines, immunizations, incision/drainage of cysts, outpatient HIV testing and care, well-child care, CHDP exams, addiction medicine, and screenings for anemia, lead, vision, hearing and tuberculosis. Additionally, the clinic provides services offsite to seniors in skilled nursing facilities and to the homeless.

Lakeview Health Center's program continues to integrate primary medical care and behavioral health counseling for patients with difficult problems like addiction, mental illness and chronic pain, tobacco use and obesity.



Comprehensive dental care is provided by dentists on site. Special programs include HIV dental care, oral health care for pregnant women and oral care for the developmentally disabled.

Sutter Lakeside Hospital

Sutter Lakeside Hospital operates a community clinic and a family medicine clinic.

Community Clinic

The community clinic in Lakeport provides comprehensive primary care for adults and children. Preventative care, vaccinations and physical exams are provided as well as more specialized services including osteopathic care, cardiology, sports medicine, obstetrics and gynecology and integrative medicine. The clinic also cares for those with long-term medical conditions such as diabetes, arthritis, and heart disease. The community clinic opened in 2014 and reported 5,762 patient encounters for that year.

Family Medicine Clinic

The Family Medicine Clinic is located in Lakeport at the site of Sutter Lakeside Hospital. Currently the clinic provides cardiology, podiatry, family practice and employee health. Clinicians also offer general medical care including physicals, general illness care, vaccinations, and wellness visits. The Family Medical Clinic is open from 8 am to 5 pm on weekdays.

St Helena Hospital Clearlake

The hospital provides medical, dental and mental health services at family health centers located in Clearlake, Middletown, Kelseyville, Hidden Valley Lake and Lower Lake (Konocti Wellness Center School-Based Clinic, onsite at Konocti Unified School District). In addition to physicians, services are provided by a certified nurse-midwife, nurse-practitioners, licensed clinical psychologists and clinical social workers. The 3 clinics combined provided 81,269 patient encounters in 2014.

Public Health Services

The Lake County Public Health Department offers a variety of programs at its Lakeport office. These services and programs are described below.

California Children’s Services (CCS)

The California Children’s Services (CCS) program is available for children with certain physically- handicapping conditions. The program provides diagnostic evaluations, treatment, nursing case management services, physical and occupational therapy for eligible children (0-21 years of age) related to their eligible medical condition. The CCS program also has a local Medical Therapy Unit for Physical and Occupational Therapy for eligible clients.

Child Health and Disability Prevention (CHDP) Program Administration

Administrative oversight of a program that provides for free periodic medical and dental health check-ups for infants, children and youth through age 20 if program eligible. If further medical, dental, or mental health services are needed, the Department can assist with scheduling and/or transportation information.



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Childhood Lead Poisoning Prevention Program

Nursing case management services are offered at no cost to a family when a child has a confirmed elevated blood lead level. Other program activities include community outreach and provider education.

Clinical Services

There are no clinical services currently available at Public Health.

Communicable Disease

Communicable Disease Surveillance services are conducted to collect reports and monitor reportable communicable disease data to identify local needs and to control disease outbreaks.

Dental Disease Prevention

One of the Public Health Nurses helps to convene the oral health advisory committee.

Emergency Preparedness

Lake County Public Health prepares for natural and human causes of disasters and disease threats, working collaboratively with other emergency responders, healthcare facilities, and local citizens in order to serve the community. Lake County’s Public Health Preparedness and Response program focuses on planning the response to disease threats, such as influenza pandemics, bioterrorism, and health hazards associated with natural disasters (earthquakes, floods, wildfires and others).

Overview of Health Services Available in Community Clinics: Lake County, 2016

Clinic Name	Clinic Location	Primary Care	Mental Health	Dental	Case Management and Support for Chronic Illnesses	Specialty Services	Language	Transport
Mendocino Community Health Clinic	Lakeport	Yes	Yes	Yes	HIV Care	Pediatric, Women’s Health, On-site Pharmacy, HIV Care, Psychiatrist services, Dermatology, Chiropractic, Gastroenterology	English Spanish	Van available Bus Stop
Lakeview Health Center		M-F: 9-5	Primary Care Consultation and Psychotherapy	M, W, F: 9-5 T: 9-7				

Clinic Name	Clinic Location	Primary Care	Mental Health	Dental	Case Management and Support for Chronic Illnesses	Specialty Services	Language	Transport
Lake County Tribal Health Consortium	Lakeport Satellite clinics in Clearlake and Middletown	Yes Lakeport: M-F: 7:30-5:00 Clearlake : T: 9-3:45 W: 1-4 F: 9-3:45 Middletown Wednesday: 2 nd and 4 th Wednesday	Yes <i>LCHTC uses the term Human Services to describe Mental Health Care</i>	Yes Lakeport : M-F: 7:30-5	Yes Specialized program for diabetes	Podiatry, Chiropractic, Acupuncture, Pediatrics and Obstetrics, Pain Management, Nutrition Therapy, Support groups for youth, women and men	English Spanish	Van available for eligible Native American Lake County residents Escort funds for eligible patients
Sutter Lakeside Community Clinic	Lakeport	Yes M-F: 8-5	No	No	No	Osteopathic Care, Sports Medicine, Cardiology, Integrative Medicine, Gynecology	English Spanish	Yes For qualified residents of Kelseyville, Upper Lake, Lucerne, Lakeport, Nice and Finley
Sutter Lakeside Hospital Family Medicine Clinic	Lakeport	Yes M-F: 8am-5pm	No	No	No	Cardiology, Podiatry, and Family Practice, Employee Health	English Spanish	

Community Voices

The *Lake County Community Health Survey* was distributed in various community locations throughout Lake County in hard copy and online in an attempt to reach a wide sample of residents. Only the paper copy of the survey was available in Spanish. A total of 768 surveys were completed, 67% online and 33% on paper. Five (1%) of the hard-copy surveys were completed in Spanish. These percentages are within 5% of the 2013 community health survey responses.

A total of 96 individuals attended one of the 6 community focus groups. While no one group was expected to be representative of Lake County, *in the aggregate* the groups reflected a diversity of residents, particularly those with needs most often addressed by community needs assessments. All of the groups were English-



speaking, and overall women and men were represented in fairly equal numbers. The participants were typically 40-65 years of age, although two groups had a predominance of older adults and one was comprised mostly of young adults. The focus groups were held at a variety of host organizations.

Focus group participants were asked to make recommendations for “improving the health of people in the community,” including suggestions about the kinds of services they would like to see added, expanded, or improved in Lake County. The facilitators did not prompt the responses but reminded attendees of the significant health needs they had earlier identified; in only about half of the groups the participants tied their recommendations to the top health needs.

There was little consistency in the above listing of recommendations among the groups: 5 of the 22 ideas were made by 2 of the 6 focus groups; the remainder of the ideas was suggested by only 1 group. The 5 common recommendations related to:

- Preventive nutrition-related education
- Preventive health education aimed specifically at youth
- Activities to involve and engage children and youth
- Mental/emotional health counseling
- Inter-agency collaboration

What was given little attention across the focus groups in the recommendations, given the importance of the needs the participants had identified earlier, and that might have been expected to be advocated for (and which were also significant concerns in the last CHNA), were recommendations related to:

- Alcohol and other drug treatment and recovery services.
- Dental services for low-income, especially limited scope of adult Denti-Cal benefits.
- Affordable wellness centers, particularly with closure of Sutter Lakeside Hospital's Wellness Center, mentioned by several participants in a couple of the groups.
- Transportation challenges and its impact on ability to get to work, keep medical appointments, and engage in social and recreational opportunities.
- Medical provider recruitment and retention, particularly for more in-county medical specialist services.

Sixteen key informants were identified by the Steering Committee, and 12 (75%) agreed to participate in an interview. The interviews, which were conducted by telephone, generally lasted an average of 45 minutes. The key informants generally represented a cross-section of the Lake County health and human service community that in addition to health care professionals from public and community-based organizations also included policy makers, administrators, and other individuals with an informed perspective about unmet health needs. While most of the interviewees spoke to the issues they knew best from their professional roles, many were also able to consider and describe additional health-related needs when prompted with questions to help them think about population characteristics, geography, political landscape and other factors that influence community health and access to services.

Interviewees were asked what they thought were the 3 most significant health problems/needs in Lake County that needed more attention. They were not prompted with a list of top-ranked needs from the previous CHNA or from regional and local statistical data but asked for their perspectives about this as an open-ended question.

The interviews yielded fairly consistent results with the community survey and focus group responses conducted for this assessment except for transportation, which received more attention as a problem by the key informants. Most of the identified needs directly tied to the perceived challenges in Lake County they described. Nearly all of the items had been identified as problems in the previous 2 CHNAs. Two of the highest need issues—substance abuse and community-based mental health services—received mention by at least three-quarters of the interviewees. Food (as a resource issue for low-income families) and nutrition and affordable health care for non-insured/under-insured were not indicated in the list of significant needs this time.

Substance Use/Abuse

Key informants identified substance abuse as across the board needs for: prevention education (e.g., school children and youth, parents); training (e.g., medical providers who over-prescribe painkillers); stronger enforcement (including of growing and selling); treatment and recovery services; and efforts to change societal norms and make it “not OK” concerning underage drinking, tobacco use, alcohol abuse and legal and illegal drugs. When asked, most interviewees perceived the problems to have worsened (“the problem is severe”) and tolerance higher (“people do these things for a reason. What are they trying to self-medicate from?”), despite various programs, services and campaigns.

Mental Health

Community-based mental/emotional health services received the second-most common attention as a serious unmet health need in Lake County. As in the last CHNA, the observations included the lack of *affordable* individual and family therapy and support groups for people experiencing chronic stress, anxiety, depression and poor coping skills. It was also noted that some of these mental health situations that end up in the emergency department could have been avoided with adequate access to community-based therapist services. For those with more acute needs, the lack of local inpatient placement beds continues to require out-of-county placement, generally by ambulance (impacting local availability for ambulance services). The association between mental health problems and substance abuse (“there is a mental health component as an underlying cause”) was noted by 3 of the interviewees. A couple individuals remarked that more support was needed to support children continuing to experience emotional stress from the 2015 wildfires.

Further comments that highlight the needs and system deficiencies included:

- “Mental health is missing so many people because of the funding structure.”
- “It’s painful to watch people deteriorate to the level where they’re eligible for the County’s mental health services.” (The County’s funding for mental/behavioral health services is understood to be available only for the most severely mentally ill.)
- “County Mental Health won’t accept some of the severe mentally ill. It’s almost useless to refer.”
- “Lots of single parent families could sure use even a little help [with coping] to get over a hump.”
- “A significant percentage of the law enforcement calls are related to mental health.”



Preventable and Chronic Health Conditions

Getting people to adopt healthier habits was mentioned by 4 individuals as one of the top health needs in the county, with the problems of obesity and diabetes as the most common examples. A couple of people commented that it was hard to get some people, including “those who need it most,” to attend health education sessions/events (“the population is so diverse, not everyone wants to take advantage of free programs;” “they aren’t interested unless it benefits them;” “people are too busy raising kids”).

Health Access

Despite greater access to health *coverage* for more people (through the Affordable Care Act and enrollment of Medi-Cal beneficiaries into managed care [Partnership Health Plan]), provider *capacity* because of unwillingness to accept public insurance continues to be a concern.

Key informants described the access problem relative to physicians as retention as well as recruitment. The problem, similar to other small counties, is largely due to the attractiveness of cultural opportunities and greater earning potential in larger cities (“despite the county’s lower cost of living”), a wish to practice nearer a university medical center, and a desire to live elsewhere because of the “lack of professionalism” and “poor reputation of the county.” In addition to medical services, one of the key informants identified the need for affordable dental services among the county’s highest health priorities.

Although all of the interviewees understood that Lake County’s economic base could not support all or a sufficient range of specialty services, those who ranked this a top concern believed more should be done to attract and retain the most critical specialists, which in their view included orthopedic surgery, ENT and psychiatry.

Transportation

The need for better transportation options, mainly concerning client travel to medical appointments (“the routes aren’t user friendly for medical services access”), seniors’ access to social opportunities, and young people to recreational and other activities, was identified as a top priority by 4 of the 12 key informants. (Note: transportation challenges were perceived to be a top concern in only 1 of the 6 focus groups.) Concern was also expressed about health and safety in relation to “dangerous road conditions”. One interviewee pointed out that the public transit system “takes all day if you’re going to use it” as the reason there were “no takers for the bus passes some organizations give out.”

Additional Comments Related to Significant Health Needs

Additional input from the key informants that did not always tie to specifically identified need issues but expressed themes that would be important to consider when prioritizing implementation strategies include the following:

- “It’s not necessarily that the problems are getting worse, it’s that we’re running out of time to address them [losing a whole generation of children in the meanwhile].”
- “The Tribal groups struggle with all of these health issues the most.”
- “Lack of jobs is a huge issue equating to hopelessness.”
- “It’s a vicious cycle: people don’t have the skills, have difficulty finding work, can’t find work that is



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meaningful, can't keep the job, get discouraged and lack motivation to try again, and the cycle starts all over again. It starts with doing what it takes to keep children in school, motivated, engaged, healthy.”

- “There’s a defeatist attitude because of gangs and crime in Clearlake so we write them off. How do you re-enfranchise them? How do you break this cycle?”
- “There’s a large subset of anti-establishment/anti-government types—a whole cultural and support network of these people—that are more apparent in rural areas because of small population size, and this bleeds over into people’s perception of Lake County.”

Identified Priority Needs from 2016 CHNA

Identified Priority #1 from 2016 CHNA

Healthy Behaviors (Access to services, Housing and Homelessness, Substance Use Disorders)

Goal

Increase healthy behaviors by increasing the number of and access to programs and education services offered to all families and individuals in our community resulting in a 10% improvement in county health statistics.

Short-term Objective

Increase the number of patients enrolled in programs to improve health and increase educational offerings.

Interventions:

1. **Living Nicotine Free** with Live Well is an intensive three-month program for 20 at-risk patients who desire to quit the use of tobacco products. This program includes one-on-one telephone support, group meetings, a targeted cell phone app, weekly reminders via text messaging, the use of nicotine replacement products and referral to the Live Well Program to implement a whole health approach to cessation.
2. **Live Well** originated as a pain management program. Over the past decade, Live Well has become a fully integrated multi-disciplinary intervention that is designed to improve the quality of life for patients enrolled. Program components include: behavioral health, addiction and pain management, dietary counseling and health coaching. While pain and addiction management remains the primary focus of Live Well, services provided will aid the healing of many chronic diseases.
3. **Health Initiatives**- Health Initiatives will ensure the community is utilizing available free or low-cost, evidence-based services, campaigns and toolkits offered by regional, state and national organizations:
 - National Diabetes Prevention Program
 - Active for Life
 - Weight Watchers
 - 1-800-NO BUTTS
 - The Great American Smoke Out
 - FitKids360
 - Active Aging
4. **Cancer Screening**: Cancer is a leading cause of premature death in Lake County. Malignant neoplasms, including lung and prostate cancer, is the number one cause of premature death in Lake County. Patients will receive prevention education and encouraged to get cancer prevention screenings.
5. **Project Restoration** - This broad initiative plays a vital role with the entire population health strategy. Its development is based on the evidenced-based theories of the Camden Coalition. A wide-range of governmental, social service, health care and non-profit organizations are being organized through Hope Rising's community team, The Healthy Clearlake Collaborative, to implement an initiative that will include: high utilizer identification, readmission prevention, homeless solutions, intensive case management through the Live Well Intensive Program, mental



health, substance abuse support, comprehensive data analysis and evaluation. This initiative will strengthen the community collaborations and move the county from discussion to action.

Intermediate Objective: Reduce the number of hospital admissions and poor health days. Healthy behaviors will show increased improvement.

Interventions:

1. **Living Nicotine Free:** Patients enrolled will remain smoke free after 12 months.
2. **Live Well:** Increase in the # of patients with medication adherence; decrease in poor health days; increase in physical activity.
3. **Health Initiatives:** # of patients entering Adult smoking cessation classes and weight management classes; decrease in poor health days; increase in physical activity.
4. **Cancer Screening:** Increase in the # of mammogram, prostate and colorectal screenings.
5. **Project Restoration:** Reduction in substance abuse and chronic conditions

Long-term Objective 1: 10 % reduction in the premature death rates due to cancer

Interventions:

1. **Living Nicotine Free:** Reduction in lung cancer deaths and smoking related cancer deaths.
2. **Cancer Screening:** Reduction in undiagnosed cancers and years of potential life lost.

Long Term Objective 2: 10% reduction in hospital admissions

Interventions:

1. **Live Well**
2. **Project Restoration**

Long Term Objective 3: 10% improvement in county health outcome statistics.

1. **Living Nicotine Free:** 10% reduction in adult smokers (nicotine use).
2. **Live Well:** 10% reduction in chronic diabetes-related hospital admissions
3. **Health Initiatives:** 10% improvement in diet and nutrition; 10% reduction in poor mental health day.
4. **Cancer Screening:** 10% improvement in years of potential life lost.
5. **Project Restoration:** 10% reduction in readmissions

Evaluation Metrics

Objective	Baseline Measurement	Performance Target	Indicator	Data Source
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Increase access to programs, health knowledge and participation	Enrollment	10% improvement	# of screenings and visits; # maintaining improved health	Clinic and hospital records
Reduced hospital admissions	Admissions	10% reduction	# of patients admitted	Hospital records
Reduce premature deaths	Cancer deaths	10% reduction	Cause of death attributed to cancer	County statistics
Improved health rankings	Premature deaths, hospital admissions	10% improvement	# years of potential life lost	Annual rankings

Identified Priority #2 from 2016 CHNA

Clinical Care (Access to Services, Substance Use Disorders, Housing and Homelessness and Mental Health)

Goal

Reduce hospital admissions and premature death through targeted accessible services and programs that address the highest utilizers and needs of the community.

Short-term Objective 1: Establish county-wide opioid prescribing guidelines

Interventions:

1. **Safe Rx:** Already proven to be a success, Safe Rx is an opioid reduction program. This program exists to support a healthier and safer community by improving the quality of life and functionality of individuals with pain. This intervention has also been shown to reduce harm from prescription drug misuse/abuse through collaborative partnerships that focus on prevention, treatment and recovery.

Short Term Objective 2: Identify patients at risk for increased health issues.

Interventions:

1. **Live Well** - Diabetes management groups, diabetes screenings
2. **Live Well Intensive Program** – Diabetes management groups, diabetes screenings
3. **Project Restoration** – High Utilizer case management
4. **Health Literacy Training** - The Medi-Cal population is known for its unique challenges. Language, culture, education and literacy barriers are prevalent (Granger, 1999). Each plays a role in the management of chronic conditions. Furthermore, according to a John Hopkins University study (2004), 83% of Medicaid dollars are spent on chronic disease (Table U demonstrates the health literacy barrier in Medicaid). This training will be geared toward all employees who have direct patient contact. Emphasis will be placed on the “teach back” approach to maximize patient understanding.

Intermediate Objectives

Intermediate Objective 1: Reduce # of new and renewed opioid prescriptions and increase the number of patients tapering off long term opioid use

1. **Safe Rx**
2. **Project Restoration**

Intermediate Objective 2: Reduce E.D. visits

1. **Safe Rx**
2. **Live Well**
3. **Live Well Intensive Program**
4. **Health Literacy Training**
5. **Project Restoration**

Intermediate Objective 3: Increase Diabetes monitoring

1. **Live Well**
2. **Health Literacy**

Long-term Objective: Reduce Premature Death

1. **Safe Rx** – Reduction of opioid related premature deaths by 10%
2. **Live Well** - Reduction of years of potential life lost by 10%
3. **Live Well Intensive Program** - Reduction of years of potential life lost by 10%

Evaluation Metrics

Objective	Baseline Measurement	Performance Target	Indicator	Data Source
Establish county-wide opioid prescribing guidelines	Guideline adoption	10% Reduction in new opioid prescriptions	# prescriptions; New suboxone providers	Partnership Health Plan, CURES data; Safe RX dashboard
Identify patients at risk for increased health issues	Live Well program enrollments	10% increase	#patients identified and enrolled	Live Well, Partnership Health Plan
Reduce opioid prescriptions and taper off patients on long term use	Opioid Prescriptions	10% reduction	# prescriptions; # patient appointments	Partnership Health Plan, CURES data; Safe RX dashboard
Reduce E.D. visits	ED visits	10% reduction	# recurring ED visits for enrolled patients	Partnership Health Plan, hospital records



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Increase Diabetes monitoring	Diabetes monitoring	10% reduction in diabetes ED visits/hospital admissions	#patients enrolled in Live Well Diabetes management	Live Well, Partnership Health Plan
Reduce Premature Death	Years of life lost	10% reduction	Improved premature death ranking	Annual health rankings

Identified Priority #3 from 2016 CHNA

Social and Economic (Access to Services, Substance Use Disorders, Housing and Homelessness and Mental Health)

Goal

Improve Social and Economic Factors through Cross Sector Collaborations - SHCL’s Community Wellness Strategy addresses the social, economic and environmental determinants of health. We lift up the role of community and community organizations as vital settings that create the conditions of health. We also understand the importance of non-medical resources in communities that promote well-being and prevent disease. Excellent medical care alone is not sufficient to create healthy communities. In order to create a healthy Lake County, we must work with others to create health-promoting physical, social and economic environments. Supporting and leading collaborations is one important way we live the Adventist Health Mission of supporting physical, mental and spiritual health and wellness, and maintain our commitment to do nothing in a silo, outside of partnership.

Short-term Objective: Create community partnerships

Interventions:

- Hope Rising Task Force-** St. Helena Hospital, Clear Lake provides the backbone leadership and support to build and strengthen this community collaboration committed to mobilizing and inspiring community partnerships and actions that support individual, collective and community health and wellness. Hope Rising brings cohesive communication to the broad range of work throughout the community, supports leadership development in service providers and community members, and provides leadership for Signature Projects, including SafeRX (see above description), and anchor activities including countywide wellness publications and resources guides, events and evaluation. Hope Rising provides oversight and vision for the first of four Local Action Teams, The Healthy Clearlake Collaborative, which is focused specifically on the City of Clearlake and surrounding areas through The Youth Leadership Summit and Project Restoration, both referenced earlier in this document.
- The Healthy Clearlake Collaborative-** The Healthy Clearlake Collaborative is supporting the local school district by strengthening the high school leadership development programs, hosting an intensive summit aligned with the overall goals of the moment, developing civic and community leadership opportunities and training, streamlining curriculum and supporting the implementation of healthy behaviors curriculum in the lower grades.
- Safe Rx** - Already proven to be a success, Safe Rx is an opioid reduction program. This program exists to support a healthier and safer community by improving the quality of life and functionality of individuals



with pain. This intervention has also been shown to reduce harm from prescription drug misuse/abuse through collaborative partnerships that focus on prevention, treatment and recovery.

4. Project Restoration

Intermediate Objective: Achieve community buy-in on projects and secure funding

Interventions:

1. **Hope Rising Task Force**
2. **The Healthy Clearlake Collaborative**
3. **Safe Rx**
4. **Project Restoration**

Long-term Objective: Specific long-term indicators identified and health assessments are improved

1. **Hope Rising Task Force**
2. **The Healthy Clearlake Collaborative**
3. **Safe Rx**
4. **Project Restoration**

Evaluation Metrics

Objective	Baseline Measurement	Performance Target	Indicator	Data Source
Create community partnerships	Collaboration to develop joint initiatives	Buy in of major county organizations	# organizations involved and \$ raised	Self-reporting
Community buy-in	Participation	10% improvement in health	# of participants with improved outcomes	Hospital and clinic records
Long term indicators	Participation	10% improvement in health rankings	# of participants with improved outcomes	County Health Rankings

Identified Priority #4 from 2016 CHNA

Physical Environment (Access to Services, Mental Health)

Goal

The Nutritional Services department has an opportunity to impact the health and wellness, attitudes of patients, employees and community members. This comprehensive revitalization project is focused on creating a vibrant and integral space which focuses on health and wellness through innovative menu offerings, engaged staff, sufficient resource investment, visually appealing environment and displays, as well as the utilization of fresh produce and the reduction of vending machines and unhealthy options. Our Nutritional Services Transformation provides the opportunity to model healthy choices to residents and organizations.



Short-term Objective: Remodel of Mountain View Cafe

Interventions:

1. **Nutrition Services Remodel:** Remove vending machines, upgrade furnishings and expand hours.

Intermediate Objective 1: Launch of Room Service

Interventions:

1. **Nutrition Services Remodel:** Develop and implement room service for all inpatient rooms there by expanding the nutrition services to patients to on-call and expanded hours. Expand menus to include more fresh, nutritious and healthy menu selections.

Intermediate Objective 2: Community Garden

Interventions:

1. **Nutrition Services Remodel:** Create a community garden and grow produce for nutrition services, allowing patients, employees and community members to have access to fresh produce.

Intermediate Objective 3: Kitchen Remodel

Interventions:

1. **Nutrition Services Remodel:** Upgrade kitchen equipment and layout to accommodate efficiency of work and processing of fresh produce from the garden. Included in the remodel is updated retail space offering more nutritious offerings.

Long-term Objectives

Long Term Objective 1: Improved patient experience and employee engagement scores

Interventions

1. **Nutrition Services Remodel:** More accessible, healthy and nutritious food for patient, employees and the community.

Long Term Objective 2: Decrease in food waste and increase in food sales

Interventions

1. **Nutrition Services Remodel**

Evaluation Metrics



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Objective	Baseline Measurement	Performance Target	Indicator	Data Source
Café Remodel	Completed remodel	Healthier environment and food options	Improved patient experience and employee engagement scores	Self-reporting
Room Service	Implementation	All patient rooms receive room service	# rooms receiving room service	Self Reporting
Community Garden	Harvested produce	Harvest used in nutrition services	Menu options offering garden-grown fresh produce	Self Reporting
Kitchen Remodel	Completed construction	Kitchen reopened with new equipment	Improved patient experience and employee engagement scores	Self Reporting
Decrease in food waste	More food consumption	20% reduction in waste	Improved patient experience and employee engagement scores	Self Reporting

Identified Needs from CHNA, Not Addressed

For the 2016-2019, St. Helena Hospital Clear Lake has elected to adopt a broad strategy that addresses all the priority needs, identified.

Making a difference: Evaluation of 2014-2016 CHP

A Time of Recovery

In the summer of 2015, as the current CHNA was being rolled out, Lake County experienced the devastation of several momentous wildfires, including the Rocky-Jerusalem and Valley Fires. Nearly one-third of county residents experienced evacuations during the Valley Fire, 4 deaths occurred, and nearly 2,000 structures burned including approximately 1,300 residential structures. In the fall of 2016, during the ongoing recovery from the Rocky-Jerusalem and Valley Fires, Lake County suffered the Clayton Fire. This fire caused the evacuation of St. Helena Hospital Clear Lake for 64 hours. The community lost an additional 300 homes and 12,000 residents were evacuated for one week. The long-term effects of these traumatic events on the health and well-being of Lake County are still being assessed and remain to be seen.

Along with Public Health and other community partners, Lake County hospitals are pivotal for having a collaborative role in engaging the community and implementing community health improvement strategies. Drawing from the implementation strategies, Sutter Lakeside Hospital and St. Helena Hospital Clear Lake developed strategies in response to the immediate preceding CHNA identified priorities and the Hospitals and other Lake County organizations implemented those strategies to address the significant health needs (Table 1). In many cases these activities were not new because the problems were not new; the grave need for more mental health support, for instance, continues to be a significant issue. The resources committed and the progress made by the partners since the 2013 CHNA continues to move the county in a positive direction despite such unforeseen events as the horrific wildfires of 2015.

The 2013 CHNA became the common impetus for strategic action and collective impact in Lake County. Many collaborative initiatives were instituted since that time and remain ongoing, including:

- Wellness Roadmap
- Hope Rising
- The Healthy Clearlake Collaborative

Healthy choices/healthy behaviors

- Community Wellness Projects
- Clearlake Food Pantry
- Food Hub
- Wellness RX
- Lake County Hunger Task Force
- Lake Family Resource Center
- Farm to School
- Climb to the Peak of Health

Mental health and well being

- St. Helena Hospital Clear Lake, in identifying mental health as critical need area:
 - Created a new position through an initiative with Partnership Health, a huge asset to its medical team. This MSW also serves as a warm hand-off between primary care and the client as well as linking clients up to needed social services.

- Added additional full-time positions for a psychologist, MSWs and LCSWs at Live Well, a program of treatment and support to enable clients to increase mobility, manage pain and improve quality of life.
- Added tele-psychiatry to expand services

Prevention and treatment of substance abuse

- SafeRX Lake County
- Live Well
- Tobacco Control

Strategic Partner List

St. Helena Hospital Clear Lake soon to be known as St. Helena Hospital Clear Lake supports local partners to augment our own efforts, and to promote a healthier community. Partnership is not used as a legal term, but a description of the relationships of connectivity that are necessary to collectively improve the health of our region. One of our objectives is to partner with other nonprofit and faith-based organizations that share our values and priorities to improve the health status and quality of life of the community we serve. This is an intentional effort to avoid duplication and leverage the successful work already in existence in the community. Many important systemic efforts are underway in our region, and we have been in partnership with multiple not-for-profits to provide quality care to the underserved in our region.

Community Partners

• North Coast Opportunities	• Redwood Children’s Services
• Partnership Health Plan of California	• Lakeview health Center
• Sutter Hospital Lakeside	• Lake County Health Department
• Lake County Behavioral Health	• Veterans Administration
• City of Clearlake	• Lake County Fire Protection
• Lake Family Resource Center	• Lake County Department of Social Services
• Health Leadership Network	• Lake County Continuum of Care
• Lake County Sheriff	• Lake County Office of Education
• Lake County Tribal Health Consortium	• Lake Transit Authority
• Lake County Sheriff Department	• Mendo Lake Credit Union
• Clearlake Police Department	• The Camden Coalition
• Hilltop Recovery	• Lucerne Community Clinic
• Woodland College Clear Lake Campus	• Marymount California University, Lucerne
• Middletown Rancheria	• Redbud Health Care District

Community Benefit Inventory

St. Helena Hospital Clear Lake soon to be known as St. Helena Hospital Clear Lake knows working together is key to achieving the necessary health improvements to create the communities that allow each member to have safe and healthy places to live, learn, work, play, and pray. Below you will find an inventory of additional interventions taken from our Community Benefit Inventory for Social Accountability (CBISA) software and documented activities.

Year 2016-Inventory

Priority Needs	Interventions	Partners	Measures of Success/Outcomes
<i>Collaborative Relationships/ Coordination of Services</i>	Hope Rising Lake County Leadership Committee	Sutter Lakeside Hospital Lakeview Health Center Partnership Health Plan of California Lake County Health Services Lake Family resource Center Redwood Children's Services	SafeRx, Super-Utilizer Initiative, Healthy Clearlake Collaborative
<i>Collaborative Relationships/ Coordination of Services</i>	Safe RX Steering Committee	Sutter Lakeside Hospital Lakeview Health Center Partnership Health Plan of California Lake County Health Services Lake County AODS	Countywide prescribing guidelines, needle swap program, reduction in new and renewed opioid prescriptions
<i>Collaborative Relationships/ Coordination of Services</i>	Healthy Clearlake Collaborative	Lake County Office of Education Konocti School District City of Clearlake Clearlake Police Department Redwood Children's Service North Coast Opportunities Lake Family Resource Center	Collaborative strategic implementation of the Health Element of Clearlake
<i>Collaborative Relationships/ Coordination of Services</i>	Rural Health Network Development	Health Leadership Network, Lower Lake HUB, Hero Project	Development of the Wellness Roadmap, Lower Lake Hub operations for Students (500 served), Hero Project implementation (10,000 served)



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Priority Needs	Interventions	Partners	Measures of Success/Outcomes
Healthy Choices/ Healthy Behaviors	Wellness RX	Live Well North Coast Opportunities	Provided participants 6 week course to improve wellness and health literacy.
Healthy Choices/ Healthy Behaviors	Diabetes Education Class	Live Well	Weekly education and support group for 20 weekly participants
Healthy Choices/ Healthy Behaviors	Bright Start OB Classes	Family Health Center	Provided weekly childbirth and parenting education classes to 350 participants
Mental Health and Well Being	Intensive Outpatient Care Management	Live Well	Reduced emergency department visits and readmissions for 35 enrolled patients
Mental Health and Well Being	Wellness RX	Live Well	Stress management classes for 12 months for 19 patients
Mental Health and Well Being	Sleep Better	Live Well	Psychologist led Education and support group for sleep hygiene. Groups met for a 5 week series for 5 participants.
Mental Health and Well Being	Art Therapy	Live Well	10 session art therapy for Live Well patients meeting every two weeks, 5 participants each meeting.
Mental Health and Wellbeing	Physical Activity Events and promotion	Lake County Milers, Hardester’s Markets	SHCL staff organized and sponsored 2/3K walk run for Turkey Trot and sponsored and volunteered at Spring Has Sprung 5K race. Over 500 children and adults participated
Mental Health and Well Being	Hygiene Kits		Prepared and distributed 100 hygiene kits to low-income patients without access to basic hygiene products



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Priority Needs	Interventions	Partners	Measures of Success/Outcomes
Prevention and Treatment of Substance Abuse	Safe RX	Sutter Hospital Lakeside Lakeview Health Center Partnership Health Plan of California Lake County Health Services Lake County AODS	Countywide prescribing guidelines, needle swap program, reduction in new and renewed opioid prescriptions
Prevention and Treatment of Substance Abuse	Intensive Outpatient Care Management	Live Well	Reduced emergency department visits and readmissions for 35 enrolled patients
Health Access	Transportation	Live Well	Taxi and bus vouchers provided to low-income patients/families that do not have access to transportation to and from the hospitals and clinics
Health Access	Intensive Outpatient Care Management	Live Well	Reduced emergency department visits and readmissions for 35 enrolled patients
Health Access	Sleep Lab		Sleep lab expansion
Health Access	3-D Mammography		Installation of 3D Mammography machine
Health Access	Dental Screenings	Heroes of Health and Safety	Provided dental screenings and information to 200 individuals at health fair
Health Access	Dental Screenings	Family Health Center Konocti Unified Scholl District Middletown School District	Provided dental screenings in Pomo, Burns Valley, Eastlake, Konocti Education Center and Middletown schools
Other Community Benefit Activities	Health Fairs		Distribution of health education materials to 1000’s of Lake County



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Priority Needs	Interventions	Partners	Measures of Success/Outcomes
<i>Other Community Benefit Activities</i>	Operation Christmas Joy	Mendo Lake Credit Union	Provided Christmas gifts and food to 40 low income families.

Total number of people served: **261,637**

Connecting Strategy and Community Health

As hospitals move toward population health management, community health interventions are a key element in achieving the overall goals of reducing the overall cost of health care, improving the health of the population, and improving access to affordable health services for the community both in outpatient and community settings. The key factor in improving quality and efficiency of the care hospitals provide is to include the larger community they serve as a part of their overall strategy.

Health systems must now step outside of the traditional roles of hospitals to begin to address the social, economic, and environmental conditions that contribute to poor health in the communities we serve. Bold leadership is required from our administrators, healthcare providers, and governing boards to meet the pressing health challenges we face as a nation. These challenges include a paradigm shift in how hospitals and health systems are positioning themselves and their strategies for success in a new payment environment. This will impact everyone in a community and will require shared responsibility among all stakeholders.

Population health is not just the overall health of a population but also includes the distribution of health. Overall health could be quite high if the majority of the population is relatively healthy—even though a minority of the population is much less healthy. Ideally such differences would be eliminated or at least substantially reduced.

Community health can serve as a strategic platform to improve the health outcomes of a defined group of people, concentrating on three correlated stages:

- 1) The distribution of specific health statuses and outcomes within a population;
- 2) Factors that cause the present outcomes distribution; and
- 3) Interventions that may modify the factors to improve health outcomes.

Improving population health requires effective initiatives to:

- 1) Increase the prevalence of evidence-based preventive health services and preventive health behaviors,
- 2) Improve care quality and patient safety and
- 3) Advance care coordination across the health care continuum.

Our mission as a health system is to share God's love by providing physical, mental and spiritual healing and we believe the best way to re-imagine our future business model with a major emphasis of community health is by working together with our community.



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Financial Assistance Policies

Adventist Health (AH) facilities exist to serve patients. They are built on a team of dedicated health care professionals – physicians, nurses and other health care professionals, management, trustees, and volunteers. Collectively, these individuals protect the health of their communities. Their ability to serve well requires a relationship with their communities built on trust and compassion. Through mutual trust and goodwill, Adventist Health and patients will be able to meet their responsibilities. These principles and guidelines are intended to strengthen that relationship and to reassure patients, regardless of their ability to pay, of AH's commitment to caring.

The purpose of this policy is to enact and ensure a fair, non-discriminatory, consistent, and uniform method for the review and completion of charitable emergency and other Medically Necessary care for individuals of our community who may be in need of Financial Assistance.

St. Helena Hospital Clear Lake soon to be known as St. Helena Hospital Clear Lake provides discounts to eligible low-income patients. If you can't pay part of your bill, please contact our customer Service Department. We will review your financial situation to determine if you are eligible for financial assistance. If you have questions please call our dedicated customer service division at 1-800-404-6627. They are available to assist you Monday through Thursday, 8:00 am to 5:30 pm and Friday, 8:00 to 4:30 pm Pacific Time. More can information can be found by accessing our link, <https://www.adventisthealth.org/clear-lake/pages/default.aspx> and clicking the "Pay my Bill" link (located near the top of the page).

Community Benefit & Economic Value for Prior Year

St. Helena Hospital Clear Lake soon to be known as St. Helena Hospital Clear Lake mission is “to share God's love by providing physical, mental and spiritual healing.” Our community benefit work is rooted deep within our mission, with a recent recommitment of deep community engagement within each of our ministries.

We have also incorporated our community benefit work to be an extension of our care continuum. Our strategic investments in our community are focused on a more planned, proactive approach to community health. The basic issue of good stewardship is making optimal use of limited charitable funds. Defaulting to charity care in our emergency rooms for the most vulnerable is not consistent with our mission. An upstream and more proactive and strategic allocation of resources enables us to help low-income populations avoid preventable pain and suffering; in turn allowing the reallocation of funds to serve an increasing number of people experiencing health disparities.

Valuation of Community Benefit

Year 2016

ADVENTIST HEALTH CLEARLAKE HOSPITAL, INC. DBA ST. HELENA HOSPITAL CLEAR LAKE		
Charity Care and Other Community Benefit	Net Community Benefit	% of Total Cost
Traditional charity care	1,944,140	2.35%
Medicaid and other means-tested government programs	21,000	0.03%
Community health improvement services	800,453	0.97%
Health professions education	628,562	0.76%
Subsidized health services	-	-
Research	-	-
Cash and in-kind contributions for community benefit	410,025	0.50%
Community building activities	162,705	0.20%
TOTAL COMMUNITY BENEFIT	3,966,885	4.80%
Medicare	Net Cost	% of Total Cost
Medicare shortfall	2,606,105	3.15%
TOTAL COMMUNITY BENEFIT WITH MEDICARE	6,572,990	7.96%

Appendices

Glossary of terms

Medical Care Services (Charity Care and Un-reimbursed Medi-Cal and Other Means Tested Government Programs)

Free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are thereby deemed unable to pay for all or portion of the services. Charity Care does not include: a) bad debt or uncollectible charges that the hospital recorded as revenue but wrote-off due to failure to pay by patients, or the cost of providing care to such patients; b) the difference between the cost of care provided under Medicaid or other means-tested government programs, and the revenue derived there from; or c) contractual adjustments with any third-party payers. Clinical services are provided, despite a financial loss to the organization; measured after removing losses, and by cost associated with, Charity Care, Medicaid, and other means-tested government programs.

Community Health Improvement

Interventions carried out or supported and are subsidized by the health care organizations, for the express purpose of improving community health. Such services do not generate inpatient or outpatient bills, although there may be a nominal patient fee or sliding scale fee for these services. Community Health Improvement – These activities are carried out to improve community health, extend beyond patient care activities and are usually subsidized by the health care organization. Helps fund vital health improvement activities such as free and low cost health screenings, community health education, support groups, and other community health initiatives targeting identified community needs.

Subsidized Health Services – Clinical and social services that meet an identified community need and are provided despite a financial loss. These services are provided because they meet an identified community need and if were not available in the area they would fall to the responsibility of government or another not-for-profit organization.

Financial and In-Kind Contributions – Contributions that include donations and the cost of hours donated by staff to the community while on the organization's payroll, the indirect cost of space donated to tax-exempt companies (such as for meetings), and the financial value (generally measured at cost) of donated food, equipment, and supplies. Financial and in-kind contributions are given to community organizations committed to improving community health who are not affiliated with the health system.

Community Building Activities – Community-building activities include interventions the social determinants of health such as poverty, homelessness, and environmental problems.

Health Professions Education and Research

Educational programs that result in a degree, certificate, or training that is necessary to be licensed to practice as a health professional, as required by state law; or continuing education that is necessary to retain state license or certification by a board in the individual's health profession specialty. It does not include education



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Living God's love by inspiring
health, wholeness and hope

or training programs available exclusively to the organization's employees and medical staff, or scholarships provided to those individuals. Costs for medical residents and interns may be included.

Any study or investigation in which the goal is to generate generalized knowledge made available to the public, such as underlying biological mechanisms of health and disease; natural processes or principles affecting health or illness; evaluation of safety and efficacy of interventions for disease such as clinical trials and studies of therapeutic protocols; laboratory-based studies; epidemiology, health outcomes and effectiveness; behavioral or sociological studies related to health, delivery of care, or prevention; studies related to changes in the health care delivery system; and communication of findings and observations (including publication in a medical journal)

Community Health Needs Assessment and Community Health Plan Coordination Policy

Entity:

<input checked="" type="checkbox"/> System-wide Corporate Policy	Corporate Policy	No. AD-04-006-S
<input checked="" type="checkbox"/> Standard Policy	Department:	Administrative Services
<input type="checkbox"/> Model Policy	Category/Section:	Planning
	Manual:	Policy/Procedure Manual

POLICY SUMMARY/INTENT:

This policy is to clarify the general requirements, processes and procedures to be followed by each Adventist Health hospital. Adventist Health promotes effective, sustainable community benefit programming in support of our mission and tax-exempt status.

DEFINITIONS

1. **Community Health Needs Assessment (CHNA):** A CHNA is a dynamic and ongoing process that is undertaken to identify the health strengths and needs of the respective community of each Adventist Health hospital. The CHNA will include a two document process, the first being a detailed document highlighting the health related data within each hospital community and the second document (Community Health Plan or CHP) containing the identified health priorities and action plans aimed at improving the identified needs and health status of that community.

A CHNA relies on the collection and analysis of health data relevant to each hospital's community, the identification of priorities and resultant objectives and the development of measurable action steps that will enable the objectives to be measured and tracked over time.

2. **Community Health Plan:** The CHP is the second component of the CHNA and represents the response to the data collection process and identified priority areas. For each health need, the CHP must either: a) describe how the hospital plans to meet the identified health need, or b) identify the health need as one the hospital does not intend to specifically address and provide an explanation as to why the hospital does not intend to address that health need.
3. **Community Benefit:** A community benefit is a program, activity or other intervention that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of these objectives:
 - Improve access to health care services
 - Enhance the health of the community
 - Advance medical or health care knowledge
 - Relieve or reduce the burden of government or other community efforts

Community benefits include charity care and the unreimbursed costs of Medicaid and other means-tested government programs for the indigent, as well as health professions' education, research, community health improvement, subsidized health services and cash and in-kind contributions for community benefit.

AFFECTED DEPARTMENTS/SERVICES:

Adventist Health hospitals

POLICY: COMPLIANCE – KEY ELEMENTS

PURPOSE:

The provision of community benefit is central to Adventist Health's mission of service and compassion. Restoring and promoting the health and quality of life of those in the communities served, is a function of our mission "To share God's love by providing physical, mental and spiritual healing." The purpose of this policy is: a) to establish a system to capture and report the costs of services provided to the underprivileged and broader community; b) to clarify community benefit management roles; c) to standardize planning and reporting procedures; and d) to assure the effective coordination of community benefit planning and reporting in Adventist Health hospitals. As a charitable organization, Adventist Health will, at all times, meet the requirements to qualify for federal income tax exemption under Internal Revenue Code (IRC) §501(c)(3). The purpose of this document is to:

1. Set forth Adventist Health's policy on compliance with IRC §501(r) and the Patient Protection and Affordable Care Act with respect to CHNAs;
2. Set forth Adventist Health's policy on compliance with California (SB 697), Oregon (HB 3290), Washington (HB 2431) and Hawaii State legislation on community benefit;
3. Ensure the standardization and institutionalization of Adventist Health's community benefit practices with all Adventist Health hospitals; and
4. Describe the core principles that Adventist Health uses to ensure a strategic approach to community benefit program planning, implementation and evaluation.

A. General Requirements

1. Each licensed Adventist Health hospital will conduct a CHNA and adopt an implementation strategy to meet the community health needs identified through such assessment.
2. The Adventist Health *Community Health Planning & Reporting Guidelines* will be the standard for CHNAs and CHPs in all Adventist Health hospitals.
3. Accordingly, the CHNA and associated implementation strategy (also called the Community Health Plan) will initially be performed and completed in the calendar year ending December 31, 2013, with implementation to begin in 2014.
4. Thereafter, a CHNA and implementation strategy will be conducted and adopted within every succeeding three-year time period. Each successive three-year period will be known as the Assessment Period.
5. Adventist Health will comply with federal and state mandates in the reporting of community benefit costs and will provide a yearly report on system wide community benefit performance to board of directors. Adventist Health will issue and disseminate to diverse community stakeholders an annual web-based system wide report on its community benefit initiatives and performance.
6. The financial summary of the community benefit report will be approved by the hospital's chief financial officer.
7. The Adventist Health budget & reimbursement department will monitor community benefit data gathering and reporting for Adventist Health hospitals.

B. Documentation of Public Community Health Needs Assessment (CHNA)

1. Adventist Health will implement the use of the Lyon Software CBISA™ product as a tool to uniformly track community benefit costs to be used for consistent state and federal reporting.

2. A written public record of the CHNA process and its outcomes will be created and made available to key stakeholders in the community and to the general public. The written public report must include:
 - a. A description of the hospital's community and how it was determined.
 - b. The process and methods used to conduct the assessment.
 - c. How the hospital took into account input from persons who represent the broad interests of the community served.
 - d. All of the community health needs identified through the CHNA and their priorities, as well as a description of the process and criteria used in the prioritization.
 - e. Existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.
3. The CHNA and CHP will be submitted to the Adventist Health corporate office for approval by the board of directors. Each hospital will also review their CHNA and CHP with the local governing board. The Adventist Health government relations department will monitor hospital progress on the CHNA and CHP development and reporting. Helpful information (such as schedule deadlines) will be communicated to the hospitals' community benefit managers, with copies of such materials sent to hospital CFOs to ensure effective communication. In addition, specific communications will occur with individual hospitals as required.
4. The CHNA and CHP will be made available to the public and must be posted on each hospital's website so that it is readily accessible to the public. The CHNA must remain posted on the hospital's website until two subsequent CHNA documents have been posted. Adventist Health hospitals may also provide copies of the CHNA to community groups who may be interested in the findings (e.g., county or state health departments, community organizations, etc.).
5. For California hospitals, the CHPs will be compiled and submitted to OSHPD by the Adventist Health government relations department. Hospitals in other states will submit their plans as required by their state.
6. Financial assistance policies for each hospital must be available on each hospital's website and readily available to the public.

Corporate Initiated Policies: (For corporate office use)

References: Replaces Policy: AD-04-002-S
Author: Administration
Approved: SMT 12-9-2013, AH Board 12-16-2013
Review Date:
Revision Date:
Attachments:
Distribution: AHEC, CFOs, PCEs, Hospital VPs, Corporate AVPs and Directors



2017 Community Health Plan

This community health plan was adopted on April 20, 2017, by the Adventist Health System/West Board of Directors. The final report was made widely available on May 15, 2017.

CHNA/CHP contact:

Shelly Mascari
Director of Community Wellness

Phone: 707-995-5656

Email: shelly.mascari@ah.org

St. Helena Hospital Clear Lake
15322 Lakeshore Drive, Suite 201
Clearlake, CA 95422

Request a copy, provide comments or view electronic copies of current and previous community health needs assessments: <https://www.adventisthealth.org/pages/about-us/community-health-needs-assessments.aspx>