Adventist Health

Together Inspired

Adventist Health and Rideout
2022 Community Health Plan

The following Implementation Strategy serves as the 2020 – 2022 Community Health Plan for Adventist Health and Rideout and is respectfully submitted to the Office of Statewide Health Planning and Development May 19th, 2023, reporting on 2022 results.

Executive Summary

Introduction & Purpose

Adventist Health and Rideout is pleased to share its Community Health Implementation Strategy. This follows the development of its 2019 Community Health Needs Assessment (CHNA) in accordance with requirements in the Affordable Care Act and IRS 990 Schedule H requirements and approved by the Adventist Health Board of Directors on October 17, 2019.

After a thorough review of the health status in our community through the community health needs assessment (CHNA), we identified areas that we could address using our resources, expertise, and community partners. Through these actions and relationships, we aim to empower our community and fulfill our mission of "Living God's love by inspiring health, wholeness and hope."

The results of the CHNA guided the creation of this document and aided us in how we could best provide our community and the vulnerable among us. This Implementation Strategy summarizes the plans for Adventist Health and Rideout to develop and collaborate on community benefit programs that address prioritized health needs identified in its 2019 CHNA. Adventist Health and Rideout has adopted the following priority areas for our community health investments.

Prioritized Health Needs – Planning to Address

- Health Priority #1: Access to Mental/Behavioral/Substance Abuse Services
- Health Priority #3: Access to Basic Needs Such as Housing, Jobs and Food
- Health Priority #5: Access to Quality Primary Care Health Services

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, we hope you imagine a healthier region and work with us to find solutions across a broad range of sectors to create communities that define the well-being of people.

The purpose of the CHNA was to offer a comprehensive understanding of the health needs in Adventist Health and Rideout's service area and guide the hospital's planning efforts to address those needs.

The significant health needs were identified through an analysis of secondary data and community input. These health needs were prioritized according to a set of criteria. Primary and secondary data were analyzed to identify and prioritize significant health needs. The process began with the identification of 10 potential health needs (PHNs); noting these PHNs were consistent as they had been identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the service area. After these were identified, PHNs were prioritized based on rankings

provided by primary data sources. Data were also analyzed to detect emerging health needs, if any, beyond those 10 PHNs identified in previous CHNAs. For further information about the process to identify and prioritize significant health needs, please refer to Adventist Health and Rideout CHNA report at the following link: https://www.adventisthealth.org/about-us/community-benefit/

Adventist Health and Rideout and Adventist Health

Adventist Health and Rideout is an affiliate of Adventist Health, a faith-based, nonprofit integrated health system serving more than 80 communities on the West Coast and Hawaii.

Vision

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

Mission Statement

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

Adventist Health Includes:

- 23 hospitals with more than 3,393 beds
- 370 clinics (hospital-based, rural health and physician clinics)
- 14 home care agencies and eight hospice agencies
- 3 retirement centers & 1 continuing care retirement community
- A workforce of 37,000 including medical staff physicians, allied health professionals and support services

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 all faiths to enhance the health of the communities we serve.

Our commitment to quality health care stems from our heritage, which dates to 1866 when the first Seventh-day Adventist healthcare 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.

Summary of Implementation Strategies

Implementation Strategy Design Process

Stakeholders from the 19 hospital facilities in the Adventist Health System were invited to participate in a Mission Integration Summit on September 26 and 27, 2019. During this two day-long event, participants were introduced to the 2019 Adventist Health Implementation Strategy Template. After the summit, each hospital was invited to participate in a series of technical assistance calls and consultation sessions with representatives from Adventist Health Community Integration and Conduent Health Communities Institute to further develop and refine their implementation strategy.

Adventist Health and Rideout Implementation Strategy

The implementation strategy outlined below summarizes the strategies and activities by Adventist Health and Rideout to directly address the prioritized health needs. They include:

- Health Need #1: Access to Mental/Behavioral/Substance Abuse Services
  - Behavioral Health Collaborative
  - ED Bridge Program
- Health Need #3: Access to Basic Needs Such as Housing, Jobs and Food
  - Food Security Program
  - Partnership with the local Food Bank and Food Pantries
  - Housing Navigation & Sustainability Program
- Health Need #5: Access to Quality Primary Care Health Services
  - Street Medicine Program

The Action Plan presented below outlines in detail the individual strategies and activities Adventist Health and Rideout will implement to address the health needs identified though the CHNA process. The following components are outlined in detail in the tables below: 1) actions the hospital intends to take to address the health needs identified in the CHNA, 2) the anticipated impact of these actions as reflected in the Process and Outcomes measures for each activity, 3) the resources the hospital plans to commit to each strategy, and 4) any planned collaboration to support the work outlined.

No hospital can address all the health needs identified in its community. Adventist Health and Rideout is committed to serving the community by adhering to its mission, and using its skills, expertise and resources to provide a range of community benefit programs. This Implementation Strategy does not include specific strategic plans to address the remaining significant health needs identified in the 2019 CHNA, which are addressed in other ways (see below).

Significant Health Needs – NOT Planning to Address

- Health Need #2: Prevention of Disease and Injury through Knowledge, Action, and Access to Resources: Adventist Health and Rideout focuses on wellness and prevention through health education classes and programs. AHRO will continue providing classes and programs to the community.
- Health Need #4: Access and Functional Needs: Access to transportation services is a large need in the primary service area. AHRO currently addresses this need by offering free transportation to and from the hospital, Cancer Center and clinics. In addition to this transportation service, we also provide bus passes, gas cards and food cards to low-income patients to help with travel needs.
- Health Need #6: Access to Specialty and Extended Care: Adventist Health and Rideout is consistently recruiting specialty providers to increase access for the community. We plan to continue these efforts.
- Health Need #7: Active Living and Healthy Eating: Adventist Health and Rideout currently offers free classes on diabetes and other health issues in addition to encouraging healthy lifestyles. Adventist Health and Rideout has also integrated Blue Zones into our community which sets out to create a community where people live longer, happier, and healthier lives.
- Health Need #8: Safe and Violence-Free Environment: Adventist Health and Rideout agrees that this is a huge need throughout the community, but at this time, we feel addressing this need will require dedicated effort from many other community organizations. We cannot tackle this community need on our own.

At this time, we believe we can focus efforts and resources on the other prioritized health needs to make a larger impact.

COVID 19 Considerations

The COIVD-19 global pandemic has caused extraordinary challenges for Adventist Health hospitals and health care systems across the world including keeping front line workers safe, shortages of protective equipment, limited ICU bed space and developing testing protocols. They have also focused on helping patients and families deal with the isolation needed to stop the spread of the virus, and more recently vaccine roll out efforts.

Adventist Health, like other health care systems, had to pivot its focus to meet the most urgent healthcare needs of its community during the pandemic, as well as reassess the ability to continue with some community health strategies due to public health guidelines for social distancing. Adjustments have been made to continue community health improvement efforts as possible, while ensuring the health and safety of those participating. The Strategy Action Plan Grids on the following pages reflect updated activities for each strategy.

In FY21, Adventist Health and Rideout supported efforts launched by the Adventist Health system as well as localized efforts. Including the following actions in response to the needs created or exacerbated by COVID-19:

- Offered virtual health care visits to keep community members safe and healthy
- Featured the online symptom tracker to help community members determine if they may have COVID-19 or other flu type illness and what steps to take
- Participated in a communitywide effort to vaccinate eligible community members to help stop the spread of the virus via on-going community pop-up clinics including the annual Sikh festival, the largest in Sikh festival outside of India; hospital campus also hosted a mass vaccination clinic in 2021
- Adventist Health and Rideout created a 68-bed surge build out
- Adventist Health and Rideout developed a Resiliency Program and Resiliency Rooms for staff to minimize stress and provide respite
- Participated in a community task force, providing daily communication to Yuba County regarding COVID-19 numbers
- Created and distributed messaging and updates to staff and the public regarding AHRO policies, COVID-19 CDPH guidance as well as PSAs associated with COVID-19 recommendations/pre-cautions and seeking the appropriate level of care to minimize an influx of patients in the Emergency Department

Locally, Adventist Health and Rideout would like to send a special thanks to our community and our community partners for all they did to assist us in our time of need. Adventist Health and Rideout reached out to our community requesting PPE and the response from our community was overwhelming. The love and support showered on the hospital during this unprecedented event was expansive and extraordinary. These gestures motivated our associates and providers to continue to treat patients, day after day, during the pandemic. We thank our local Yuba Sutter area for their unwavering generosity and kindness.

The Adventist Health + Blue Zones Solution

Our desire to improve community well-being grew out of not only our mission at Adventist Health -to live God's love by inspiring health, wholeness and hope – but also by the sheer need as seen across our system hospitals. Overwhelmingly, we see issues related to health risk behaviors, mental health and chronic illnesses throughout the communities we serve. That is why we have focused our work around addressing behavior and the systems preventing our communities from achieving optimal health.

In 2020, Adventist Health acquired Blue Zones as a step toward reaching our solution. By partnering with Blue Zones, we will be able to gain ground in shifting the balance from healthcare – treating people once they are ill – to transformative health and wholeness – changing the way communities live, work and play.

Across the globe lie blue zones areas – places where people are living vibrant, active lives well into their hundreds at an astonishing rate—and with higher rates of well-being. Attaining optimal well-being means that our physical, emotional, and social health is thriving. Blue Zones Project works with communities to make sustainable changes to their environment, policies, and social networks to support healthy behaviors. Instead of a focus on individual behavior change, it is an upstream solution focused on making healthy options easy in all the places people spend most of their time. Blue Zones Project is committed to measurably improving the well-being of community residents and through their proven programs, tools and resources, utilizes rigorous metrics to inform strategies and track progress throughout the life of the project. This includes well-being data, community-wide metrics, sector-level progress and outcome metrics, transforming community well-being by making changes to environment, policy, worksites and social networks that create healthy and equitable opportunities for all.

In July of 2021, Rideout Adventist Health proudly launched Blue Zone Project Yuba Sutter (BZPYS). The BZPYS team wakes up each morning focused on partnering and collaborating with community leaders and organizations active in the sectors of built environment, education, economic and workforce development, mental and physical well-being, policy and public health. Together the BZPYS team and sector leaders develop a community Blueprint that strategically aligns and leverages the actions and resources of the sectors where we live, learn, work and play to help advance the efforts around the community's biggest Social Determinant of Health challenges while connecting them to Health-Related Social Needs organizations.

Equity is a strategic priority woven throughout the Blueprint and programs. Policies and initiatives are developed in a way that honors the local culture that is focused on reaching out to all populations. Each year BZPYS sector leads come together to evaluate and update the Blueprint to ensure community alignment.

2022 Outcome Metrics

Overall Engagement: 1,134 individuals

- 17 Purpose Workshops
- 9 Cooking Demonstrations
- 6 Moai Launches
- 30 Blue Zones Story Speech

Blue Zones Site Approvals

- New Earth Market
- Bridge Coffee Co.
- Kynoch Elementary
- Hilbers, Inc.
- Yuba Water Agency
- Sutter County Administration

Adventist Health and Rideout Implementation Action Plan

PRIORITY HEALTH NEED: ACCESS TO MENTAL/BEHAVIORAL/SUBSTANCE ABUSE SERVICES

GOAL STATEMENT: TO RAISE AWARENESS AND IMPROVE ACCESS TO SUBSTANCE USE AND MENTAL HEALTH SERVICES IN THE EMERGENCY DEPARTMENT

Mission Alignment: Well-being of People

Strategy 1: Expand Emergency Department SUD and BH Initiatives

Programs/ Activities	Process Measures	Results: Year 1	Short Term Outcomes	Results: Year 2	Medium Term Outcomes	Results: Year 3
Continue Behavioral Health Collaborative in Rideout ER	Number of patients treated for behavioral health needs in ED	Previous report available upon request	Overall decrease of hours for each patient's LOS	Previous report available upon request	Increase the number of discharges from ED to home (decrease number of patients transferred to psychiatric facility)	See narrative below
Implement ED Bridge Program	Number of patients referred for substance use treatment in the ED;	Previous report available upon request	Increase Suboxone education and treatment #Suboxone	Previous report available upon request	Decrease in patients presenting to ED with substance use disorders; Increase in patients completing treatment	See narrative below

Source of Data:

- Cerner, ED Referral Logs, SUN Referral Logs

Target Population(s):

Behavioral Health Patients as well as patients with substance use disorder

Adventist Health Resources: (financial, staff, supplies, in-kind etc.)

- ED Staff
- County Behavioral Health crisis counselors
- Tele-Psychiatry Equipment
- Substance Use Navigator
- X-Waivered Physicians

Collaboration Partners: (place a "*" by the lead organization if other than Adventist Health)

- Sutter-Yuba Behavioral Health, CEP America, Pathways, Local FQHCs, Aegis Treatment Center

CBISA Category:

A - Community Health Improvement

Strategy Results 2022:

Behavioral Health Collaborative: The volume of behavioral health patients in the Adventist Health and Rideout Emergency Department has steadily increased in recent years due to the lack of funding for behavioral health services and lack of facilities/providers in our rural area. To deliver the highest quality of care for behavioral health patients in the Emergency Department, Adventist Health and Rideout partnered with county resources to embed county-paid crisis counselors in the Emergency Department 24 hours a day. In 2021, AHRO's Emergency Department saw 2,341 patients presenting with behavioral health needs and 2,548 in 2022, approximately a 9 percent increase. Using tele-psychiatry services and clear clinical pathways the team worked together to see 100 percent of the patients with a behavioral health diagnosis. Medications were started or resumed, safety plans designed, and follow up appointments were arranged by the team. As a team, the county and hospital have created a process to provide high quality care to psychiatric patients in the ED.

In 2021, 1,245 patients were discharged home from the ED and 856 discharged to a psychiatric facility. In 2022, 1,535 patients were discharged home from the ED and 820 discharged to a psychiatric facility. AHRO was successful in our efforts to increase the number of individuals discharging home and decrease the number of individuals discharging to a psychiatric facility.

ED Bridge Program: To address the growing opioid problem in the area, Adventist Health and Rideout and Vituity applied for and was awarded a $175,000 grant in 2019 and another grant was awarded in 2020 for an additional $100,000. Although zero dollars were awarded in 2021, AHRO was able to secure additional grant funding to support the ED Bridge Programs' ongoing efforts in 2022 in the amount of $120,000. The grants have afforded the program the opportunity to hire a Substance Use Navigator (SUN), provide ED staff training, and provide 32 ED physician X-waiver credentialing to build the Medically Assisted Treatment (MAT) Program. In 2023 the law changes, allowing all providers to be allowed to prescribe suboxone, requiring all providers to take 8 hours' worth of training. The SUN works to identify people with opioid use disorder in the emergency room. Patients are then able to immediately receive treatment for their withdrawal symptoms with the medication buprenorphine (suboxone) and are linked from the ED into continued outpatient treatment in the community clinics. In 2021, 329 patients were seen by the SUN, however, in 2022, the program increased by 245 percent, providing services to 809 individuals. Additionally, from 2021 to 2022 the number of individuals provided community resources increased 286 percent, from 208 patients to 597.

Other Community Benefit Programs include the following:

Meds-to-Beds: Adventist Health and Rideout is among many hospitals nationwide that has a "Meds-to-Beds" program, in which prescription drugs are given directly to patients just before they are sent home from the hospital or emergency room. This program serves as more than just a convenience; for some patients, this is the only way they will obtain necessary medications for chronic medical conditions and other required treatments. AHRO is not allowed to bill for medications that will be used at home; these drugs must come from an outpatient pharmacy. To bridge this gap, AHRO partnered with the Sutter

Pharmacy for both discharge counseling and dispensing of medications. In situations where the patient is unable to pay for the critical medications, Adventist Health and Rideout will pay for the medications at no cost to the patient. Number of community members served in 2022: 214, an increase of 74 individuals served from 2021.

Blue Zones: Create the healthiest possible physical, emotional, and social school environment for students and families. Making Yuba Sutter Schools Blue Zones Project (BZP) Approved™.

- YES Charter Academy and Kynoch Elementary are Blue Zones Approved
- BZP is also working with schools to develop safe routes to school and create Walking School Bus programs. Safe routes to schools and Walking School Bus programs bring children, families and community together creating opportunities for more connection.

Improve the well-being of individuals living in Yuba Sutter, resulting in better health and increased quality of life and longevity.

- Facilitation of Purpose Workshops - When individuals find a clarity of purpose, they can enjoy a more centered and vibrant life — and even live longer. A Purpose Workshop is a two-hour event led by a certified facilitator that helps people find clarity of purpose. It's about discovering, or rediscovering, gifts, talents, and values. It's also a time of reflection and interactive discussions. At the end, individuals can walk away encouraged and equipped with a purpose statement as well as tools for living a more purposeful life.

People with purpose are happier, more successful, and live longer. Nearly seven years longer. With purpose, you can also do more with less. That means cramming fewer activities into your already overcrowded schedule. Less stress to "get it all done."

- Moai's: Moai meaning, coming together for a common purpose. Blue Zones Projects helps to facilitate Walking, Potluck and Purpose Moai's.
- BZP also creates volunteer opportunities to bring community together while beautifying open spaces in an effort to create environments where people will gather, connect and move naturally. There are also efforts to help build a centralized database for volunteer opportunities for volunteers to access.

BZP is working with Marysville, Yuba County and Sutter County to pass a smoking ban ordinance in Parks (Yuba City has one). BZP is working with Bi- County Health Officer Dr. Luu and both the Yuba and Sutter Tobacco coalitions to strategize additional policy changes as well as additional community outreach and education.

PRIORITY HEALTH NEED: EXPAND SCREENING AND PARTNER WITH COMMUNITY ORGANIZATIONS TO INCREASE ACCESS TO FOOD RESOURCES						
GOAL STATEMENT: IMPROVE ACCESS TO FOOD RESOURCES IN THE COMMUNITY						
Mission Alignment: Well-being of People						
Strategy 1: Expand screening with community organizations to increase food resources						
Programs/ Activities	**Process Measures**	**Results: Year 1 2020**	**Short Term Outcomes**	**Results: Year 2 2021**	**Medium Term Outcomes**	**Results: Year 3 2022**
1.A. Expand Food Security Program	Number of patients referred to community pantries Number of patients served in the community	Previous report available upon request	Expand screening program to Clinics and Cancer Center	Previous report available upon request	Reduce number of readmitted patients identifying as food insecure	See narrative below
Source of Data: • AHRO Cerner Data, Referrals						
Target Population(s): • Patients identified as food insecure at Adventist Health and Rideout						
Adventist Health Resources: (financial, staff, supplies, in-kind etc.) • Nursing (screenings), Case Management (referrals), Community Outreach Registered Dietitian						
Collaboration Partners: (place a "*" by the lead organization if other than Adventist Health) • Yuba-Sutter Food Bank, St. Andrew Presbyterian Church Mother Hubbard's Cupboard						
CBISA Category: • A – Community Health Improvement						

Strategy/Narrative Results 2022:

Food Security Program: Food insecurity is a nation-wide issue. Food insecurity means that someone has uncertain or limited availability or access to nutritionally adequate foods. Food insecurity triggers behaviors that exacerbate poor health and lifestyles. Research connects food insecurity with chronic disease, hospitalizations, poor disease management, developmental and mental health. All of this contributes to an increase in health care spending. Due to the demographics and low socio-economic status of the Yuba-Sutter population, we frequently see food insecure patients at Adventist Health and Rideout. To address this need, AHRO initiated a food security program, which begins with a screening

process for all patients that are seen in the AHRO Emergency Department. If a patient is identified as food insecure, a referral is submitted to the Community Outreach Registered Dietitian who then follows up with the patient and provides person specific community resources, a connection to a local food pantry, and food upon discharge.

In 2022, Adventist Health and Rideout identified 748 patients as food insecure. This number includes the patient population admitted to the hospital, in the ED, patients of The Rideout Cancer Center, clients in the Street Medicine Program, as well as individuals experiencing food insecurities identified in our community by partners like the Western Farm Workers.

Of these individuals, 37% were considered homeless, 33% were 55 years of age or older, and 19% were 65 years of age or older. All individuals served in the Food Security program are vulnerable, lack the resources necessary to obtain food or proper nutrition, and are underserved. This program has allowed us to reduce the number of folks being readmitted to the hospital with reoccurring food Insecurities.

551 non-perishable food bags were provided to individuals experiencing homelessness through outreach from our Street Medicine Team.

In 2021, The Food Security Program was awarded a grant in the amount of $20,000. This funding is available through 2023. This funding has provided the ability to purchase food for the most vulnerable patients and has helped serve families directly associated with our partner agencies. The partnership between the Food Security Program and The Yuba-Sutter Food Bank has increased the number of individuals served and has added more resources to the Yuba-Sutter community.

In 2021, A grant in the amount of $80,000 was awarded to hire a Registered Dietitian (RD) to help expand the Food Secure Program and assist in providing medically tailored meals as well as develop an on-site food pantry. The Community Outreach RD was hired in late 2022 and has been able to expand our Food Security program into a Food is Medicine program. This program previously served only those experiencing food insecurities, but the program was expanded in 2022 to include those with underlying health conditions that could be additionally addressed with meals medically tailored to their health concerns. Our RD meets patients where they are, both in their homes and on the streets, educating patients on their disease and specific dietary requirements using evidence-based practices and interventions. The RD provides patient centered nutrition counseling using motivational interviewing techniques to help patients set lasting dietary goals. The RD conducts baseline nutrition assessments, sets goals and follows up with patients to assess progress and the need for additional assistance and intervention. The RD also manages a food pantry where the RD is able to tailor the foods in the pantry that are provided to patients to treat disease related malnutrition and provide nutrient dense foods to our most at risk populations.

Other Community Benefit Programs include the following:

Bariatric Support Group: Bariatric support groups were offered, in person, until March of 2020 due to Covid-19. AHRO developed a way to continue delivering these support groups virtually and is still in use as of 2021 and 2022. Our bariatric surgery support group is offered at no charge to people who have had

or plan to have bariatric surgery. The group is a wonderful way for patients to gain knowledge, network with and support one another in the community. The number of individuals served in 2022 decreased from 2021 due to staff shortages.

Number of Community Members Served: 6

Blue Zones:

- Created a Food Policy Council (FPC). *The FPC will work across sectors, engaging with government policy and programs, grassroots/non-profit projects, local businesses, and food workers.* Common activities of food policy councils include:
    - *Create connections with Local Food Supply*
    - *Creating Policies to Support the Food System*
    - *Guiding Decision-making* - Making recommendations to government bodies
    - *Producing Knowledge* - Gathering, synthesizing, and sharing information on community food systems
- In conversations with local farmers and the community to create a Farmer's Market in downtown Marysville.
- In conversations with schools, local leaders, and agriculture community to bring more local farm products to school programs and strategize on creating sustainability in local food systems where locally sourced produce is reaching more local eaters.
- Convene discussion on creation of a VeggieRX program.
- BZP facilitates community cooking demonstrations to promote healthy eating.
- Addressing housing needs. Items that BZP will be working on:
    - Task: Ensure that an audit of development code regulations includes impediments to "missing middle" housing and accessory dwelling units, excessive parking requirements, and other regulatory issues that limit the range of available housing and increase housing costs.
    - Task: Consider non-traditional housing development opportunities with institutional partners such as hospitals and military.
    - Task: Partner with economic-development groups, chamber of commerce, health-system officials, city and county leaders, the local housing authority, and Habitat for Humanity to develop a comprehensive housing-development plan that includes diverse housing options to meet the needs of the community and support economic growth.

PRIORITY HEALTH NEED: ACCESS TO QUALITY PRIMARY CARE HEALTH SERVICES

GOAL STATEMENT: TO IMPROVE ACCESS TO PRIMARY CARE SERVICES FOR THE COMMUNITY

Mission Alignment: Well-being of People

Strategy 1: Street Nursing Program

Programs/ Activities	**Process Measures**	**Results: Year 1**	**Short Term Outcomes**	**Results: Year 2**	**Medium Term Outcomes**	**Results: Year 3**
1.A. Establish and expand Street Nursing Program	Establish minimum of 2 sites utilizing the coordinated entry centers	Previous report available upon request	Operationalize Street Telemedicine Program by end of 12/31/2019 Increase Street Nurse Hours/Number of days	Previous report available upon request	Reduction in ED visits/Utilization (Decrease in number of patients sent to ED from Street Nurse)	See narrative below
1.B. Address social determinants of health	Create referral database for managing social determinants of health and initiate referrals	Previous report available upon request	Add substance use resources/counselors to Street Nurse program	Previous report available upon request	Increased number of substance use counseling interactions	See narrative below

Source of Data:

- Cerner, Street Medicine Log, Health Management Information Systems (HMIS)

Target Population(s):

- Individuals experiencing homelessness

Adventist Health Resources: (financial, staff, supplies, in-kind etc.)

- Community Outreach Nurses
- Community Outreach Social Workers
- Tele-health – Vituity
- ED Substance Use Navigator
- Supplies

Collaboration Partners: (place a "*" by the lead organization if other than Adventist Health)

- Life Building Center, Hands of Hope, Sutter Yuba Homeless Consortium, Yuba and Sutter County, local churches, 14 Forward, Better Ways, Harmony Village, Habitat for Humanity, REST, Marysville PD, Yuba City PD, Yuba and Sutter

PRIORITY HEALTH NEED: ACCESS TO QUALITY PRIMARY CARE HEALTH SERVICES
County Sheriff department, The Salvation Army, Homeless Engagement and Activation Response Team (HEART), Behavioral Health iCare Team, New Haven
CBISA Category: A - Community Health Improvement

Strategy Results 2022:

Street Medicine Program:

In 2019, Adventist Health and Rideout initiated a Street Nursing Program in response to the growing population of those experiencing homelessness in the Yuba Sutter Community. As the program has expanded services offered and has a multidisciplinary staff, the program is now referred to as the Street Medicine Program. The Street Medicine Team consists of two full time Community Outreach Nurses, one Per Diem Community Outreach Nurse, two Community Outreach Social Workers, one providing case management and one providing housing navigation, a group of tele-docs making Tele-Medicine available 5 days a week, and a Community Outreach Associate. The team provides medical screenings, case management services, and housing navigation to the individual's experiencing homelessness in the Yuba and Sutter communities. In 2022, The Adventist Health Street Nurse Team saw 371 new patients out in the field. The team conducted 3,574 follow up visits; this translates to each patient experiencing several encounters with our team due to the trust and relationship built. The Street Medicine Team reaches out to individuals experiencing homelessness where they are and provides items such as hygiene products and non-perishable food. The total encounters for the Street Medicine Team in 2022 including new patients, follow visits, and outreach, was 6,396. In 2022, the program showed significant growth, in staff, in days per week, and in outreach locations made possible by several different awarded grant dollars. The Street Medicine Team does outreach with several partner agencies in the streets and river bottoms of the Yuba Sutter Communities. Other outreach locations include Hands of Hope, The Life Building Center, Better Ways, Harmony Village and Prosperity Village.

Program Outcomes to note for 2022:

- 371 new individuals served
- 3,574 follow up visits conducted
- 35 clients established care with a Primary Care Doctor
- 65 PCP appointments attended with the patient to assist in a warm hand off and alleviate fear
- 54 prescriptions were paid through our 340B program
- 63 individuals moved from homelessness and entered into temporary housing such as a shelter
- 45 individuals were moved from homelessness and were entered into permanent housing
- 342 individuals were seen by the tele-medicine doctor out in the field
- 15 were referred to the Substance Use Navigator for resources and referrals to substance use treatment and recovery.

The AHRO Street Medicine program was successfully able to increase the number of individuals seen by tele-medicine out in the field and in turn reduce the number of individuals sent to the emergency room for treatment. In 2021, 78 individuals of the 2,561 were sent to the emergency department for

additional care and 314 were able to be seen via tele-health. In 2022, only 55 individuals of the 3,574 were sent to the emergency department for additional care and 342 were able to be seen by tele-medicine. This shows an overall reduction in the number of individuals sent to the ER and an increase of individuals seen by tele-medicine.

Homeless Discharge Planning: In addition to the action already in motion to combat homelessness and assist this vulnerable population, SB 1152 requires hospitals to include plans for coordination of services to shelters, medical care, and behavioral health care in their homeless patient discharge policy. Specifically, hospitals must discharge homeless patients to a social service agency, a nonprofit social services provider, or a governmental service provider. Hospitals must also ensure that these agencies are prepared to accept the patient and the patient has agreed to the placement. Patients experiencing homelessness may also be discharged to their "residence" (the principal dwelling place of the patient) or an alternative destination. Under SB 1152, hospitals must ensure and document the following before discharging any homeless patient: The patient must have food and water unless there is a medical reason, they must have weather-appropriate clothing, have a source of follow up care, have a supply of medications, they must have necessary medical durable equipment, they must be offered screening for infectious diseases, must have been offered vaccination, the patient must be alert and oriented to person, place, and time, they must be assisted to enroll in eligible, affordable health insurance coverage, and the patient must have transportation to the discharge destination. The hospital must also maintain a log of homeless patients discharged and locations to which they were discharged.

Number of Community Members Served: 1,174

Blue Zones: Built environments is a priority with Blue Zones Project. Creating environments where multi-modal transportation, including walking, bicycling, and transit supports natural movement in the course of daily activity as well as helps to simply remove barriers to get from point A to point B, essential to accessing and visiting health care providers.

PRIORITY HEALTH NEED: OTHER COMMUNITY BENEFIT PROGRAMS
GOAL STATEMENT: TO IMPROVE THE WELL-BEING OF PEOPLE WITHIN OUR COMMUNITY
Mission Alignment: Well-being of People

Strategy Results 2022:

Rideout Healthy Kids: We offer our free Adventist Health and Rideout Healthy Kids School Assemblies for K-8th grade students in Yuba, Sutter and Colusa counties. Due to COVID-19 these efforts went virtual. This program provides health education to elementary and middle school children in an interactive musical theater performance. Since Spring 2014, Adventist Health and Rideout Healthy Kids has performed every fall and spring in 11 tours, over 200 performances for over 68,000 students, faculty, staff and community members at public and private schools, community health fairs and other events, service clubs, banquets, and many other community activities, bringing the message of good health, wellness and encouragement to audiences young and old. Due to COVID-19 it is unclear on the specific number of individuals impacted as in-person events ceased. As an alternative, the performers created videos that were accessible online; they were sent to every K-6 grade educator in the Yuba and Sutter area with the goal to share with all families participating in "remote" learning.

Number of Community Members Served: Approximately 75,000

Smoking Cessation Education: Adventist Health and Rideout provides a free smoking cessation program for the community. This program teaches the "Freedom from Smoking Course" from the American Lung Association. The class offers participants a step-by-step plan for quitting smoking and will help assist smokers gain control over their behavior. The number of individuals served in 2022 decreased from 2021 due to staff shortages.

Number of Community Members Served**:** 10

Cancer Support Group: Adventist Health and Rideout offers multiple programs for cancer patients and survivors. In addition to treating the body when a patient has cancer, Adventist Health also looks for ways to help the emotional healing of our patients. Adventist Health and Rideout offers cancer support groups to support our patients as well as their loved ones. In 2021, due to COVID-19, these support groups were placed on hold, however, were able to resume in 2022. Additionally, prior to COVID-19, AHRO offered a weekly "Chemotherapy and You" class designed to help prepare patients and caregivers for Chemotherapy treatment. Class topics also provided education on side effects, management, and central line access.

Number of Community Members Served: 144

Transportation after Discharge: Adventist Health and Rideout contracts with SP+ to provide transportation services to patients upon hospital discharge, transportation to and from primary care, and to and from oncology appointments. This service is provided at no cost to the patients. In addition to the contract with SP+, the Adventist Health and Rideout Foundation assists cancer center patients, senior care and other patients with transportation needs and more by providing provisions such as gas cards, bus passes and food cards to help low-income patients with their travel needs. A new passenger van was donated to Adventist Health and Rideout by the Geweke Caring for Women Foundation. The van offers patients free transportation to and from the hospital and the cancer center.

Number of Community Members Served: 7,172

Community Education Fairs and Events: Adventist Health and Rideout regularly participates in a multitude of community events where staff volunteers to provide education to the community.

Community Events attended:

- Rideout Auxiliary Installation of Officers Luncheon
- 8 Speakers Bureau
- Rotary Club of Yuba City Crab Feed
- Chamber of Commerce Annual Gala
- Have a Heart for Kids 5K
- A Women's Day Luncheon Event
- Cardiology Symposium
- Bike Around the Buttes
- Y-S United Way Blue Jean Soiree
- First 5 Yuba County Health Fair
- United Way Community Resource Fair
- Just For Yuba County Dads Drive-thru
- Downtown Yuba City Summer Stroll
- Cancer Survivor Event
- Marysville Peach Festival
- 10th Annual Dance with Our Stars
- Beale Military Liaison Committee Golf Tournament
- Annual Blues and Brews and BBQ
- MJUSD Annual Employee Health & Benefits Fair
- Yuba City Walk to End Alzheimer's
- Twenty fifth Annual Sodbusters
- Annual Marysville Stampede and Rodeo
- Sutter County Health and Wellness Fair
- Pink October Walk/Run – Race for Awareness
- Taste of Yuba Sutter
- Pink October Golf Tournament - Scramble for a Cure
- Pink October Event at Hard Rock Casino & Hotel
- City of Yuba City Senior Resource Fair
- Salvation Army Red Kettle Kick-Off
- Annual Sikh Parade & Festival
- Marysville Christmas Tree Lighting & Parade

Community Members Served: Over 13,000

Inspire Hope/World Vision: Inspire Hope Project is a community-based initiative designed to assist our nonprofit partners and faith communities with various household items aimed at improving the quality of life serving families in need. This service is possible due to our partnership with World Vision, an international faith-based nonprofit that connects businesses who have goods with charities that need them. Through our Inspire Hope Project we work to build relationships with other nonprofit

organizations, who can ensure goods are directly given to families and individuals with the greatest need. In 2022, a minimum of 43 partners worked collectively to get resources to 150 members of our community. Resources include items such as living room furniture, bedroom furniture, kitchen supplies including dining room sets, small and necessary home goods items, as well as tents, sleeping bags, non-perishable food, and more. This partnership has supported Adventist Health's mission of inspiring health, wholeness, and hope.