


# Ukiah Valley Medical Center

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



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**OUR MISSION:**  
Living God's love by inspiring health,  
wholeness and hope

### Adventist Health Overview

Ukiah Valley Medical Center 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.

## Hospital Identifying Information



Number of Beds: 67 licensed; 49 operated

Mailing Address: 275 Hospital Drive, Ukiah, CA 95482

Contact Information: Doug Shald – Marketing Dept.

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

- Ukiah Valley Medical Center

- Rural Health Clinics:

Ukiah Valley Rural Health Centers with locations in Ukiah, Ft. Bragg (secondary service area), and Lakeport (secondary service area) providing primary and specialty care

- Hospital Based Outpatient Clinics:

- General Surgery

- Ophthalmology

- ENT

Adventist Health Specialty Services -  
Gastroenterology

Adventist Heart Institute - Cardiology

- Diagnostic Services

Laboratory Draw Stations (3 in Ukiah – 1 in  
Lakeport – 1 in Fort Bragg)

Medical Imaging Outpatient Locations (2 in Ukiah)

Community Health Development Team

Doug Shald

Manager, Marketing & Communication

Jill Kinney

NCR Administrative Director, Marketing & Communication

Sandy O'Ferrall

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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://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 determinant 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, Ukiah Valley Medical Center has adopted the following priority areas for our community health investments for 2017-2019:

- Mental Health
- Childhood Obesity & Family Wellness
- Childhood Trauma

*Ukiah Valley Medical Center will also provide support, as appropriate, to the following community-identified priority areas: 1) Housing, 2) Poverty.*

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

**Counties:** Mendocino County

**Major Towns:** Ukiah, Willits, Redwood Valley, Hopland, Calpella, Potter Valley

**Secondary Towns/Cities:** Ft. Bragg, Laytonville, Boonville

**Our location:** Ukiah is the largest community in the county, with a population of 16,186 per the California Department of Finance Estimates for January 2016. As the County Seat of Government and the business/education/shopping center for much of Mendocino, Lake, and even Sonoma Counties, the weekday population swells to roughly 35,000. Sunset Magazine recently profiled Ukiah, praising it's "19<sup>th</sup> century architecture, charming tree-lined neighborhoods, and laid-back vibe."

**Geography:** The town of Ukiah is located along the busy Highway 101 corridor, just 120 miles north of San Francisco and 260 miles south of the Oregon border. It is also situated near the east/west intersection of Highway 20, providing access to the Central Valley and Coast.

**Transportation:** There are not many options for transportation within Ukiah other than driving an automobile. The Ukiah/Willits/Fort Bragg area is served by Mendocino Transit Authority (MTA) with bus routes seven days per week to some areas. Other transportation options include Dial-A-Ride and two privately owned taxi companies. Uber and Lyft are close to breaking into the community with limited and sporadic weekend availability.

The Rail Trail is a nearly one mile paved pedestrian and bicycle path which runs along the North Coast Railroad Authority's right-of-way as acknowledgment that city residents had been using the rail corridor as an informal transportation route for years. Now a formal asphalt path legally welcomes trail users to the centrally located corridor, with lights allowing for use after dark. This trail is conveniently situated adjacent to the hospital and clinic properties. There are plans to expand another 0.8 miles to Ukiah's rapidly developing retail core on Commerce Drive.

### Demographics of the community

The 2010 Census reported that Ukiah had a population of 16,075. The population density was 3,403.7 people per square mile (1,314.2/km<sup>2</sup>). The racial makeup of Ukiah was 11,592 (72.1%) White, 174 (1.1%) African American, 601 (3.7%) Native American, 412 (2.6%) Asian, 34 (0.2%) Pacific Islander, 2,385 (14.8%) from other races, and 877 (5.5%) from two or more races. Hispanic or Latino of any race were 4,458 persons (27.7%).

The Census reported that 15,301 people (95.2% of the population) lived in households, 281 (1.7%) lived in non-institutionalized group quarters, and 493 (3.1%) were institutionalized.



There were 6,158 households, out of which 2,049 (33.3%) had children under the age of 18 living in them, 2,317 (37.6%) were opposite-sex married couples living together, 938 (15.2%) had a female householder with no husband present, 356 (5.8%) had a male householder with no wife present. There were 484 (7.9%) unmarried opposite-sex partnerships, and 56 (0.9%) same-sex married couples or partnerships. 2,064 households (33.5%) were made up of individuals and 919 (14.9%) had someone living alone who was 65 years of age or older. The average household size was 2.48. There were 3,611 families (58.6% of all households); the average family size was 3.18.

The population was spread out with 3,981 people (24.8%) under the age of 18, 1,562 people (9.7%) aged 18 to 24, 4,184 people (26.0%) aged 25 to 44, 4,011 people (25.0%) aged 45 to 64, and 2,337 people (14.5%) who were 65 years of age or older. The median age was 35.9 years. For every 100 females there were 92.8 males. For every 100 females age 18 and over, there were 89.3 males.

There were 6,488 housing units at an average density of 1,373.8 per square mile (530.4/km<sup>2</sup>), of which 2,673 (43.4%) were owner-occupied, and 3,485 (56.6%) were occupied by renters. The homeowner vacancy rate was 2.6%; the rental vacancy rate was 3.7%. 6,733 people (41.9% of the population) lived in owner-occupied housing units and 8,568 people (53.3%) lived in rental housing units.

### Priority Areas Identified

1. Mental Health
2. Childhood Obesity & Family Wellness
3. Childhood Trauma

### *Key Findings and/or Health Disparities Related to Mental Health:*

Mental Health is a top concern of CHNA interviews and survey respondents. It is strongly linked to homelessness: 41% of local homeless people report having a serious mental illness. There are gaps in local mental health services, especially wrap-around and full-service models. Stigma interferes with willingness to seek assistance, and with community understanding.

- Percentage of adults in Mendocino County (11%) who have likely had serious psychological distress in the last year, based on the Kessler 6 scale, is higher than the state average (8%). It is important to note that a much higher percentage of Native Americans (65%) report serious distress than in California overall (18%).
- Percentage of adults in Mendocino County (20%) needing behavioral health services for emotional/mental health problems or use of alcohol and/or drugs who did not receive services is higher than California overall (16%).

- The age-adjusted death rate due to suicide (deaths per 100,000 population) in Mendocino County (23.9) is more than double the rate of California overall (10.2). Important to note that suicide deaths account for only part of the problem. An estimated 25 attempted suicides occur per every suicide death.

*Key Findings and/or Health Disparities Related to Childhood Obesity & Family Wellness:*

Children and youth are populations of concern for many survey respondents and interviews. 41% of the county's children are overweight, and the trend worsens as they get older. 59% of local children do less than 1 hour of activity per day. Some families lack access to affordable, nutritious food while fast food is relatively cheap and accessible. Childhood obesity is linked to adult obesity and many serious chronic illnesses:

- 5<sup>th</sup> grade students who are at a healthy weight or underweight in Mendocino County (52.3%) is significantly lower than California overall (59.6%)
- 7<sup>th</sup> grade students who are physically fit in Mendocino County (59.7%) is significantly lower than California overall (65.1%)
- Teens who use alcohol in Mendocino County (49.4%) is significantly higher than California overall (31.3%)

*Key Findings and/or Health Disparities Related to Childhood Trauma:*

Childhood trauma and adverse childhood experiences (ACEs) have an extremely negative impact on the health, safety, and well-being of individuals and our community. They lead to harmful health behaviors, poor performance at school and work, and higher risk for serious health conditions in adulthood. The county's rates of child abuse and domestic violence calls for help are among the highest in California. Thousands of children are being raised by grandparents, and 28% of county households face severe housing problems.

In Mendocino County:

- Adults reporting past Adverse Childhood Experiences (ACEs) is 30.8%, significantly worse than California overall (16.7%)
- Substantiated child abuse rate (cases per 1,000 children) is 19.0, more than double California overall (8.2)
- Perinatal substance use prior to knowledge of pregnancy is 55%, significantly higher than California overall (24%)

Children in grandparent-headed households have disproportionately high rates of poverty. Children in grandparent-headed households are especially likely to display behavioral and emotional problems because of the events leading up to the move into the grandparent's home including economic crises, family conflict, neglect or abuse, and separation from one or both parents.

In Mendocino County, the number of grandparent-headed households responsible for grandchildren under 18 years with incomes at or below federal poverty levels has increased nearly 40% in recent years, from 1,723 in 2010 to 2,778 in 2014.



Domestic violence affects everyone around it including family members, neighbors, and the larger community. Children exposed to domestic violence can experience physical, emotional, and behavioral responses which include feeling afraid, guilty and sad, having sleep disturbances, stomach aches and headaches, inability to concentrate, among other problems. In Mendocino County, the number of domestic violence-related calls has increased nearly 40% in recent years, from 375 calls in 2010 to 590 in 2013.

### Information Gaps

Information gaps that impact the ability to assess health needs were identified. Some of the secondary data are not always collected on a regular basis, meaning that some data are several years old. Primary data collection and the prioritization process were also subject to limitations. Themes identified during interviews were likely subject to the experience of individuals selected to provide input. The final prioritized list of significant health needs is also subject to the affiliation and experience of the individuals who participated in the prioritization process.

## Community Health Needs Assessment Overview

### [Link to final CHNA report](#)

Successful partnerships for community improvement require the sharing of information and awareness of what Ukiah Valley Medical Center's assessments and priorities for the community are. The complete report of our latest Community Health Needs Assessment can be found at [www.uvmc.org/chna](http://www.uvmc.org/chna)

### Methodology for CHNA

The Community Health Needs Assessment is Ukiah Valley Medical Center's principal tool for understanding the emerging or unmet needs of its community. In 2014, Ukiah Valley Medical Center joined the first-ever collaborative Community Health Needs Assessment and Improvement (CHNA/CHIP) initiative, consisting of the following core partners: Mendocino County Health & Human Services Agency (HHS), Alliance for Rural Community Health (ARCH), North Coast Opportunities (NCO), and our sister hospital in Willits, Frank R. Howard Memorial Hospital. Healthy Mendocino serves as coordinator of the newly formed CHNA Planning Group, under the auspices of NCO.

The purpose of the CHNA process was to identify the most pressing health priorities facing Mendocino County residents and commit to a coordinated set of strategies to improve the health and well-being of our residents. While many agencies and organizations collect and act on health information, this process was distinct because it was community-driven, with several local agencies collaborating on a single community health needs assessment, thus achieving a greater combined impact on local health than the partners could achieve separately. Through this initial effort, we are developing tools and processes designed to meet the ongoing needs of multiple partner organizations, to maximize coordination and economies of scale. The ultimate goal of these efforts is to help create the conditions for the best possible health and well-being for Mendocino County residents.

While the CHNA/CHIP effort is not new, what is new is the emphasis that funders, the federal government, and accrediting organizations are giving to genuine collaboration in the effort among local organizations and agencies. Besides meeting external requirements, such combined efforts can yield a comprehensive view of local needs and lay the foundation for joint solutions and economies of scale.

### Community Voices

The CHNA Planning Group adopted the Mobilizing for Action through Planning and Partnership (MAPP) process as its planning framework to guide the CHNA process. The MAPP tool was chosen to capture an in-depth picture of community health status through quantitative and qualitative data collection methods. Three of the four MAPP assessments were selected for this CHNA:

1. Community Themes & Strengths Assessment

- a. *Community Health Survey* provided in hardcopy and online format. Total of 1,486 residents completed; 1,402 in English and 84 in Spanish.
  - b. *Key Informant Interviews* of sixteen key stakeholders in the community, including representatives of government, healthcare, the courts, nonprofits, media, health and human services, and private business.
2. Community Health Status Assessment
  3. Local Public Health System Assessment

The CHNA Planning Group helped to conduct the assessments. Their participation has resulted in broad representation of key community leaders, advocates and allies who have collectively helped shape and inform the process. Planning Group members' knowledge of their organizations priorities and the communities and population groups they serve have greatly enriched the process.

## Identified Priority Needs from 2016 CHNA

### Mental Health

*Vision:* County-wide mental health consciousness is reflected in a proactive, no-shame view of the issues. Communities, agencies, and schools take a comprehensive approach to care and case management. People with mental illnesses and their families and health practitioners have access to needed treatment and case management resources across the continuum of care.

*Goals:*

- Educate the community about mental illness to reduce stigma and increase resilience.
- Expand treatment and case management options and access.
- Improve prevention for all residents and all mental health conditions.

### Childhood Obesity & Family Wellness

*Vision:* Healthy, active children in healthy families; wide access to healthy food and safe recreational opportunities

*Goals:*

- Increase public awareness of relevant community programs and resources.
- Change the health environment at workplace, recreation, and community meeting venues, offering access to healthy foods.
- Engage the community in the Safe Routes to Schools initiative as an effective way to improve family and community health.

### Childhood Trauma

*Vision:* All children grow up in stable and supportive families, and families have support in times of crisis.

*Goals:*

- Educate community members and leaders about the impact of adverse childhood experience (ACEs).
- Increase support for at-risk families, including parents struggling with substance abuse.
- Develop and promote local policies that strive to prevent childhood trauma.
- Change the health environment at the workplace and recreation and community meeting venues by offering access to healthy foods.

The identified priority areas are community projects with many other organizations and interested citizens involved. Teams have been established for each priority area and are working on a logic model including strategies and are being addressed at each ongoing meeting.

Childhood Trauma – What is the Problem?

Adverse childhood experiences (ACEs) in Mendocino County lead to poor community health outcomes.

INPUTS	OUTPUTS	OUTCOMES		
IF WE HAVE:	AND WE DO:	THEN WE EXPECT:	AND WE WANT:	AND WE HOPE:
<ul style="list-style-type: none"> <li>▪ Collaboration among service providers</li> <li>▪ Providers and organizations that can address kids’ needs (teen drug treatment, affordable housing, foster family support, parent drug treatment, children’s health, meaningful work and job training)</li> <li>▪ Funding</li> <li>▪ Easily accessible services for families</li> <li>▪ Strong relationships with schools</li> </ul>	<ol style="list-style-type: none"> <li>1. Promote general awareness of the effects of ACEs and the importance of resiliency.</li> <li>2. Provide skills based trainings that address the impacts of ACEs and teaches resiliency.</li> <li>3. Support direct service programs that provide hands-on assistance to families experiencing trauma.</li> </ol>	<ul style="list-style-type: none"> <li>▪ Confident/competent parents who are empowered to build resilient children</li> <li>▪ Increase the number of parents seeking services</li> <li>▪ Well-informed schools that know how and where to access services</li> <li>▪ Clinics and other service providers are ready to deliver trauma support and other mental health services to children and youth</li> <li>▪ Community Resiliency Model trained community members work with children and families to build their resiliency skills</li> </ul>	<ul style="list-style-type: none"> <li>▪ Decrease the number of reports to Child Welfare</li> <li>▪ Decrease the high school drop-out rate</li> <li>▪ Increase graduation rate</li> <li>▪ Decrease teen pregnancy rate</li> <li>▪ Decrease youth crime rate</li> <li>▪ Reduce substantiated child abuse rate</li> <li>▪ Decrease number of adults with childhood ACEs</li> <li>▪ Decrease substance abuse in teens</li> <li>▪ Decrease childhood obesity</li> </ul>	<ul style="list-style-type: none"> <li>▪ A community of hope, optimism and prosperity</li> <li>▪ A community that understands the impact of ACEs</li> <li>▪ Families are empowered to seek help to mitigate ACEs</li> <li>▪ Community agencies are trauma informed</li> </ul>

Partners Involved

The Community Health Improvement Project (CHIP) is a collaborative effort among citizens and organizations to improve local health and the factors that influence it. Ukiah Valley Medical Center is founding partner of this collaborative. See appendix for complete list.

## Identified Need from CHNA, Not Addressed

All needs were met from our CHNA



## Making a difference: Evaluation of 2014-2016 CHP

### Priority Area 1: Behavioral Health: Access to Care and Care Delivery

UVMC realizes the critical community need for additional behavioral health services for individuals living with mild to moderate mental illness and is proactively seeking ways to improve access to the most appropriate level of care.

- Convened a meeting with Universal Health Services (UHS) and its affiliates and key stakeholders in the community to evaluate known gaps in service delivery and ways in which UHS can shore up those gaps through capital partnership, operating agreement, or other.
- UVMC provided support to two family medicine physicians so they can participate in the Train New Trainers (TNT) Primary Care Psychiatry (PCP) Fellowship certificate program at UC Davis Health System, Department of Psychiatry and Behavioral Services. This year-long clinical education certificate program will teach the physicians how to complete an evidence-based and efficient psychiatric interview in the busy primary care or medical setting. They will also be trained to effectively diagnose and treat commonly encountered psychiatric conditions such as: mood, anxiety, and psychotic and substance misuse disorders. Most importantly, these trainees will learn how to teach these principles to their primary care colleagues.

With more than 20% of the population living with one or more of these common psychiatric conditions, it is imperative that our family medicine physicians have the training and skills to effectively treat these conditions in the primary care setting.

Additionally, in 2016 we:

- Continued to provide data and advocacy regarding mental health crisis emergency room utilization and length of stay to the County of Mendocino for a grant that provided for a mobile mental health outreach worker in outlying areas of our remote county.
- Worked with the County of Mendocino Behavioral Health & Recovery Services (BHRS) and their contracted service providers to ensure those experiencing serious mental illness receive timely care in the most appropriate setting. We also actively participated on the Mental Health Advisory Board providing advocacy for our community in receiving behavioral health services.

### Priority Area 2: Chronic Disease: Provide Health Education and Access to Care for At-Risk Community Groups with Emphasis on: Diabetes, Stroke, and Cancer Prevention

UVMC maintained the Joint Commission's Primary Stroke Certification by the American Heart Association and American Stroke Association in part by providing health education and outreach to the community. Free seminars open to the public:

1. *Living with a Healthy Heart*: education on the most current methods of heart disease prevention, diagnosis, lifestyle management and treatment from our team of cardiologists.

2. *Stroke Prevention*: tips to prevent stroke and how to identify the signs and symptoms of stroke presented by our certified stroke educator.
3. Monthly “lunch and learn” wellness seminars discussing topics such as preparing healthy meals and exercise for beginners.

Additionally, in 2016 we:

- Sponsored the Go Red! Event and provided heart health information, InBody Fit testing, and random blood sugar testing to approximately 200 community members.
- Strengthened our partnership with Cancer Resource Center (CRC) of Mendocino County which increased the number of referrals both to and from CRC.
- Held a community fun run, Colors for Cancer 5k, to raise money for expansion of our Focus on Healing program, a healing arts program for cancer patients countywide, regardless if they are receiving treatment at UVMC.

Priority Area 3: Advanced aging care with emphasis on orthopedic care

UVMC recruited a new full-time orthopedic surgeon, which significantly increased access to orthopedic care both in the emergency room and clinic settings.

Additionally, in 2016 we:

- Conducted public education seminars on joint replacement surgery

## Strategic Partner List

Ukiah Valley Medical Center 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**

- Alliance for Rural Community Health (ARCH)
- Anderson Valley Health Center
- Cancer Resource Centers of Mendocino County and UCSF Institute for Health Policy Studies
- Community Development Commission
- Community Foundation of Mendocino County
- Consolidated Tribal Health Project, Inc.
- FIRST 5 Mendocino
- Frank R. Howard Memorial Hospital
- Greater Ukiah Chamber of Commerce
- Healthy Mendocino
- Mendocino County Aids and Viral Hepatitis Network (MCAVHN)
- Mendocino Coast Clinics
- Mendocino Community Health Clinic
- Mendocino County Sheriff's Office
  
- Mendocino County Health and Human Services Agency
- Mendocino County Youth Project
- MendoLake Credit Union
- North Coast Opportunities (NCO)
- Pacific Redwood Medical Group
- Partnership HealthPlan
- Redwood Children's Services
- Redwood Coast Medical Services
- Ukiah Valley Primary Care Medical Group
- United Way of the Wine Country
- Ukiah Police Department

## Community Benefit Inventory

Ukiah Valley Medical Center 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 Need	Interventions	Description	Partners	# of Community Members Served	Measures of Success/Outcomes
Behavioral Health: <i>Access to care &amp; care delivery</i>	Access to Care & Care Delivery	Supported two family medicine physicians in a Train New Trainers (TNT) Primary Care Psychiatry fellowship certificate program	UC Davis Health System, Dept of Psychiatry and Behavioral Services; Adventist Health Physicians Network	TBD upon certificate completion	Year-long clinical education teaches physicians how to complete an evidence-based and efficient psychiatric interview in the busy practice setting as well as diagnose and treat community encountered psychiatric conditions. Most importantly, both physicians (trainees) will learn how to teach these principles to their primary care colleagues.
	Care Delivery	Entered into a Memorandum of Understanding (MOU) with the County and it's contracted behavioral health provider	Mendocino County Behavioral Health & Recovery Services (BHRS) and Redwood Quality Mangement Company (RQMC); Adventist Health Physicians Network	estimate 1,100	MOU established coordinated interagency protocols for the assessment and treatment of persons with mental illness in UVMC's Emergency Department

Behavioral Health: <i>Access to care &amp; care delivery</i>	Care Delivery	Hosted quarterly stakeholder meetings with ED physicians, ED staff, and partner agencies	Mendocino County Behavioral Health & Recovery Services (BHRS), Redwood Quality Mangement Company (RQMC), Mendocino County Sheriff's Dept, City of Ukiah Police Dept, Pacific Redwood Medical Group	estimate 1,100	Purpose of meetings is for ongoing review and improvement of crisis care delivery in a collaborative and patient-first format
	Care Delivery	Offered free seminar on <i>Families and Addiction</i>	Adventist Health Physicians Network (AHPN)	46	Offered seminar which addressed how to cope with addiction and restore family balance
	Care Delivery	Provided ED utilization data for a County grant program	Mendocino County Behavioral Health & Recovery Services (BHRS)	17	Provided data regarding mental health crisis emergency dept utilization and length of stay to the County for a grant that provided for a mobile mental health outreach worker in outlying areas of our remote county
	Care Delivery	Provided training to select employees on the <i>Community Resiliency Model</i>	FIRST 5, County of Mendocino Health & Human Services Agency	estimate 90	Provided eight-hour training course to select employees on the <i>Community Resiliency Model</i> . Supported one RN to take advanced education to become a certified train-the-trainer.

Chronic Disease: <i>Emphasis on diabetes, stroke, and cancer prevention</i>	Health Education	Offered free seminar on <i>Living with a Healthy Heart</i> with up-to-date research and Q&A with local cardiologists	California Medical Group (CMG)	52	Offered seminar which addressed current methods of heart disease prevention, diagnosis, lifestyle management, and treatment from our team of cardiologists
	Health Education & Screening	Offered free diabetes testing at various events throughout the county	Various	1,042	Offered free diabetes testing at various health fairs, community events, and other programs throughout the inland county
	Health Education & Screening	Provided free diabetes education and support group	Various	809	Provided free diabetes education and support group open to any diabetic or pre-diabetic community member led by a registered nurse and registered dietitian
	Health Education & Screening	Offered free support group for stroke patients and their caregivers and families	Various	34	Offered free support group, <i>Strokevivor</i> , for stroke patients and their caregivers and families
	Care Delivery	Hosted community 5k fun run to benefit cancer program	Cancer Resource Center, North Coast Striders, Adventist Health Physician Network, Ukiah High School, Redwood Empire Fairgrounds	330	Held a community fun run, Colors for Cancer 5k
	Health Education & Screening	Offered free support group for individuals with asthma, COPD, or other	Adventist Health Physicians Network (AHPN)	40	Offered free support group, Better Breathers Club, for individuals with respiratory issues including asthma, COPD, etc

		respiratory issues			
	Health Education & Screening	Offered free smoking cessation program open to all community members	Susan Boling, Educator	42	Offered free smoking cessation program open to all community members
Advanced Aging Care: <i>Emphasis on Orthopedic Care</i>	Health Education & Screening	Provided free seminars on joint health and treatment options	Adventist Health Physicians Network (AHPN), Ukiah Senior Center	122	Provided free seminars on joint health and treatment options with up-to-date research and Q&A with local orthopedic surgeons
Other	Training & Education	Provide financial contribution to the local nursing program	Mendocino College; Mendocino College Foundation	Unknown	Provide funding to cover approximately half the salary for the registered nursing instructor at Mendocino College
	Health Fair	Provide free <i>Children's Health Fair (Wild About Health)</i> in partnership with local coalition	FIRST 5, Savings Bank of Mendocino County, NCO, Mendocino Community Health Clinic, etc	440	Provided free health fair to local children including screenings for diabetes, hearing, vision, and more. Offered nutrition education, effective handwashing, bicycle safety training, and free bicycle helmets

## 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.



## Financial Assistance Policies

At Ukiah Valley Medical Center, we're committed to keeping you healthy. As a result, your ability to pay should never stop you from seeking needed care.

When you come to us for treatment, our patient financial services department will be happy to talk to you about payment options. Our financial assistance program offers:

- If you are uninsured, you may be eligible to receive a discount for your services under our Uninsured Discount policy.
- If you are uninsured, our financial counselors will help you find out if you qualify for a government program such as Medicaid (Medi-Cal in California). If one of these programs is right for you, they may be able to assist you with the application process.
- If you do not qualify for a government program, we provide discounts to eligible low-income patients and underinsured patients. Please contact our patient financial services department if you cannot pay part of your bill. We will review your financial situation to determine if you are eligible for financial assistance.

The Adventist Health Financial Assistance Policy and Financial Assistance Program brochure are available in both English and Spanish on our website at [www.uvmc.org/financialhelp](http://www.uvmc.org/financialhelp). You can also access the list of physicians who are covered under the hospital's Financial Assistance Policy. For more information, please call us during normal business hours at (707) 462-3111.

## Community Benefit & Economic Value for Prior Year

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

<b>UKIAH ADVENTIST HOSPITAL DBA UKIAH VALLEY MEDICAL CENTER</b>		
<b>Charity Care and Other Community Benefit</b>		
	Net Community Benefit	% of Total Cost
Traditional charity care	2,272,118	1.58%
Medicaid and other means-tested government programs	16,446	0.01%
Community health improvement services	77,383	0.05%
Health professions education	-	-
Subsidized health services	518,744	0.36%
Research	-	-
Cash and in-kind contributions for community benefit	73,628	0.05%
Community building activities	-	-
<b>TOTAL COMMUNITY BENEFIT</b>	<b>2,958,319</b>	<b>2.05%</b>
<b>Medicare</b>		
	Net Cost	% of Total Cost
Medicare shortfall	12,772,519	8.86%
<b>TOTAL COMMUNITY BENEFIT WITH MEDICARE</b>	<b>15,730,838</b>	<b>10.91%</b>

## 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.



**OUR MISSION:**  
Living God's love by inspiring health,  
wholeness and hope

### 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 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:**

- System-wide Corporate Policy**
- Standard Policy**
- Model Policy**

**Corporate Policy**  
**Department:**  
**Category/Section:**  
**Manual:**

**No. AD-04-006-S**  
**Administrative Services**  
**Planning**  
**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.

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**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:**

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Marketing & Communications Manager

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Northern California Network of Adventist Health 275 Hospital Drive,  
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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>