Rideout Memorial Hospital + Adventist Health

2019 Community Plan Update/Annual Report

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Adventist Health Overview

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

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

OUR VISION:
We will transform the health experience of our communities by improving health, enhancing interactions and make care more accessible.

Adventist Health entities include:

- 21 hospitals with more than 3,200 beds
- More than 280 clinics (hospital-based, rural health and physician clinics)
- 13 home care agencies and seven hospice agencies
- Four joint-venture retirement centers
- Compassionate and talented team of 35,000 associates, medical staff physicians, allied health professionals and 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.

Letter from the President

Dear Friends and Colleagues,

Since April 2018 Rideout Memorial Hospital has been working under one umbrella with Adventist Health. Proud to be known as Adventist Health and Rideout, we are compelled by our mission — *to Live God's love by inspiring health, wholeness and hope*.

The union with Adventist Health allowed us to focus our resources on community integration work and further live our mission in the community. As a non-profit healthcare system, we go to great lengths to make meaningful impact to the overall health and wellbeing of the community.

In 2019, we partnered with Sutter Surgical Hospital North Valley to conduct a Community Health Needs Assessment (CHNA). The assessment identified the community's top health needs. We took this information and formulated a plan to address these community needs.

The identified health needs in our community are like community needs throughout California and the country. The opioid epidemic has impacted our community, as has substance use, homelessness and food insecurity. These issues are magnified due to a shortage of mental and behavioral health services, and the lack of affordable housing and jobs. We also know that there is a gap in knowledge related to disease prevention and health literacy in our community.

Improving overall community health is only possible through strong collaborations and partnerships with other organizations and programs in the Yuba-Sutter area. These complex problems require expertise, engagement and investment beyond the hospital. We need to leverage the knowledge, resources and collaboration between everyone in our community to ensure our community health interventions are systematic and sustained.

Our goal is to make meaningful impacts to community health throughout Yuba and Sutter counties. As you read through the following Community Plan Annual Report, I encourage you to think through solutions that would help us make an impact. We would love to hear your feedback and suggestions.

On behalf of Adventist Health and Rideout, I sincerely thank you for your interest in improving the health and wellbeing of our community.

Rick Rawson,

President

Rideout Memorial Hospital

Rideout Regional Medical Center is a 221-licensed-bed, acute care facility
Mailing Address: 726 4th St. Marysville, CA 95901
Contact Information: Monica Arrowsmith, Business Development Leader; Email: arrowsms@ah.org
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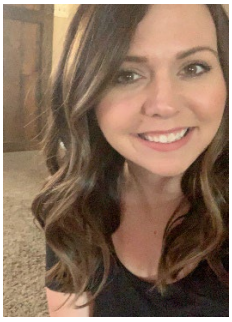
- **Rideout Emergency Department**, located inside Rideout Regional Medical Center, is the only emergency room between Southern Butte County and Sacramento. It is a Level III Trauma Center and STEMI-Receiving Center.
- **The Fountains Skilled Nursing & Rehab Center**, a 145-bed skilled nursing facility, which includes a 24-bed Rehabilitation unit
- **The Courtyard Assisted Living**, a 54-unit residence for seniors
- **The Gardens**, a 25 private and 11 semi-private bed facility staffed with skilled and professional caregivers for Dementia and Alzheimer's patients. The Gardens also offers an adult day care support center including six additional deluxe units
- **Rideout Cancer Center,** a partnership between Rideout Health and UCD Health System, is a 42,000 Sq. Ft. outpatient cancer treatment center
- **Rideout Surgery Center**, a free-standing outpatient surgery center

Rideout Clinics

- Rideout General Cardiology Clinic
- Rideout Interventional Cardiology Clinics
- Rideout Cardiothoracic Clinic
- Rideout Ear, Nose & Throat Clinic
- Rideout General, Bariatric Surgery
- Rideout Orthopedics Clinic
- Rideout Urology Clinic
- Rideout Vascular Clinic
- Rideout Women's Health
- Rideout Occupational Health and Drug Testing
- Rideout Oncology Clinic
- Rideout Primary Care Clinic UCD
- Rideout Primary Care Clinic Town Center
- Rideout Family Physicians

Community Health Development Team

Monica Arrowsmith
Business Development Leader



Cassie Alvarez
Business Development & Mission Integration

CHNA/Implementation Strategy contact:

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Request a paper copy from Administration/President's office. To provide comments or view electronic copies of current and previous community health needs assessments go to: https://www.adventisthealth.org/about-us/community-benefit/

Invitation to a Healthier Community

Fulfilling the Adventist Health 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 2016 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 2016 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, Rideout Memorial Hospital + Adventist Health have adopted the following priority areas for our community health investments for 2017-2019:

- Access to Quality Primary Care Health Services and Prescription Drugs
- Access to Affordable, Health Food
- Access to Mental, Behavioral, and Substance Abuse Services
- Access to Specialty Care
- Access to Health Education and Health Literacy
- Access to Transportation and Mobility
- Additional Identified Health Need – Collaboration and Coordination among Community Services & Programs

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

- Do our interventions make 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.

2019 Community Benefit Update

In 2016, Rideout Memorial Hospital conducted a community health needs assessment and was followed by a 2017 Community Health Plan (Implementation Plan) that identified the priority needs listed below. The prioritized needs were chosen based on community health data and the voices of our community. Working together with our community 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 supporting the health of our communities.

Priority Need – Access to Primary Care Health Services and Prescription Drugs

Street Nursing Program: Adventist Health and Rideout initiated a street nursing program in response to the growing population experiencing homelessness. According to the 2017 Point-in-Time Count, 760 total individuals were identified as experiencing homelessness in the region. This number includes adults and children of varying ages and races/ethnicities. We believe there were well over 1,000 people living in tents or in cars near our river's edge at this time. Many people are nearing the end of their resources and are about to become homeless.

In January 2019, AHRO officially started the Street Nursing Program. The Street Nursing Team consists of a RN Street Nurse and a Patient Care Coordinator. This team provides medical screenings and case management services to the homeless population two days a week at the local Coordinated Entry Sites.

In 2019, Adventist Health and Rideout was awarded a grant for $100,000 to purchase and outfit a vehicle to serve as a mobile clinic, supplementing the Street Nursing Program. AHRO was also awarded a grant from Vituity in December 2019 to provide tele-health services to patients. The telehealth platform allows physicians in the Emergency Room to video conference the patient in the field to determine the appropriate treatment for that patient. In some cases, the physician recommends that that patient comes to the ED for treatment that cannot be completed by the street nurse.

Here are the numbers for Street Nursing Outreach in 2019:

- 400 unique patients served
- 1,400 patient encounters/visits
- 1,972 AHRO staffed hours

Other program details:

- 114 patients received disease management education
- 147 patients were connected to community resources
- 133 follow-up primary care appointments were made
- 67 patients were referred for insurance coverage applications
- 10 tele-health visits with AHRO ED Providers
- The layout design for the Mobile Clinic (van) was completed, approved by the capital committee, and will be funded in 2020. The goal is to operationalize this van by the end of 2020.

- Number of Community Members Served: 400

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. In order to bridge this gap, AHRO partnered with the Medicine Shoppe Pharmacy for both discharge counseling and dispensing medications. In situations where the patient is unable to pay for the critical medications, Adventist Health and Rideout will pay for the medications.
Here are the numbers for 340B Charity Care outreach in 2019:

- 194 Patients
- 613 medication prescriptions filled
- $ 57,163.05 of drugs received at cost to patients (cost of drugs with no markup)

  - Number of Community Members Served: 194

Partners – Access to Primary Care Health Services and Prescription Drugs

- The Medicine Shoppe Pharmacy
- Hands of Hope / Life Building Center (Coordinated Entry Sites)
- Yuba County and Sutter County Public Health and Homeless Service Departments
- Yuba-Sutter Homeless Consortium
- Vituity ED Physician Group
- Salvation Army
- Better Ways (homeless shelter in Sutter County)
- 14 Forward (homeless shelter in Yuba County)
- Marysville Police Department
- Local Clinics – Harmony Health, Peach Tree Clinic, Ampla Health Clinics, Marysville Clinic
- Local Churches

What was the impact in 2019 for your priority area?

The programs implemented to address access to primary care health services and prescription drugs continue to have an impact on the community. Without a Meds-to-Beds program, 194 patients would not have received their critical medications, which could have resulted in subsequent emergency room visits and inpatient stays. The Street Nursing Program had a significant impact to the population experiencing homelessness. The Street Nursing team consistently shares information regarding the lack of trust in this population. At the beginning of the program, patients were reluctant to engage with the street nurse team due to a lack of trust. The ratio of unique patients (400) to total encounters (1,400) in indicative of the trust building that occurred as a result of this program and

team. We believe that this trust and relationship building will continue to improve, and the team will see even greater numbers in subsequent years.
Quantifiable measures were not developed for the 2016 CHNA. AHRO developed metrics in 2019 and results will be shared in all annual reports in the future.

Program highlight – Street Nursing Program

A Street Nursing Program patient was pregnant and reported not having medications to control her diabetes. She had missed multiple doctor's appointments, had not connected with her OB, and had no primary care doctor. The street nurse determined that the patient needed immediate medical attention and sent her to the Adventist Health and Rideout emergency room via ambulance. She was admitted to Adventist Health and Rideout and received treatment for her uncontrolled diabetes. The patient was discharged from the hospital after three days.

The patient followed up with the Street Nursing team after she was discharged. The team discovered that the patient was not taking her insulin. She did not have needles and did not understand how to take the medication correctly. This scenario is not unique to this patient. The team frequently finds that medication noncompliance is due to lack of understanding, education and required resources.

To remedy the situation, the street nurse went into action. She went through the patient's medication, contacted her provider and the pharmacist to gain understanding of the medication instructions, and educated the patient about the medications and how to administer insulin correctly. The team discovered that the prescription for needles was called in incorrectly and was able to correct the order and the pharmacy agreed to have it ready for pickup that same day. Moving forward, the street nurse monitored the patient's blood sugars twice a week until delivery to ensure her blood sugar levels were never too high or too low. Once the diabetes was under control, the patient began to feel much better, gaining energy and color.

The patient care coordinator's primary focus was getting the patient housed prior to delivering the baby. The patient care coordinator called on of her community resources for help and was successful! The "Homeless to Housed" project is typically for seniors with health conditions, but the program managers made an exception. The Homeless to Housed project paid for the patient, baby and the baby's father were to stay in a hotel with full case management until housing is located. The patient care coordinator worked with county resources to arrange a car seat, clothing, and diapers to be provided to the family at time of discharge from the hospital.

Momma, baby, and father are all doing well in the program and the father found employment after help with mock interviews, resume building, and hard work on his behalf. The couple was so excited and thankful that the street nursing team were some of the first people the couple texted when the father got the job.

Priority Need – Access to Affordable, Healthy Food

Food Insecurity Program: Food insecurity is a nation-wide issue. In California, one in ten people are food insecure. 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 problems. All of this leads 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 insecurity program, which begins with a screening process for all inpatients. Patients are screened for food insecurity upon admission by AHRO case managers. If a patient is identified with food insecurity, a referral is submitted to the Yuba-Sutter Food Bank where the volunteers gather a three-day supply of food for each patient. This food is boxed and ready for the patient upon discharge from the hospital.
In 2019, Adventist Health and Rideout identified 514 patients as food insecure. Additional program details are below:

- 280 patients (54%) were identified as homeless
- 258 patients were given referrals to the food bank to pick up food
- 206 patients were provided community resources for food
- 16 patients were set up with Meals on Wheels

In addition, our commitment to this partnership with the Yuba-Sutter Food Bank includes volunteering at the Food Bank warehouse once a month and sponsoring food drives. In 2019, Adventist Health and Rideout employees volunteered 406.5 hours at the Food Bank.

  - Number of Community Members Served: 514

Partners – Access to Affordable, Healthy Food

- Yuba-Sutter Food Bank
- Local churches
- Sutter County Health Division

What was the impact in 2019 for your priority area?

The program implemented to address access to affordable, health food continues to have an impact on the community. Without this program, patients who identify as food insecure would be discharged home without food and without referrals to the Yuba-Sutter Food Bank or other local food pantries. For some people, finding resources and figuring out how to navigate the public health system is very hard. This program links patients to the food bank for immediate and future needs. We believe that this partnership with the Yuba-Sutter Food Bank will continue to improve the health and wellbeing of the population and we'll see even greater numbers in subsequent years.
Quantifiable measures were not developed for the 2016 CHNA. AHRO developed metrics in 2019 and results will be shared in all annual reports in the future.

Program highlight – Access to Affordable, Healthy Food

On one of the last few days of 2019, a diabetic homeless patient from Butte County was admitted to Adventist Health and Rideout for dehydration, weakness, and non-compliance with his diabetes medications. This patient was also deemed food insecure. After meeting with the patient at bedside, the patient care coordinator was able to get to know him a little better. He told the patient care coordinator that he was from the Oroville area and has struggled with homelessness and compliance with his diabetic medications for quite some time. He expressed his desire to return to the Oroville area and get back on his feet.

Due to the holiday season, the patient care coordinator knew it was going to be difficult to find a shelter for the patient, let alone find one in another county that would be willing to accept him. By the grace of God, she was able to contact the manager of the Oroville Rescue Mission who agreed to not only hold a bed for the patient, but to keep the patient's diabetic medications in the refrigerator. The patient care coordinator was able to secure transportation for the patient back to Butte County. He was also provided with a list of Butte County resources for food distribution sites.

Priority Need – Access to Mental, Behavioral, and Substance Use Services

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. In 2017, AHRO's Emergency Department saw 1,898 patients with behavioral health complaints. The county was closing its involuntary psychiatric services, which would further impact the volumes of behavioral health patients in the Emergency Department.
In order to deliver the highest quality of care for behavioral health patients in the Emergency Department, Adventist Health and Rideout partnered with county resources and agreed to imbed county-paid crisis counselors in the Emergency Department 24 hours a day. 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 are started or resumed, safety plans designed, and follow up appointments are arranged by the team. As a team, the county and hospital have created a process to provide high quality care to the psychiatric patient in the ED.
The Behavioral Health Collaborative saw 2,148 behavioral health patient visits in 2019. By working together, we have safely discharged back into our community approximately 50% of the patients seen. This ability to discharge patient's home is made possible through the creation of a robust safety program and discharge plans by our county worker's and tele-psychiatry services. Every patient receives true psychiatric care while they are in the ED and this includes the same type of assessment, medication recommendations, and discharge and safety plans performed by behavioral health experts.

- Number of Community Members Served: 2,227

ED Bridge Program: In order to address the growing opioid problem in the area, Adventist Health and Rideout and Vituity applied for and was awarded a $175,000 grant from the California Bridge

Program. Funding was received in 2019 for ED staff training, physician X-waiver credentialing, and used to hire a Substance Use Navigator, who helps identify people with opioid use disorder in the emergency room. Patients are able to immediately receive treatment for their withdrawal symptoms in the ED with the medication buprenorphine (suboxone), and then the Substance Use Navigator links them from the ED into continued outpatient treatment in the community clinics. Through this grant, we were able to support 32 ED providers to do the extensive X-Waiver training program to build a MAT program from the ground up. The Bridge Program started in May 2019.

- Number of Community Members Served: 400

Sexual Assault Response Team (SART): Adventist Health and Rideout aided the Rideout Emergency Department Sexual Assault Response Team (SART) by providing equipment and training to help women and children of sexual assault crimes. In 2019, the SART team met with the District Attorney, Local Police Departments, Victim Advocates, and Casa De Esperanza. The team also conducted trainings with staff at Casa De Esperanza.

- Number of Community Members Served: 50

Partners – Access to Mental, Behavioral, and Substance Abuse Services

- Sutter-Yuba Behavioral Health
- Vituity ED Physician Group
- Pathways
- Harmony Health
- Aegis Treatment Center
- ATS
- Peach Tree
- Ampla Health

Program highlight – Access to Mental, Behavioral, and Substance Use Services

Our Substance Use Navigator (SUN) began this journey with Dr. Morley and the rest of the ER and hospital staff in March of 2019 to get the Bridge Program up and running in the Rideout ER department. A few weeks into the position, the SUN met a young man in the ER who was there for alcohol withdrawal. Over the next couple of weeks, the SUN tracked the patient, meeting with him as often as possible.

Over a short period of time, the patient had been into the ER 16 times and was experiencing a decline in health as well as losing his job and on the verge of losing his place to live. We were able to get the patient into a residential treatment center for alcohol detox and treatment, and the patient ended up staying at the center for 90 days. The patient did very well addressing his issues and was discharged from treatment. He has since got his job back; his housing is secure, and he continues to stay sober almost one year later and has had no further hospital visits.

Priority Need – Access to Specialty Services

Specialty Clinics: Adventist Health and Rideout has opened, enhanced or added new specialty care physicians to our clinics. These new physicians now provide patient care at:

- Rideout Interventional Cardiology Clinic
- California Heart Center
- Rideout Women's Health Clinic
- Rideout Vascular Clinic
- Rideout Orthopedics Clinic
- Rideout Primary Care Clinic
- Rideout Urology Clinic
- Rideout General and Bariatric Surgery Clinic

Priority Need – Access to Health Education and Health Literacy

Childbirth & Breastfeeding Preparation Classes: Registered Nurses from the Labor and Delivery Unit teach what to expect when you are in labor. This class also helps with breastfeeding instruction

- Number of Community Members Served: 211

Breastfeeding Support Group: Registered Nurses and Lactation Specialists from the Labor and Delivery Unit support new mothers and babies with breastfeeding, self-care and physical wellbeing. Classes are held weekly.

- Number of Community Members Served: 682

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. 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.

- Number of Community Members Served: 5,160

Every 15 Minutes: Adventist Health and Rideout helped with Every 15 Minutes Program at local high schools. This two-day program is designed to bring awareness to the consequences of drinking and texting while driving. AHRO had six volunteers, for a total of 180 hours.

- Number of Community Members Served: Approximately 400 students

Impact Teen Drivers Program: Adventist Health and Rideout's Trauma Department helped with the Impact Teen Drivers Program at local high schools. This program is designed to educate teens on safe driving.

- Number of Community Members Served: 1,375 students

Fall Prevention Education: Adventist Health and Rideout's Trauma Department provided fall prevention education and assisted living training for staff, patients and families. The Trauma Department also educated hospital staff and guests on fall prevention,

- Number of Community Members Served: Approximately 75

"Stop the Bleed" and "Save a Life" Education: Adventist Health and Rideout's Trauma Department helped with the "Stop the Bleed" program at local high schools. Stop the Bleed teaches students how to control bleeding and save a life. Students learned tourniquet application, wound packing and holding pressure to stop traumatic bleeding.

- Number of Community Members Served: 303

Heart Disease Education: Adventist Health and Rideout participated in the Early Heart Attack Educational Program and sponsored a Women's Heart Health Lunch and Learn in 2019. These events taught the community the early signed of a heart attack and CPR. They also were designed to educate and raise awareness of heart disease and prevention.

- Number of Community Members Served: 180

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.

- Number of Community Members Served: 20

Cancer Support Group: Adventist Health and Rideout offers multiple programs for Cancer patients and survivors. Included in the offerings are a weekly support group for individuals and caregivers. These weekly sessions help those in need of emotional support, loss of life transition, and other stressors. AHRO also offers a "Chemotherapy and You" weekly class designed to help prepare patients and caregivers for treatment. This class also educates on side effects, management, and central line access. AHRO offers a peer navigation program and a wig bank program, which connects patients who lose their hair with wigs through the American Cancer Society.

- Number of Community Members Served: 456

COPD Support Group: The Better Breathers Club is a support group for those living with COPD. The group meets monthly and covers educational topics including oxygen, sleep apnea, nutritional needs, exercise and medications.

- Number of Community Members Served: 28

Weight Management Support Group: The AHRO Bariatric Surgery Support Group is offered at no charge to people who have had or are planning to have bariatric surgery. The group facilitates networking and education and meets once a month.

- Number of Community Members Served: 45

Teen Leadership Council (TLC): Local high school students from eight surrounding high schools are recruited to attend the TLC, a 12-month program designed to engage young adults who have demonstrated outstanding leadership skills and a strong desire to make a difference in our community and healthcare.

- Number of Community Members Served: 30

Community Education Fairs and Events: In addition to the specific classes and education opportunities above, Adventist Health and Rideout participated in a number of community events where staff volunteered to provide education to the community. These events include but are not limited to: Have a Heart for Kids – 5K Run, Relay for Life, Summer Stroll, Sutter County Health & Wellness Fair, Senior Resource Fair and Walk to End Alzheimer's.

- Number of Community Members Served: 6,470

Partners – Access to Health Education and Health Literacy

- Local High Schools
- American Lung Association
- American Cancer Society

Priority Need – Access to Transportation and Mobility

Transportation after Discharge: Adventist Health and Rideout contracts with SB+ to provide transportation services to patients upon hospital discharge, transportation to and from primary care and oncology appointments. This service is provided at no cost to the patients.
In addition to the contract with SB+, 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 indigent or 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 offer patients free transportation to and from the hospital and the cancer center.

- Number of Community Members Served: ~100

Partners – Access to Transportation and Mobility

- SB+
- Geweke Caring for Women Foundation

Changes in 2019

Adventist Health and Rideout completed a Community Health Needs Assessment (CNHA) with Sutter Surgical Hospital North Valley in May 2019. The purpose of that CHNA was to identify and prioritize significant health needs of the service area. The CHNA efforts determined the new list of Prioritized Significant Health Needs as follows:

1. Access to Mental/Behavioral/Substance Abuse Services
2. Prevention of Disease and Injury through Knowledge, Action, and Access to Resources
3. Access to Basic Needs Such as Housing, Jobs, and Food
4. Access and Functional Needs
5. Access to Quality Primary Care Health Services
6. Access to Specialty and Extended Care
7. Active Living and Healthy Eating
8. Safe and Violence-Free Environment

In response to the CHNA, Adventist Health and Rideout created process measures to help determine community benefit outcomes. These process measures are included in the 2020 Community Health Implementation Strategy. The organization will focus on the strategy set forth in that plan for the next year.

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.

OUR MISSION:
To share God's love by providing physical, mental and spiritual healing

Community Benefit

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.