Adventist Health Clear Lake

2017 Community Plan Update/Annual Report
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Adventist Health Overview

Adventist Health Clear Lake is an affiliate of Adventist Health, a faith-based, nonprofit integrated health system serving more than 75 communities on the West Coast and Hawaii.

Adventist Health entities include:

- 19 hospitals with more than 2,800 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
- Workforce of 33,000 includes more than 24,600 employees; 5,000 medical staff physicians; and 3,700 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 CEO

Since 1968, when it was founded as Redbud Community Hospital, our organization has had one purpose: to provide excellent health care for Lake County, California. Today, Adventist Health Clear Lake is building on the legacy of the last 50 years by focusing even harder on transforming the health status of our county and supporting our community toward a brighter, healthier future.

We do this not only through advanced medical technology and high quality care, but by investing our energy and resources in community impact projects and strategic collaboration with local partners. Together, Adventist Health Clear Lake and our partners are aligning local efforts to address the issues raised in our Community Health Needs Assessment. We are committed to leading innovative, results-driven initiatives that make a difference for our patients and community members.

Through strategic and creative planning, our annual Community Health Improvement Plan was developed in answer to our mission to live God’s love by inspiring health, wholeness and hope. In 2018, we are calling our entire team to create a “wow” experience for our neighbors and each other through the best employee engagement, patient experience, quality care and community impact. As we look back on the past 50 years of growth, we are inspired to work even more closely together to create the bright future our community deserves.

Thank you for your interest in this vital next step in our organization’s journey. Please contact our Community Wellness team for more information at 707.995.5884.

In hope,

David Santos
President & CEO
Hospital Identifying Information

Adventist Health Clearlake

25-bed Critical Access hospital

15630 18th Avenue, Clearlake, CA 95422

Contact: David Santos, President & CEO

(707) 995-5820

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

- Adventist Hospital Clear Lake, 15630 18th Avenue, Clearlake, Ca 95422
- Adventist Health Family Health Center, 15320 Lakeshore Drive, Clearlake, CA 95422
- Adventist Health Live Well, 15320 Lakeshore Drive, Clearlake, CA 95422
- Adventist Health Hidden Valley Clinic, 18990 Coyote Valley Drive, Hidden Valley Lake, Ca 95467
- Adventist Health Family Health Center, 52960 State Street, Kelseyville, CA 95451
- Adventist Health Konocti Wellness Center, 9340 C Lake Street, Lower Lake, CA 95457
- Adventist Health Family Health Center, 21337 Bush Street, Middletown, CA 95461
- Adventist Health General Surgery, 15322 Lakeshore Drive, Suite 101, Clearlake, CA 95422
• Adventist Health Rehabilitation Services, 14855 Olympic Drive, Clearlake, CA 95422
• Family Health Center Arbuckle, 900 King Street, Arbuckle, CA 95912
• Family Health Center Williams, 501 E Street, Williams, CA 95987
• Family Health Center Colusa, 151 E. Webster Street, Colusa, CA 95932
• Sutter Lakeside Hospital, 5176 Hill Road East, Lakeport, CA 95453
• Lakeview Health Center, 5335 Lakeshore Drive, Lakeport, CA 95453
• Lake County Tribal Health Consortium, 925 Bevins Street, Lakeport, Ca 95453
• Clearlake Veterans Affairs Medical Clinic, 15145 Lakeshore Drive, Clearlake, CA 95422
Community Health Development Team

David Santos  
President, CEO

Marc Shapiro, MD  
Chief of Staff

Shelly Mascari  
Director  
Community Wellness

Angelique Cole  
Director  
Outpatient Operations

Colleen Assavapisitkul  
RN, BSPA, HACP  
Vice President of Patient Care

Carlton Jacobson  
Regional Vice President  
Finance

Brent Dupper  
Administrative Director  
Physician Outpatient Services

Marc Shapiro, MD  
Chief of Staff

Conrad Colbrandt  
Executive Director  
Redbud Health Care District

Laurie Allen  
Project Coordinator  
Community Wellness  
Community Benefit Lead

Marylin Wakefield  
Grants Coordinator  
Community Wellness

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

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: AdventistHealth.org/communitybenefit or https://www.adventisthealth.org/pages/about-us/community-health-needs-assessments.aspx
Invitation to a Healthier Community

Fulfilling AH’s Mission

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

The Community Health Plan marks the second phase in a collaborative effort to systematically investigate and identify our community’s most pressing needs. After a thorough review of health status in our community through the Community Health Needs Assessment (CHNA), we identified areas that we could address through the use of our resources, expertise, and community partners. Through these actions and relationships, we aim to empower our community and fulfill our mission, “Living God’s love by inspiring health, wholeness and hope.”

Identified Community Needs

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

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

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

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

Building a healthy community requires multiple stakeholders working together with a common purpose. We invite you to explore how we intend to address health challenges in our community and partner to achieve change. More importantly though, we hope you imagine a healthier region and work with us to find solutions across a broad range of sectors to create communities we all want for ourselves and our families.
In 2016, Adventist Health Clear Lake, 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 1- Healthy Behaviors (Access to services, Housing and Homelessness, Substance Use Disorders)**

Intervention: **Living Nicotine Free with Live Well** is a primary intervention which targets the high tobacco use that exists in Lake County (below). This intensive offering lasts for three months and is geared for those individuals who have a desire to quit using tobacco products. One-on-one telephone support, group meetings, a targeted cell phone app, weekly reminders via text messaging, the use of nicotine replacement products and a referral to the Live Well Program to implement a holistic approach to cessation is included.

- Number of Community Members Served: 19

Intervention: **Live Well** originated as a pain management program. Over the past decade, Live Well has become a fully integrated multi-disciplinary intervention that is designed to improve the quality of life for patients enrolled. Program components include: behavioral health, addiction and pain management, dietary counseling and health coaching. While pain and addiction management remains the primary focus of Live Well, services provided will aid the healing of many chronic diseases.

- Number of Community Members Served: 2653

Intervention: **Point of Care Sepsis Protocol** systemically changed the workflow for laboratory, nursing and medical staff in order to improve patient outcomes for sepsis. ‘Door to treatment’ time for septic patients, has been improved by over 30 minutes.

- Number of Community Members Served: 950

Intervention: **Lake County Loves Babies** is an infant safe sleeping campaign designed to reduce infant deaths and injuries related to suffocation and S.I.D.S. Any Lake County family who is expecting and completes the safe sleeping training will receive a baby bundle including a Pack ‘n Play and baby essentials that support safe infant care.

- Projected Number of Community Members to be Served: 180

**Partners**

- Health Leadership Network
- Lake County Public Health
- First 5 Lake County
- Sutter Lakeside Hospital
- Easter Seals
- Medline Industries Inc.
- Mother-Wise
- Lake Family Resource Center
- Lake County Breastfeeding Coalition
- Redbud Health Care District
- North Coast Opportunities

### 2017 Measured Impact

<table>
<thead>
<tr>
<th>Objective</th>
<th>Baseline Measurement</th>
<th>Performance Target</th>
<th>Indicator</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the number of Lake County residents that have access and engage in healthy behavior programming</td>
<td>Assess the number of members enrolled in healthy behavior programming in 2016 (e.g. smoking cessation; Live Well)</td>
<td>10% increase</td>
<td># Attending classes:</td>
<td>Clinic and hospital records</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td># Attending support groups:</td>
<td>Class records</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 19 Live Nicotine Free</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• # Attending support groups:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• 850 Program attendees</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Improved score of pre and post health quizzes 90% improvement Live Nicotine Free</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Health Ranking in adult obesity improved by 1%</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Added dental services improving patient/dentist ratio by 1%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Added Mental Health services improving provider/patient improvement of 1%</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Reduced teen births by 6%</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Reduced preventable hospital stays from 50/1,000 to 42/1,000</td>
<td></td>
</tr>
</tbody>
</table>
### Priority Need 2 - Clinical Care (Access to Services, Substance Use Disorders, Housing and Homelessness and Mental Health)

**Intervention:** Safe Rx has already proven its success as an opioid reduction program. The program was established to support a healthier and safer community by improving the quality and functionality of life for individuals experiencing pain. Safe Rx has also shown the ability to reduce harm from prescription drug use/abuse through collaborative partnerships that focus on prevention, treatment and recovery. Emphasis is to be placed on adhering to county-wide opioid prescribing guidelines.

- Number of Community Members Served: 2113

**Intervention:** Project Restoration plays a vital role with the entire population health strategy. Its development is based on the evidence-based theories of the Camden Coalition. Its primary purpose is data analysis, solution identification and countywide collaborative systems design. Project Restoration will focus on: high utilizer identification, readmission prevention, streamlined access to services for vulnerable populations, homelessness...
alternatives, intensive case management (through Live Well’s Intensive Program), mental health options and substance abuse support
  - Number of Community Members Served: 13

Intervention: Restoration House Respite Beds provide an additional link to housing and healing our most vulnerable clients. Patients ready for discharge without proper housing or without home care available are able to continue their medical healing in the confines of Restoration House until able to conduct self-care in a permanent housing situation.
  - Number of Community Members Served: 6

Intervention: Live Well Intensive is an enhanced version of Live Well. This intervention is geared to provide case management/disease management services to individuals who have been identified as being at high risk or high utilizers of the system. Individuals who enroll in this program often have comorbidities and are frequent utilizers of the hospitals ED. This intervention also helps patients to gain access to provider appointments, and provides broad support to improve the social determinants of health and effectively linking to community resources.
  - Number of Community Members Served: 80

Intervention: Sepsis Protocol is an effort to reduce the time it takes to diagnose and start treatment of sepsis in a patient. Individuals presenting at the ED or inpatient are assessed for elevated lactate with specialized lab equipment that allows readings within seconds vs the 90 minutes or longer it takes using typical laboratory equipment. The elevated lactate is a baseline measurement for suspicion of sepsis in patients. In addition to elevated lactate, the protocol takes the sepsis work even further. If a patient’s lactate is elevated there is an automatic reflex to obtain other bloodwork info, such as a procalcitonin, which is an additional indication of sepsis, if elevated.
  - Number of Community Members Served: 950

Intervention: Capitated Member Communication Strategy is a program that will engage each member of the AHCL system to connect with a personalized care team, disseminate information about all services available, navigate the system, build a relationship, assist with financial forms, improve health literacy and healthy behaviors, and schedule appointments. This in-person navigator will be available all open hours at the clinic setting and will include phone in services.
  - Projected Number of Community Members Served: 7,500

Intervention: Paramedic Home Visit Program functions as an extension of the Project Restoration Program, in collaboration with Lake County Fire and Paramedics. When there is a home situation noted that may contribute to health complications for the home occupants EMT’s have an option to engage the program. Referrals initiated by paramedics, ED staff or in-patient hospital staff, and approved by patients, allow a home visit to assess action needed to provide a safer living environment and referrals to community agencies that can assist.
  - Projected Number of Community Members Served: 50
Intervention: Senior VIP Strategy is a program that will engage Lake County Seniors to participate in healthy behaviors, improve participation in health screenings, educate about healthy diet and exercise and provide assistance to navigate the health care system.

- Projected Number of Community Members Served: 1,500

Partners

- Lake County Public Health
- Lakeview Health Center – Mendocino Community Health Clinic
- Partnership Health Plan of California
- Sutter Lakeside Hospital
- Clear Lake Police Department
- North Coast Opportunities
- Lake County Fire Protection District (EMT)
- Lake Transit
- Hospice Services of Lake County
- North Coast Opportunities
- Lake County Behavioral Health

2017 Measured Impact

<table>
<thead>
<tr>
<th>Objective</th>
<th>Baseline Measurement</th>
<th>Performance Target</th>
<th>Indicator</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish county-wide opioid prescribing guidelines</td>
<td>Guideline adoption</td>
<td>10% Reduction in new opioid prescriptions</td>
<td># prescriptions reduced: 70% reduction of opioid prescriptions for all doses 10% Increase in Suboxone treated patients</td>
<td>Partnership Health Plan, CURES data; Safe RX dashboard</td>
</tr>
<tr>
<td>Identify patients at risk for increased health issues</td>
<td>Live Well program enrollments</td>
<td>10% increase</td>
<td># patients identified and enrolled Enrollment increased 418 to 669 equaling a 48% growth</td>
<td>Live Well, Partnership Health Plan</td>
</tr>
<tr>
<td>Reduce opioid prescriptions and taper off patients on long term use</td>
<td>Opioid Prescriptions</td>
<td>10% reduction</td>
<td># prescriptions reduced by 70% # patient appointments for High Dose users reduced by 85%</td>
<td>Partnership Health Plan, CURES data; Safe RX dashboard</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------------------</td>
<td>--------------</td>
<td>------------------------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>Reduce E.D. visits</td>
<td>ED visits</td>
<td>10% reduction</td>
<td># recurring ED visits for enrolled patients • Project Restoration Patients decreased ED visits 94% • Restoration House Respite care reduced ED visits 73% • Reduced preventable hospital stays from 50/1,000 to 42/1,000</td>
<td>Partnership Health Plan, hospital records</td>
</tr>
<tr>
<td>Increase Diabetes monitoring</td>
<td>Diabetes monitoring</td>
<td>10% reduction in diabetes ED visits/hospital admissions</td>
<td>#patients enrolled in Live Well Diabetes management County improvement of 2% in overall ranking for diabetes monitoring</td>
<td>Live Well, Partnership Health Plan</td>
</tr>
<tr>
<td>Reduce Premature Death</td>
<td>Years of life lost</td>
<td>10% reduction</td>
<td>Improved premature death ranking • Heart Disease improved from 133/100,000 to 115.7/100,100 • Cerebrovascular Disease improved from 42.6/100,000 to 40.8/100,000 • Chronic Lower Respiratory Disease improved from 67.3/100,000 to 58/100,000</td>
<td>Annual health rankings</td>
</tr>
</tbody>
</table>
## RESTORATION HOUSE RESPITE BEDS

<table>
<thead>
<tr>
<th>Enrollment Date</th>
<th>Prior 6 months (ED visits)</th>
<th>After enrollment (ED visits)</th>
<th>Prior 6 month (IP days)</th>
<th>After enrollment (IP days)</th>
<th>Prior 6 month (Clinic visits)</th>
<th>After enrollment (Clinic visits)</th>
<th>Prior 6 months (IP Length of stay)</th>
<th>After enrollment (IP Length of stay)</th>
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</thead>
<tbody>
<tr>
<td>10/1/2017</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>22</td>
<td>3</td>
<td>3</td>
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<tr>
<td>11/29/2017</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>18</td>
<td>0</td>
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<tr>
<td>11/1/2017</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>10</td>
<td>21</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>7</td>
<td>44</td>
<td>42</td>
<td>3</td>
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</table>

## PROJECT RESTORATION

### 6 Clients – 6 Months

<table>
<thead>
<tr>
<th></th>
<th>12 Months Pre-Intervention</th>
<th>Post Intervention</th>
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<tbody>
<tr>
<td>ED Utilization</td>
<td>$435,756</td>
<td>$560</td>
</tr>
<tr>
<td>Inpatient Utilization</td>
<td>$862,194</td>
<td>$0</td>
</tr>
<tr>
<td>911 Calls</td>
<td>$21,965</td>
<td>$0</td>
</tr>
<tr>
<td>Police Encounters</td>
<td>$22,127</td>
<td>4,060</td>
</tr>
<tr>
<td>Days Incarcerated</td>
<td>$7,475</td>
<td>$2,850</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>$1,344,337</strong></td>
<td><strong>$7,470</strong></td>
</tr>
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### SafeRx

<table>
<thead>
<tr>
<th></th>
<th>Qtr 1 Jul-Sep 2015-16</th>
<th>Qtr 2 Oct-Dec 2015-16</th>
<th>Qtr 3 Jan-Mar 2015-16</th>
<th>Qtr 4 Apr-Jun 2015-16</th>
<th>QTR 1 Jul-Sep 2016-17</th>
<th>QTR 2 Oct-Dec 2016-17</th>
<th>QTR 3 Jan-Mar 2017-17</th>
<th>QTR 4 Apr-Jun 2017-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg MED per PHC user per Qtr (target = Plan Ave., current Qtr.)</td>
<td>55</td>
<td>59</td>
<td>56</td>
<td>54</td>
<td>54</td>
<td>54</td>
<td>52</td>
<td>51</td>
</tr>
<tr>
<td>Ave. PHC users/100MPM (target = Plan Ave., current Qtr.)</td>
<td>9</td>
<td>12</td>
<td>12</td>
<td>11</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>All Opioid Users/Qtr.</td>
<td>1,745</td>
<td>1,702</td>
<td>1,692</td>
<td>1,463</td>
<td>1,345</td>
<td>1204</td>
<td>1209</td>
<td>1158</td>
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<tr>
<td>Unsafe Dose Users (&gt;120 MED)</td>
<td>163</td>
<td>155</td>
<td>137</td>
<td>117</td>
<td>112</td>
<td>100</td>
<td>98</td>
<td>80</td>
</tr>
<tr>
<td>Total Prescriptions/100MPM (target = 75% reduction)</td>
<td>8</td>
<td>17</td>
<td>16</td>
<td>15</td>
<td>12</td>
<td>11</td>
<td>9.4</td>
<td>9.5</td>
</tr>
<tr>
<td>Initial Prescriptions P100MPM (target = 50% reduction)</td>
<td>1.9</td>
<td>2.9</td>
<td>2.8</td>
<td>3.1</td>
<td>2.3</td>
<td>2.5</td>
<td>2.1</td>
<td>2.4</td>
</tr>
<tr>
<td>Dose Escalations (target = 90% reduction)</td>
<td>3%</td>
<td>25%</td>
<td>22%</td>
<td>22%</td>
<td>17%</td>
<td>15%</td>
<td>16%</td>
<td>15%</td>
</tr>
<tr>
<td>Ave. Percent Users on Unsafe Dose (&gt;120 mg. MED) (target = 75% reduction)</td>
<td>4.8%</td>
<td>8%</td>
<td>8%</td>
<td>7%</td>
<td>7%</td>
<td>8%</td>
<td>8%</td>
<td>7%</td>
</tr>
</tbody>
</table>
Meet Ellis a Resident at Restoration House

Ellis was born in Miami in 1956 but was raised in California. His dad was a General Contractor who helped build Disneyland and Disney World. His mom started a Molly Maid franchise while they were living in Florida. From the time Ellis was 12 years old summers were spent training in masonry and laying bricks.

He went to high school in Anaheim, CA but didn’t finish because the staff did not appreciate him chasing them through the halls on his motorcycle. He would later get his GED and High School diploma to please his mom. She wanted the certificate on the wall.

Ellis served in the military in Vietnam, Guatemala and Honduras but doesn’t like to talk about it. Ever.

He met Cathy at a Sturgis Motorcycle rally. They were together, living on and off the grid, for 15 years. He loved to fish and she wanted to learn so they visited Clearlake. They loved it. In the 70s they bought a little land in a remote area of Clearlake off of Jerusalem Road. They didn’t live there but came up to camp every weekend, grow their vegetables, and get away from the city.

September 19, 1988 their only child was killed in a dirt bike accident. He was 13. It was the hardest thing Ellis has ever had to face before or since, but the next year would be hard to bear as well. Just over a year later Cathy died in the Loma Prieta earthquake.

Ellis moved around a lot after that. He did contract work, masonry, pounding nails, ran an oyster bar and more. He lived in Lake County and out, spending time in Colorado and Alaska. During these years he discovered his skills as an artist. It started with carving wood, and scrimshaw but his favorite was sculpting marble. When asked today what he would like to do if he could choose anything, he says, “I would be in a shop sculpting marble. Marble lasts. Nothing destroys it, not even fire.” In 2016 the off grid cabin Ellis had been living in just outside of Clearlake Oaks was destroyed by fire.

He couch surfed for a while but became fully homeless in 2017.

His stomach started to swell and he began to understand he was sick. Friends told him to try the hospital in Fort Bragg but they treated him in the ER and released him saying only that he had cirrhosis of the liver. They next hospital stay was the very next week. 12 days in Willits where he was “scary alone.” They told him quit drinking or die. A TB scare saw him transferred to Sutter Lakeside and then ultimately to Adventist Health St. Helena. He has a large mass in his lungs that has still not been fully diagnosed but threatens his life.

He’s at Restoration House (RH) to save his life; to heal. When asked what the most important thing about RH is he answers, “It’s steering me in the right direction while taking care of my medical needs. And friendship. I’ve made a couple friends. That’s a tough word for me.”

Ellis acknowledges that he has many regrets, that he has “done good and done bad.” When asked what his purpose is now it is to “get well and become a better person” so he can “contribute to my fellow man in Clearlake or elsewhere.”

Next month Ellis will be 62.
Priority Need 3- Social and Economic (Access to Services, Substance Use Disorders, Housing and Homelessness and Mental Health) –

Intervention: **Hope Rising Task Force** - St. Helena Hospital, Clear Lake provides the backbone leadership and support to build and strengthen this community collaboration committed to mobilizing and inspiring community partnerships and actions that support individual, collective and community health and wellness. Hope Rising brings cohesive communication to the broad range of work throughout the community, supports leadership development in service providers and community members, shared data collection and analysis, and provides leadership for Signature Projects, including SafeRX (see above description), and anchor activities including countywide wellness publications and resources guides, events and evaluation. Hope Rising provides oversight and vision for the first of four Local Action Teams, The Healthy Clearlake Collaborative, which is focused specifically on the City of Clearlake and surrounding areas.

- Number of Community Members Served: 65000

Intervention: **The Healthy Clearlake Collaborative** - The Healthy Clearlake Collaborative is providing the collective support to develop and implement the Health Element of the General Plan for the City of Clearlake, which is a strategy to improve the social determinants of health for the community. Initial actions include support for student leadership development, educational opportunities around supporting vulnerable individuals and communities, and supporting resources for homeless individuals.

- Number of Community Members Served: 500

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

- Number of Community Members Served: 15,000

Intervention **Project Restoration** - Project restoration plays a vital role with the entire population health strategy. Its development is based on the evidence-based theories of the Camden Coalition. Its primary purpose is data analysis, solution identification and countywide collaborative systems design. Project Restoration will focus on: high utilizer identification, readmission prevention, streamlined access to services for vulnerable populations, homelessness alternatives, intensive case management (through Live Well’s Intensive Program), mental health options and substance abuse support

- Number of Community Members Served: 13

Intervention **Hope Rising Center for Transformation** provides a program of intensive case management for individual transformation. The program will augment the county’s transitional housing and proved a range of support to facilitate access to and retention of permanent housing. The project, based on operational and
successful housing models, is embedded with services from county agencies, nonprofits, and health care systems, creates a powerful tool for individual and community transformation.
  - Projected Number of Community Members to be Served: 400

**Partners**

- Sutter Lakeside Hospital
- Mendocino Community Health Clinics
- Lake County Behavioral Health
- Lake County Public Health
- Partnership Health Plan of California
- County of Lake Board of Supervisors
- Woodland Community College
- Redwood Community Services
- Lake County Department of Social Services
- North Coast Opportunities
- Clearlake Police Department
- Lake County Fire Protection District (EMT)
- Hospice Services of Lake County

**2017 Measured Impact**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Baseline Measurement</th>
<th>Performance Target</th>
<th>Indicator</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create community partnerships</td>
<td>Collaboration to develop joint initiatives</td>
<td>Buy in of major county organizations</td>
<td>• 17 organizations involved $1.3 Million raised</td>
<td>Self-reporting</td>
</tr>
<tr>
<td>Community buy-in</td>
<td>Participation</td>
<td>10% improvement in health</td>
<td>• 17 participants with improved outcomes in Project Restoration</td>
<td>CURES, Partnership Health Plan, Adventist Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 2113 SafeRx Members with reduced opioid prescriptions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 80 Live Well Intensive patients with improved outcomes</td>
<td></td>
</tr>
</tbody>
</table>
Program highlight

Marion moved out today.
The plan was for her ex-husband to come and pick her up at 6am so they could begin the long journey to Port Townsend, Washington where she would move in with her son for her remaining days on Hospice.
I arrived at 5:30 to help with any last minute necessities and to avoid the 6am rush to the car. This is a time to take time. The house was still dark; the only light shining was from the back door of Marion’s room. Everyone else still slept.
I tapped on her door. “Can I help you with anything?”
“I can’t put my socks on. It’s going to be cold there.”
“I can do that.”
As I knelt on the floor at her feet I was filled with memories of putting socks on the feet of my children, and also moments from footwashing ceremonies echoing a night Jesus spent with his disciples. “Love one another as I have loved you.” It was an odd mix of the holy and mundane yet nothing really felt mundane.
I moved the final personal items from her room to the living room as we waited for Dan. “He’s late,” she noted. “Mormon Standard Time. That’s what we call it. Mormons are always late.” She can say that because she is Mormon and knows. We laughed.
Eventually he arrived and we tried to put too much stuff in a too little car to move her life three states away. We created a new plan to put stuff in my car and take it to storage before they started their journey. Now it felt mundane.
Except.
Storage meant the house she and Dan had bought together when they were first married. The only house she has ever owned which she thought she had said goodbye to because she would not see it again. Less mundane. Marion sits in the car while Dan, his girlfriend and I take her belongings into the house; the things she can’t take with her.
It’s time to leave. I give her a hug.
“You’re going to send me my story right?” I had interviewed Marion several times over the last few days to write her story.
“Yes. I’ll send it to you.”
“Thank you for everything. I am so grateful for Restoration House and everyone there.”
“God go with you on your journey, Marion.”
“Heavenly Father will. And Lyn said a traveling prayer for us.”
“You’re all set then.” I get in my car and drive back to the house.
Lou is walking down the hall. “Are you just getting here?”
“No, I got here earlier to help Marion.”
I sit at my desk and he follows me in. “There’s a leak in the kitchen roof where three points come together. It’s dripping into the trash can.” We go and look. I need to call the maintenance guy. The mental list of today’s tasks is begun.
Lou starts sharing ideas about making the transition to welcoming more residents beginning in April.
It’s not even 8am, and we are planning to make space for people we have not yet met. From socks to ceilings it’s all holy.
My heart echoes Marion’s words. “Thank you for everything. I am so grateful for Restoration House and everyone there.”

See the story of Project Restoration and Restoration House here: https://youtu.be/5ltCGJTofrM

**Priority Need 4 - Physical Environment (Access to Services, Mental Health)**

Intervention: **Project Restoration/Restoration House** plays the key role in addressing this priority. Housing for the homeless is wrapped under this initiative. While the ultimate goal is permanent housing for homeless individuals, the initial phase of this project is transitional housing. Individuals who have the greatest need will be targeted for this living arrangement. The Camden Coalition with their ability to assess county-wide data and services used by homeless individuals will assist this project. Those targeted will include individuals who seek hospital/community services (e.g. ED) for shelter during inclement weather.

- Number of Community Members Served: 13

Intervention: **Nutritional Services** is looking to impact the health and wellness attitudes of patients, employees and community members. A comprehensive revitalization project is underway which is focused on creating a vibrant and integral space focusing on health and wellness. This will be accomplished through innovative menu offerings, added resources and a visually appealing environment. Above all, emphasis is to be placed on fresh and healthy food items. Through this initiative, St. Helena Hospital, Clear Lake will model healthy choices to patients, residents and organizations throughout the area.

- Number of Community Members Served: 2500

Intervention **Hope Rising Center for Transformation** – Adventist Health Clear Lake and its partners flagship facility that will offer intensive case management, transitional housing, substance use disorder treatment, and job skill training and work experience for up to 200 / per year. Program graduates will be supported through aftercare groups and access to permanent housing. The program will augment the county’s transitional housing and proved a range of support to facilitate access to and retention of permanent housing. The project, based on operational and successful housing models, is embedded with services from county agencies, nonprofits, and health care systems, creates a powerful tool for individual and community transformation.

- Projected Number of Community Members to be Served: 200

**Partners**

- Sutter Lakeside Hospital
- Mendocino Community Health Clinics
- Lake County Behavioral Health
- Lake County Public Health
- Partnership Health Plan of California
2017 Measured Impact

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Transitional/Permanent Housing</td>
<td>2017 Point in Time count for homeless individuals</td>
<td>10% Improvement in severe housing problems</td>
<td># Homeless individuals in need of transitional/permanent housing</td>
<td>Hospital Point in Time count</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Restoration House 10-bed transitional housing opened and served 17 clients</td>
<td></td>
</tr>
<tr>
<td>Café Remodel</td>
<td>Completed remodel</td>
<td>Healthier environment and food options</td>
<td>All vending machines removed and replaced with fresh options. Carbonated soda machine replaced with fresh juices and flavored waters. Addition of Coffee Cart and healthier food options daily including vegan options.</td>
<td>Self-reporting</td>
</tr>
<tr>
<td>Community Garden</td>
<td>Harvested produce</td>
<td>Harvest used in nutrition services</td>
<td>Menu options offering garden-grown fresh produce 122 days</td>
<td>Self-reporting</td>
</tr>
<tr>
<td>Kitchen Remodel</td>
<td>Completed construction</td>
<td>Kitchen reopened with new equipment</td>
<td>Improved kitchen equipment installed for improved workflow processes.</td>
<td>Self-reporting</td>
</tr>
</tbody>
</table>
Program highlight

Meet a chef in our nutrition services department who has been part of our AHCL team since 2012 and is creating vegan dishes for our employees, patients and community.

What does healthy mean to you?
Healthy means making better life choices. Not just what you eat, but through your life journey. Healthy is getting the nutritional value from what you eat and feeling good after you eat it.

Who is your wellness inspiration?
Ralph Smart's YouTube channel inspired me to go vegan. He says you have to eat right to have a good healthy lifestyle. I never thought I'd be vegan, but at the end of May 2017 I went vegan cold turkey! I can think more clearly, I'm happier, I accept challenges differently. I'm not as depressed, emotional or as sad.

What does a balanced life look like?
A balanced life looks like mind, body and soul being connected. Spiritually, mentally and physically--everything goes together. Happiness is everything to me. If you're not happy, there's no point in anything. You find happiness in the simplest things and appreciating what you have.

What's your favorite healthy food?
Since I've become vegan, I don't have a favorite healthy food--there is so much to discover! I really do like my mock tuna salad though. It's delicious, plant based and loaded with protein. I love it!

What activity makes you feel healthy?
My favorite healthy activity is jogging on the treadmill or at the park. I never jogged until the last year or so. It feels good to be able to keep my breath and run. I feel free.

What is your current wellness goal?
My current wellness goal is to try a raw challenge for seven days and see how I feel. I'm planning my menu now!

Other Community Benefits

Intervention: CPR/First-Aid Classes
  - Number of Community Members Served: 250

Intervention: Student Nursing and other Health Professionals Education
  - Number of Community Members Served: 3750

Intervention: Enrollment Assistance / Public Medical Programs
  - Number of Community Members Served: 800

Intervention: Lake County Continuum of Care Homeless Support and Advocacy
  - Number of Community Members Served: 520

Intervention: Transportation/Patient Access to Care
  - Number of Community Members Served: 3500
Partners

- Partnership Health Plan of California
- Pacific Union College
- North Coast Opportunities
- County of Lake Department of Social Services
- Redwood Community Services
- Lake Transit
Changes in 2017

The 2017 Robert Wood Johnson Foundation Health Rankings continue to show Lake County as the lowest ranked county in California. Despite the ranked and weighted outcomes, the county wide collaboration and AHCL CHP initiatives are beginning to drive change that will begin to improve the health rankings for Lake County. Our AHCL Governing Board Mission Sub-Committee is assessing the results of our 2017 work, reviewing our Community Wellness County Health Rankings Progress Report priority focus for the coming year and determining any appropriate changes to the 2017 priorities.
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 Living God’s love by inspiring health, wholeness and hope, 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.