

Adventist Health St. Helena

St. Helena, CA Health Equity Report - AB 1204

HCAI ID: 106281078

Reporting Period: January 1 – December 31, 2024



Background

Adventist Health St. Helena (AHSN) has had a historical commitment to health equity and serving all patient populations through our mission “Living God’s love by inspiring health, wholeness and hope” and through our core values: Be love; Be a force for good; Be a mission owner; Be welcoming; Be curious; Be brilliant.

California Assembly Bill 1204 governs the framework for supporting health equity initiatives. This Bill requires California hospitals to address their 10 top disparities as stratified by the Hospital Quality Institute (HQI) through Health Care Access and Information (HCAI). Adventist Health had six top disparities identified by HQI for 2024. Adventist Health St. Helena is committed to improving patient outcomes and reducing health care disparities and recognizes this work extends beyond the Hospital walls through community programs and partnerships. The developed strategy to address the top disparities per HQI is delineated in this report.

AHSN is dedicated to providing public services that enhance the well-being of our community. To better understand and address local needs, a community health needs assessment was conducted with focus groups, interviews, and surveys to prioritize areas of focus. Represented and vulnerable populations included: Agricultural workers (Spanish-speaking), civic government

and leadership, community-based healthcare workers focusing on behavioral health, education, health and human services, higher education, providers, food insecure, law enforcement, low-income, medically underserved, older adults, public health, students, tribal health services, unhoused and male and female health populations.

The Hospital's health equity interventions were based on data summarized and stratified in the AHS 2022 Community Health Needs Assessment (applies to Calendar Year 2024). As a result, AHSs focused strategies, tactics and partnerships included, but were not limited to:

- **Expanding access to care** by providing shuttle service for cancer patients who live in Lake County, and Lyft and Molly's Angels transportation resources to more local residents; providing immunizations through a mobile health program; and recruiting physicians in the specialty areas of cardiology, oncology, and general and breast surgery as well as Advanced Practice Providers.
- **Addressing Physical Health Needs** through healthy food distribution; community health education for seniors and school children; provision of screenings for chronic diseases, including hereditary genetic cancer screening; and sponsorship of Blue Zones Project Upper Valley Napa (see below).
- **Provision of Mental Health Services** through partnerships with several community non-profits which provide bilingual and affordable mental health services and reduce the stigma of seeking mental health services; and provision of grief recovery workshops.

Blue Zones

AHS sponsored the Blue Zones Project Upper Napa Valley (BZPUNV). Together, the BZPUNV team and sector leaders developed a community blueprint that strategically aligned and leveraged the actions and resources of the Upper Napa Valley resources where we live, learn, work and play to help advance the efforts related to the Upper Napa Valley's largest social determinants of health challenges.

Blue zones areas are places where people are living vibrant, active lives with high rates of well-being into their hundreds. The Blue Zones Project works with communities to make sustainable changes to their environment, policies, and social networks to support healthy behaviors. Instead of a focus on individual behavior change, the emphasis is on an upstream solutions focused on making health options easy in all the places where people spend most of their time. An example of upstream solutions are working with restaurants and grocery stores to offer health food options that are labeled as such for consumers to easily identify. Blue Zones Project is committed to measurably improving the well-being of community residents through proven programs, tools and resources, and utilization of rigorous metrics to inform strategies and track progress throughout the life of the project. This includes well-being data, community-wide metrics, sector-level progress, and outcome metrics.

Who We Serve

Adventist Health St. Helena (AHSN) is a 150-bed hospital located at 10 Woodland Road, St. Helena, CA 94574. The Community Health Needs Assessment (CHNA) was used to define the hospital's primary service area

DEMOGRAPHIC PROFILE

The following zip codes represent Adventist Health St. Helena's primary service area (PSA), accounting for 75% of hospital discharges. Additionally, we took a collaborative approach and expanded our PSA by inviting Steering Committee members to include the zip codes of those they serve.

The Adventist Health CHNA market has a total population of 196,116 (based on the 2020 Decennial Census).

The largest city in the service area is Napa city, with a population of 76,987. The service area is comprised of the following zip codes: 94567, 95423, 95467, 94515, 94576, 94508, 95451,



Adventist Health St. Helena while located the community of St. Helena in Napa County serves as a tertiary care hospital for several Adventist Health and other systems' hospitals which are located primarily in Lake and Mendocino counties. This is due in a large part to the specialty services offered at AHSN including comprehensive cardiac care (catheterization laboratory and cardiovascular surgery), behavioral health services, oncology services, and orthopedic services. In 2024 AHSN's acute care population came from the following counties.

County	% Acute Patient Population (including Behavioral Health) 2023-2024
Napa	19.6%
Lake	19.2%
Mendocino	18.0%
Sonoma	12.3%
Humboldt	8.3%

Source: AHSN Demographic Data

There is economic and health disparity between the community and the county the Hospital is located in, and the counties and communities it largely serves.

Median Household Income	
California	\$84,800
Napa County	\$94,100
Lake County	\$55,800
Mendocino County	\$57,500

Source: 2023 County Health Rankings and Roadmap (Robert Wood Johnson Foundation)

Life Expectancy	
California	81.0
Napa County	82.1
Lake County	74.8
Mendocino County	78.5

Source: 2023 County Health Rankings and Roadmap (Robert Wood Johnson Foundation)

Ethnicity				
	California	Napa County	Lake County	Mendocino County
Non-Hispanic Black	5.6%	2.2%	1.7%	0.8%
American Indian or Alaska Native	1.7%	1.3%	4.7%	6.6%
Asian	15.9%	9.1%	1.5%	2.4%
Native Hawaiian/ Other Pacific Islander	0.5%	0.4%	0.3%	0.3%
Hispanic	40.2%	35.6%	23.9%	27.2%
Non-Hispanic White	35.2%	50.4%	66.7%	62.9%

Source: 2023 County Health Rankings and Roadmap (Robert Wood Johnson Foundation)

Age, Gender, Rural				
	California	Napa County	Lake County	Mendocino County
Below 18 years of age	22.4%	19.7%	21.8%	21.1%
65 and older	15.2%	20.2%	23.1%	23.7%
Female	50.0%	49.8%	49.9%	50.2%
Rural	5.0%	13.4%	33.1%	45.2%

Source: 2023 County Health Rankings and Roadmap (Robert Wood Johnson Foundation)

2024 Health Equity Top Disparities Report

Per AB 1204, the Hospital Quality Institute comparative quality analytics platform (HQIP) stratified six (6) disparities for AHS. The data extrapolated was tracked and trended for Clinical Year (CY)2024. Data was delineated from the HQIP platform January 1, 2024- December 31, 2024. Our plan for addressing these six disparities is as follows:

Disparity	Measure	Stratification	Disparity Group	Disparity Rate	Reference Group	Reference Rate	Rate Ratio	Preferred Rate
1	HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Expected Payor	Medicaid	15.0	Private	12.1	1.2	Lower Rate Preferred
2	HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Expected Payor	Medicare	14.8	Private	12.1	1.2	Lower Rate Preferred
3	HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Age (excluding maternal measures)	50 to 64	16.4	65 and older	13.6	1.2	Lower Rate Preferred
4	HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Race and/or Ethnicity	White	14.3	Hispanic or Latino	12.5	1.1	Lower Rate Preferred
5	HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate, stratified by behavioral health diagnosis (No Behavioral Health Diagnosis)	Sex Assigned at Birth	Female	15.2	Male	13.9	1.1	Lower Rate Preferred
6	HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate	Sex Assigned at Birth	Female	14.7	Male	13.6	1.1	Lower Rate Preferred

Disparity 1:

- HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate

Disparity Group: **Medicaid (MediCal)**

Disparity Rate: **15.0%**

Rate Ratio: 1.2

2024 Adult All-Cause Readmission Rates categorized by Year and Payer



Disparity 2:

- HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate

Disparity Group: **Medicare**

Disparity Rate: **14.8%**

Rate Ratio: 1.2

2024 Adult All-Cause Readmission Rates categorized by Year and Payer



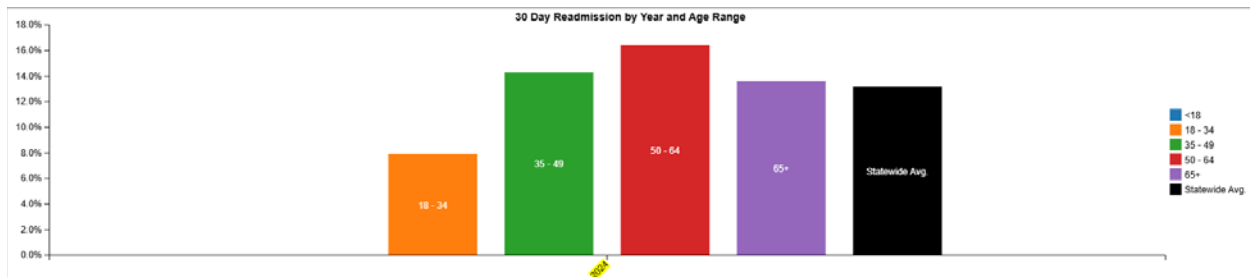
202 Adult All-Cause Readmission Rates categorized by Year and Sex

*Males having the highest readmission for 50-64 disparity group

Disparity 3:

- HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate
 - Disparity Group: **50-64**
 - Disparity Rate: **16.4**
 - Rate Ratio: 1.2

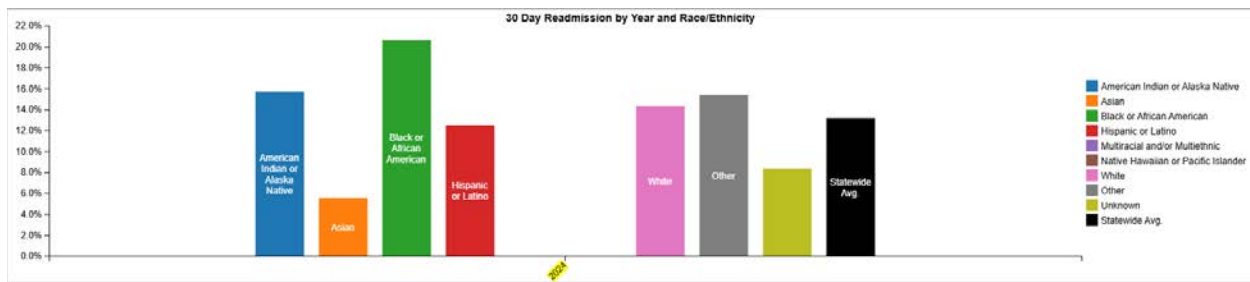
2024 Adult All Cause Readmission Rates categorized by Year and Age Range



Disparity 4:

- HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate Race and/or Ethnicity
 - Disparity Group: **White**
 - Disparity Rate: **14.3**
 - Rate Ratio: 1.1

2024 Adult All-Cause Readmission Rates categorized by Year and Race/Ethnicity



Disparity 5:

- All Cause Unplanned 30-Day Hospital Readmission Rate, Sex assigned at birth, stratified by behavioral health diagnosis (no behavioral health diagnosis)

Disparity Group: **Female**

Disparity Rate: **16.2**

Rate Ratio: 1.1



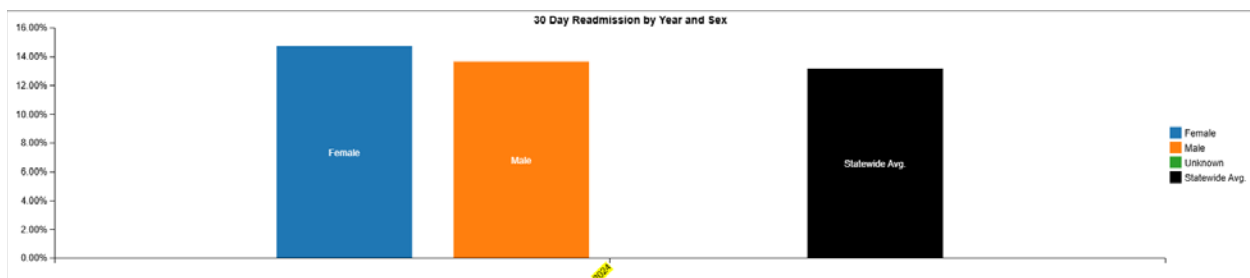
Disparity 6

- HCAI All-Cause Unplanned 30-Day Hospital Readmission Rate, Sex Assigned at birth

Disparity Group: **Female**

Disparity Rate: **14.7**

Rate Ratio: 1.1



Disparities 1-6 Data Analysis:

Disparities 1-6 are all related to All-Cause Unplanned 30-Day Hospital Readmission Rates (MediCal, Medicare, White ethnicity, and Females). Attributing factors to unplanned readmissions may be related to:

- Socioeconomic challenges (transportation for follow-up appointments, acquiring prescribed medications)
- Social support
- Environmental conditions
- Cost and insurance barriers
- Lack of providers/specialists in communities patients are transferred from

Actions Planned:

- Expanded post-discharge follow-up calls and/or provider visits (in-person or via telemedicine) for Medi-Cal and older patient populations and those with chronic disease conditions
- Improved care coordination with community/ interfacility partners
- Focus on improved nutrition and early ambulation for patients while in the Hospital (“Well Fed and Out of Bed” initiative)
- Utilization of Nurse Navigators for key destination programs
- Patient/ family education for post-discharge care
- Offer medications for dispensing before discharge (Meds to Beds Program)

The hospital aims to reduce the readmission gap between payer types, gender, and across racial/ethnic groups by 10% within 12 months. Progress will be tracked quarterly through the QAPI/Patient Safety Committee with results shared in the Hospital’s Clinical Committee meetings.

Overall Strategies to address Health Disparities

Patient-Centered Care

Adventist Health St. Helena is committed to providing patient-centered care, ensuring that the patient’s concerns, values, and preferences are central to all healthcare decisions. Our approach emphasizes respect, compassion, and collaboration, with the goal of delivering care that is personalized to each patient’s individual needs, beliefs, and cultural background.

Key Strategies

- Patient Registration: Collection of Social Determinants of Health Data to improve equitable access
- Shared Governance: The Care Team is empowered to participate in shared decision-making with patients, integrating patients’ needs, preferences, and values into individualized care plans.
- Multidisciplinary Care Rounds: Daily rounds involving physicians, nurses, pharmacists, case managers, and physical therapists to promote comprehensive and coordinated care tailored to each patient.

- Language Access Services: interpreters and translation services are provided to facilitate communication in each patient’s preferred language, ensuring understanding and inclusivity.
- Community Engagement Initiatives: Partnerships with local organizations to support food drives, health fairs, diabetes education classes, and wellness seminars.
- Bedside Shift Reporting: Nurses conduct shift handoffs at the bedside, actively involving patients and families in discussions about their care and treatment plans.
- Spiritual and Emotional Support: On-site chaplaincy services provide individualized spiritual care and emotional support to patients and families of all faith and ethnic backgrounds.
- Personalized Care Plans: Care plans are collaboratively developed to reflect each patient’s cultural, spiritual, and personal preferences.
- Digital Patient Engagement: Patients have secure online access to test results, visit summaries, and messaging with providers.
- Patient Education and Communication: The teach-back method is utilized to confirm patient understanding of diagnoses, treatment plans, and discharge instructions upon care transition

Patient Safety

At Adventist Health St. Helena, patient safety is a top priority, ensuring a healthcare environment that minimizes risk and prevents errors to provide quality of care.

Key Strategies

- Environment of Care Rounds, ensuring a safe patient care environment
- Interdisciplinary morning safety huddles, and department-based safety huddles
- Mortality and Sepsis Review Committee
- Implementation of an electronic hand hygiene monitoring system
- Daily review of line and catheter necessity and early removal
- Antibiotic Stewardship Program: Ensures appropriate antibiotic selection, dosing, and duration. High-risk antibiotic orders are regularly reviewed to optimize therapy and reduce resistance

Addressing Patient Social Determinants of Health (SDOH)

Adventist Health St. Helena supports patients’ social needs through data collection on admission. Included in the SDoH are questions regarding: housing instability, food insecurity, utility difficulties, transportation needs, and interpersonal safety. The data is utilized for care planning and interventions during the patient’s stay and upon discharge. For 2024 AHS data demonstrated the following response rates:

Social Determinate of Health	Response %
Housing Instability	8.0%
Food Insecurity	11.3%
Utility Difficulties	4.7%
Transportation Needs	10.7%

Interpersonal Safety	0.0%
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Source: AHSN Social Determinants of Health Data

In addition to the Hospital's data collection on SDOH, data was reviewed from the Robert Wood Johnson Foundation *2023 County Health Ranking and Roadmap* to validate the Hospital's data collection and to review data from the counties that the Hospital receives the highest percentage of transfers.

Food Insecurity	
California	9%
Napa County	9%
Lake County	15%
Mendocino County	14%

Source: *2023 County Health Ranking and Roadmap* (Robert Wood Johnson Foundation)

Key Strategies

- Food Insecurity: One of the highest ranking needs in the populations served by AHSN has been food insecurity. In partnership with community resources and grants the Hospital Foundation's Mobile Health team provides food distribution and the Hospital provides resource guides for free and low-cost food for the three counties which house the largest percentage of the Hospital's patient population.
- Transportation: Provided shuttle service for cancer patients from distant county, and transportation services for local population.

Effective Treatment

Adventist Health St. Helena delivers timely, evidence-based care to achieve the best possible patient outcomes.

Key Strategies:

- Obtained The Joint Commission Disease-Specific Primary Stroke Certification and partners with the University of San Francisco to provide telemedicine support for stroke patients. In addition, AHSN participates in the American Heart Association Get with the Guidelines Stroke Registry to ensure that stroke patients receive the most current evidence-based care. The Hospital also provides community education on how to recognize early signs of stroke.
- Obtained and maintains The Joint Commission Disease-Specific Advanced Total Joint Replacement Certification and participates in the American Joint Replacement Registry ensuring that the Hospital is providing current evidence-based care, and participates in national database which measures improvements in quality of life post-procedure
- Obtained and maintains Certification by the Commission on Cancer which promotes cancer prevention, research, education, and monitoring of comprehensive quality care in the Hospital's Martin O'Neil Cancer Center
- Participates in the following cardiovascular service line national registries which measure compliance with current evidence-based practices and clinical outcomes:

- Society for Thoracic Surgery Cardiac Surgery Database (Outcomes registry for adult cardiac surgery)
- STS/ ACC TVT Registry (Monitors patient safety and outcomes related to transcatheter aortic valve replacement (TAVR))
- Carotid Arter Stent Registry
- CathPCI Registry (assessed treatments and outcomes of patients who receive diagnostic catheterization and/or percutaneous coronary (PCI) procedures) Ensuring adherence to clinical practice guidelines.
- EP Device Implant and LAAO Registries

Care Coordination

Adventist Health St. Helena promotes a collaborative care coordination model, ensuring that physicians, nurses, pharmacists, and other specialists communicate effectively so each patient's treatment plan is well-coordinated. These efforts ensure continuity of care, enhance patient safety, and support smooth transitions across healthcare settings.

Key Strategies:

- Care Transition Program: Case managers coordinate discharge planning, follow-up appointments, and connection to community resources.
- Post-Discharge Follow-Up: Patients receive follow-up calls to review medications, monitor symptoms, and confirm appointments.
- Multidisciplinary Rounds: Nurses, case managers, physicians, rehabilitation services, and pharmacists meet to discuss patient needs for safe and coordinated discharges
- Transportation Support: Provide assistance to patients who lack access to transportation for appointments
- Community Coordination: Coordination with post-acute and community services for home health and referrals to additional resources based on Health Related Social Needs

Access to Care

Adventist Health St. Helena is committed to ensuring patients can easily connect with providers and receive necessary tests and treatments without barriers.

Key Strategies:

- Financial access is supported through charity care, financial assistance programs, insurance access through financial coordinators, and flexible payment options.
- Transportation services help patients attend scheduled appointments and follow-up care.
- Provide free immunizations and health screening through partnerships with County and local health agencies.
- Community Outreach Programs addressed Food Insecurity, Nutrition, Activity, Wellness, Mental Health