Sutter Health

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Sutter Davis Hospital

2022 – 2024 Implementation Strategy Plan
Responding to the 2022 Community Health Needs Assessment

2000 Sutter Place, Davis, CA 95616
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www.sutterhealth.org

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Introduction

The Implementation Strategy Plan describes how Sutter Davis Hospital, a Sutter Health affiliate, plans to address significant health needs identified in the 2022 Community Health Needs Assessment (CHNA). The document describes how the hospital plans to address identified needs in calendar (tax) years 2022 through 2024.

The 2022 CHNA and the 2022 - 2024 Implementation Strategy Plan were undertaken by the hospital to understand and address community health needs, and in accordance with state law and the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

The Implementation Strategy Plan addresses the significant community health needs described in the CHNA that the hospital plans to address in whole or in part. The hospital reserves the right to amend this Implementation Strategy Plan as circumstances warrant. For example, certain needs may become more pronounced and merit enhancements to the described strategic initiatives. Alternately, other organizations in the community may decide to address certain community health needs, and the hospital may amend its strategies and refocus on other identified significant health needs. Beyond the initiatives and programs described herein, the hospital is addressing some of these needs simply by providing health care to the community, regardless of ability to pay.

Sutter Davis Hospital welcomes comments from the public on the 2022 Community Health Needs Assessment and 2022 - 2024 Implementation Strategy Plan. Written comments can be submitted:

- By emailing the Sutter Health System Office Community Benefit department at SHCB@sutterhealth.org;

Through the mail using the hospital's address at 2000 Sutter Place, Davis, CA 95616; and

- In-person at the hospital's Information Desk.

Executive Summary

Sutter Davis Hospital is affiliated with Sutter Health, a not-for-profit parent of not-for-profit and for-profit companies that together form an integrated healthcare system located in Northern California. The system is committed to health equity, community partnerships and innovative, high-quality patient care. Our over 65,000 employees and associated clinicians serve more than 3 million patients through our hospitals, clinics and home health services.

Learn more about how we're transforming healthcare at sutterhealth.org and vitals.sutterhealth.org

Sutter Health's total investment in community benefit in 2021 was $872 million. This amount includes traditional charity care and unreimbursed costs of providing care to Medi-Cal patients. This amount also includes investments in community health programs to address prioritized health needs as identified by regional community health needs assessments.

As part of Sutter Health's commitment to fulfill its not-for-profit mission and help serve some of the most vulnerable in its communities, the Sutter Health network has implemented charity care policies to help provide access to medically necessary care for all patients, regardless of their ability to pay. In 2021, Sutter Health invested $91 million in charity care. Sutter's charity care policies for hospital services include, but are not limited to, the following:

1. Uninsured patients are eligible for full charity care for medically necessary hospital services if their family income is at or below 400% of the Federal Poverty Level ("FPL").
2. Insured patients are eligible for High Medical Cost Charity Care for medically necessary hospital services if their family income is at or below 400% of the FPL and they incurred or paid medical expenses amounting to more than 10% of their family income over the last 12 months. (Sutter Health's Financial Assistance Policy determines the calculation of a patient's family income.)

Overall, since the implementation of the Affordable Care Act, greater numbers of previously uninsured people now have more access to healthcare coverage through the Medi-Cal and Medicare programs. The payments for patients who are covered by Medi-Cal and Medicare do not cover the full costs of providing care. In 2021, Sutter Health invested $557 million more than the state paid to care for Medi-Cal patients.

Through community benefit investments, Sutter helped local communities access primary, mental health and addiction care, and basic needs such as housing, jobs and food. See more about how Sutter Health reinvests into the community by visiting sutterpartners.org.

Every three years, Sutter Health affiliated hospitals participate in a comprehensive and collaborative Community Health Needs Assessment, which identifies significant community health needs and guides our community benefit strategies. The assessments help ensure that Sutter invests its community benefit dollars in a way that targets and addresses real community needs.

Through the 2022 Community Health Needs Assessment process for Sutter Davis Hospital, the following significant community health needs were identified:

1. Access to Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavioral Health and Substance Use Services
3. Injury and Disease Prevention and Management
4. Active Living and Healthy Eating
5. Access to Quality Primary Care Health Services
6. System Navigation
7. Access to Specialty and Extended Care
8. Increased Community Connections
9. Safe and Violence-Free Environment
10. Access to Functional Needs
11. Access to Dental Care and Preventive Services

The 2022 Community Healthy Needs Assessment conducted by Sutter Davis Hospital is publicly available at www.sutterhealth.org.

2022 Community Health Needs Assessment Summary

Community Health Insights (www.communityhealthinsights.com) conducted the assessment on behalf of Sutter Davis Hospital. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Northern California.

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model. This model of population health includes many factors that impact and account for individual health and well-being. Further, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary

(quantitative) data. Qualitative data included one-on-one and group interviews with 29 community health experts, social service providers, and medical personnel. Additionally, 18 community residents or community service provider organizations participated in 3 focus groups across the county. Finally, 14 community service providers responded to a Service Provider Survey asking about health need identification and prioritization and 1,574 community residents participated in the Community Health Status Survey (community survey).

Focusing on social determinants of health to identify and organize secondary data, datasets included measures to describe mortality and morbidity and social and economic factors such as income, educational attainment, and employment. Further, the measures also included indicators to describe health behaviors, clinical care (both quality and access), and the physical environment.

At the time that this CHNA was conducted, the COVID-19 pandemic was still impacting communities across the United States, including SDH's service area. The process for conducting the CHNA remained fundamentally the same. However, there were some adjustments made during the qualitative data collection to ensure the health and safety of those participating. Additionally, COVID-19 data were incorporated into the quantitative data analysis and COVID-19 impact was captured during qualitative data collection. These findings are reported throughout various sections of the report.

The full 2022 Community Health Needs Assessment conducted by Sutter Davis Hospital is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

Yolo County was chosen as the geographical area for the CHNA because it is the primary service area of the two hospitals participating in the joint assessment and is the statutory service area of the public health department. Yolo County is located northwest of Sacramento along the Interstate 5 corridor and includes both urban and rural communities. The City of Woodland is the county seat of Yolo County.

Significant Health Needs Identified in the 2022 CHNA

Quantitative and qualitative data were analyzed to identify and prioritize significant health needs. This began by identifying 12 potential health needs (PHNs) based on a review of CHNAs previously conducted throughout Northern California. The data associated with each PHN were then analyzed to discover which, if any, of them were significant health needs for the service area.

PHNs were selected as significant health needs if the percentage of associated quantitative indicators and qualitative themes exceeded selected thresholds. Data were also analyzed determine if there were any emerging significant health needs in the service area beyond the initial 12 PHNs.

All significant health needs were then prioritized based on 1) the percentage of key informant interviews and focus groups that indicated the health needs was present within the service area; 2) the percentage of times key informant interviews and focus groups identified the health needs as being a top priority; and, when available, 3) the percentage of service provider survey respondents who identified the health needs as being a top priority.

The following significant health needs were identified in the 2022 CHNA:

1. **Access to Basic Needs Such as Housing, Jobs, and Food**
   Access to affordable and clean housing, stable employment, quality education, and adequate food for good health are vital for survival. Maslow's Hierarchy of Needs suggests that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health. Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, influence individual health as much as health behaviors and access to clinical care.

2. **Access to Mental/Behavioral Health and Substance-Use Services**

Individual health and well-being are inseparable from individual mental and emotional outlook. Coping with daily life stressors is challenging for many people, especially when other social, familial, and economic challenges occur. Access to mental, behavioral, and substance use services is an essential ingredient for a healthy community where residents can obtain additional support when needed.

3. **Injury and Disease Prevention and Management**
   Knowledge is important for individual health and well-being, and efforts aimed at injury and disease prevention are powerful vehicles to improve community health. When community residents lack adequate information on how to prevent, manage, and control their health conditions, those conditions tend to worsen. Prevention efforts focus on reducing cases of injury and infectious disease control (e.g., sexually transmitted infection (STI) prevention and influenza shots), and intensive strategies in the management of chronic diseases (e.g., diabetes, hypertension, obesity, and heart disease) are important for community health improvement.

4. **Active Living and Healthy Eating**
   Physical activity and eating a healthy diet are important for one's overall health and well-being. Frequent physical activity is vital for prevention of disease and maintenance of a strong and healthy heart and mind. When access to healthy foods is challenging for community residents, many turn to unhealthy foods that are convenient, affordable, and readily available. Communities experiencing social vulnerability and poor health outcomes often live in areas with fast food and other establishments where unhealthy food is sold. Under-resourced communities may be challenged with food insecurity, absent the means to consistently secure food for themselves or their families, relying on food pantries and school meals often lacking in sufficient nutrition for maintaining health.

5. **Access to Quality Primary Care Health Services**
   Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and other similar resources. Primary care services are typically the first point of contact when an individual seeks healthcare. These services are the front line in the prevention and treatment of common diseases and injuries in a community.

6. **System Navigation**
   System navigation refers to an individual's ability to traverse fragmented social services and healthcare systems in order to receive the necessary benefits and supports to improve health outcomes. Research has demonstrated that navigating the complex U.S. healthcare system is a barrier for many that results in health disparities. Furthermore, accessing social services provided by government agencies can be an obstacle for those with limited resources such as transportation access and English proficiency.

7. **Access to Specialty and Extended Care**
   Extended care services, which include specialty care, are care provided in a particular branch of medicine and focused on the treatment of a particular disease. Primary and specialty care go hand in hand, and without access to specialists, such as endocrinologists, cardiologists, and gastroenterologists, community residents are often left to manage the progression of chronic diseases, including diabetes and high blood pressure, on their own. In addition to specialty care, extended care refers to care extending beyond primary care services that is needed in the community to support overall physical health and wellness, such as skilled-nursing facilities, hospice care, and in-home healthcare.

8. **Increased Community Connections**
   As humans are social beings, community connection is a crucial part of living a healthy life. People have a need to feel connected with a larger support network and the comfort of knowing they are accepted and loved. Research suggests "individuals who feel a sense of security, belonging, and trust in their community have better health. People who don't feel connected are

less inclined to act in healthy ways or work with others to promote well-being for all." Assuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a healthy community. Furthermore, healthcare and community support services are more effective when they are delivered in a coordinated fashion, where individual organizations collaborate with others to build a network of care.

9. **Safe and Violence-Free Environment**
   Feeling safe in one's home and community is fundamental to overall health. Next to having basic needs met (e.g., food, shelter, and clothing) is having physical safety. Feeling unsafe affects the way people act and react to everyday life occurrences. Furthermore, research has demonstrated that individuals exposed to violence in their homes, the community, and schools are more likely to experience depression and anxiety and demonstrate more aggressive, violent behavior.

10. **Access to Functional Needs**
    Functional needs includes adequate transportation access and conditions which promote access for individuals with physical disabilities. Having access to transportation services to support individual mobility is a necessity of daily life. Without transportation, individuals struggle to meet their basic needs, including those needs that promote and support a healthy life. The number of people with a disability is also an important indicator for community health and must be examined to ensure that all community members have access to necessities for a high quality of life.

11. **Access to Dental Care and Preventive Services**
    Oral health is important for overall quality of life. When individuals have dental pain, it is difficult to eat, concentrate, and fully engage in life. Oral health disease, including gum disease and tooth decay are preventable chronic diseases that contribute to increased risk of other chronic disease, as well as play a large role in chronic absenteeism from school in children. Poor oral health status impacts the health of the entire body, especially the heart and the digestive and endocrine systems.

2022 – 2024 Implementation Strategy Plan

The implementation strategy plan describes how Sutter Davis Hospital plans to address significant health needs identified in the 2022 Community Health Needs Assessment and is aligned with the hospital's charitable mission. The strategy describes:

- Actions the hospital intends to take, including programs and resources it plans to commit,
- Anticipated impacts of these actions and a plan to evaluate impact, and
- Any planned collaboration between the hospital and other organizations in the community to address the significant health needs identified in the 2022 CHNA.

Prioritized Significant Health Needs the Hospital Will Address

The Implementation Strategy Plan serves as a foundation for further alignment and connection of other Sutter Davis Hospital initiatives that may not be described herein, but which together advance the hospital's commitment to improving the health of the communities it serves. Each year, programs are evaluated for effectiveness, the need for continuation, discontinuation, or the need for enhancement. Depending on these variables, programs may change to continue focus on the health needs listed below.

1. Access to Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavioral Health and Substance Use Services
3. Injury and Disease Prevention and Management
4. Active Living and Healthy Eating
5. Access to Quality Primary Care Health Services

6. System Navigation
7. Access to Specialty and Extended Care
8. Increased Community Connections
9. Safe and Violence-Free Environment
10. Access to Functional Needs
11. Access to Dental Care and Preventive Services

Access to Basic Needs Such as Housing, Jobs, and Food

Name of program/activity/initiative	Permanent Supportive Housing Project
Description	Sutter Health is partnering with the City of West Sacramento, Mercy Housing California, Yolo County Health and Human Services and Yolo County Housing Authority to help fund the completion of the permanent supportive housing project (PSH). Mercy Housing has developed and operates 134 affordable communities in California with more than 9,190 homes serving lower-income seniors, families, and people who have experienced homelessness. Mercy Housing will develop and manage the 85-unit PSH project with Yolo County Health and Human Services providing the on-site supportive services such as case management and related health services. Yolo County Housing Authority will be a co-developer and has awarded 60 project-based vouchers. The project will aim to expand the available housing for individuals experiencing homelessness; and improve the overall well-being of people experiencing homelessness by targeting four social determinants of health, including housing stability, physical health, behavioral health, and self-sufficiency.
Goals	The goal is to complete the construction of the permanent supportive housing project.
Anticipated Outcomes	The anticipated outcome is to provide permanent supportive housing to individuals in need, as well as connecting clients with supportive services.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided and other successful linkages.
Name of program/activity/initiative	Healthy Living with Diabetes Program (HLDP)
Description	The Healthy Living with Diabetes Program (HLDP) aims to equip the low-income patients with diabetes management skills and access to the healthy food. There will be an addition of two new Paraprofessional Diabetes Educators (PDEs), a Registered Nurse (RN) who is also a Certified Diabetes Educator (CDE), and a Garden Coordinator to the HLDP team. PDEs will be bilingual, bicultural individuals cross trained as Comprehensive Perinatal Services Program (CPSP) providers. Coverage and coordination of diabetes-related services offered will improve the patient health with particular attention to addressing inequitable outcomes in blood sugar management associated with poverty and ethnicity. There will be targeted efforts to increase access for perinatal patients with diabetes through CenteringPregnancy groups and one-on-one diabetes case management at each site, in addition to implementing strategies to reach more vulnerable populations. Lastly, funding will also assist in the construction of the garden and outdoor classroom and purchase supplementary produce from local farms and the local food bank, which will further educate patients on how they can incorporate

	sustainable and affordable options at home. This program addresses multiple prioritized significant health needs, such as injury and disease prevention and management; access to basic needs; and active living and healthy eating.
Goals	The goal of the program is to increase patient access to culturally sensitive diabetes education, increase the number of low-income Latino patients with diabetes under control (A1C <9), conduct regularly scheduled classes for gardening, and distribute at least 25,000 pounds of California grown fresh fruits and vegetables, primarily through Group Medical Visits and CenteringPregnancy group visits
Anticipated Outcomes	The anticipated outcomes are to see a significant downward trend in the A1C values among patients receiving greater HLDP intensity (e.g. participating in 4 or more group visits or 3 or more one-on-one education visits). Patients participating in CenteringPregnancy and Sweet Success are anticipated to increase likelihood of giving birth to normal-weight, full-term babies. In addition, during the postpartum period patients are anticipated to return their blood sugar to normal levels, and reduce risk of acquiring diabetes.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided and other successful linkages.
Name of program/activity/initiative	Family Poverty Reduction Program
Description	Yolo County is embarking on a very exciting pilot program that will target the lowest income and most vulnerable homeless families in the County with children under the age of 6. The program will provide these families intensive case management, housing, health, mental health and employment resources and a living wage basic income stipend that will put each families' income over the California Poverty Measure (CPM) for 2 full years. Each family will be screened for income, existing benefits and family size and will receive a monthly stipend that is at a minimum $1 over the CPM for their family size. Participants for the pilot were identified through the CalWORKS Housing Support Program (Homeless Families) and 65 current families were selected. Each family will essentially be lifted above the CPM for two full years to assist them in breaking the cycle of generational poverty and reaching self-sufficiency. A research team at the University of California Davis will be conducting a full study and evaluation of the program and its results to share with our funders, the larger anti-poverty community and State of California as a possible statewide pilot.
Goals	The goals of the program are to successfully complete a 2 year pilot to show the impact of families living above the California Poverty Measure (CPM) and report out the impact it has on financial, mental, and physical health, and other benefits.
Anticipated Outcomes	The anticipated outcome of the program is a completed 2-year pilot and improved financial, mental, and physical health.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Paul's Place
Description	As part of Getting to Zero, Sutter Health has committed to match up to $2.5 million in private donations to Paul's Place – a multi-functional housing center designed to serve the most vulnerable individuals experiencing homelessness in Davis by providing housing and support

	services. Working with community leaders to leverage both public and private sector resources, we can come together as a community to raise the capital necessary to finance Paul's Place.
Goals	The goal is to complete the construction of Paul's Place.
Anticipated Outcomes	The anticipated outcomes of the program is to work toward obtaining project approval from both the city of Davis planning commission and city council in 2021 to complete construction of the project, which will result in more housing and supportive services for clients.
Metrics Used to Evaluate the program/activity/initiative	Dollars raised, anecdotal stories, number of people served, number of resources provided, type of resources provided, and other successful linkages.
Name of program/activity/initiative	Plan to Address Homelessness
Description	HPAC Executive Director, working with HPAC Board and homeless service providers, will create an updated plan to address homelessness in Yolo County. Over 100 homeless service providers, as well as community advocates, participate in monthly HPAC governance meetings and will be invited to participate in the updating of the plan. The HPAC Board is comprised of an elected formal board that includes representation from the local governments and a confederation of agencies and non-profit homeless providers, victim service providers, legal services, mental health agencies, law enforcement, persons with lived experience, and community advocates.
Goals	The goals of the program are to complete the updated plan to address homelessness by June 1, 2022.
Anticipated Outcomes	The anticipated outcome is to provide Yolo County and homeless service providers with an updated plan to address homelessness.
Metrics Used to Evaluate the program/activity/initiative	Number of participants, number of events, anecdotal stories, and a completed report.
Name of program/activity/initiative	Eviction Prevention Program
Description	The Eviction Prevention Program provides up to $700 in rental assistance to pay rent for families who have received an eviction notice.
Goals	The goals of the program is to prevent homelessness by keeping individuals and families housed during a short-term financial emergency.
Anticipated Outcomes	The anticipated outcome of the program is to increase the number of individuals and families housed and prevent homelessness.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, amount of financial assistance provided, and anecdotal stories.
Name of program/activity/initiative	School Based Mental Health Services
Description	School Based Mental Health Services targets Sacramento City Unified School District (nearly 50,000 students) and Washington Unified School District (over 8,000 students). Student outreach is conducted through education around mental health wellness to reduce stigma related to mental health and promote access to mental health services. Students are provided referrals and linkages to appropriate mental health services. The program includes Family & Youth Partnership, which is peer partner services and support groups designed to inform, educate, support, and empower parents/caregivers to be able to advocate and be fully engaged with their child/youth's educational and social well-being. Access is given to skill building and targeted behavior groups and Sutter Health's funding will cover group costs for students who do not qualify for Medi-Cal.

	Sutter's funding will also help provide school supplies for low-income students and Life Fund, which offers strategic, targeted assistance to at-risk youth and families by providing financial resources to meet basic needs (i.e. access to food, clothing, housing, and/or transportation) and/or provide educational or social opportunities as youth work toward completing treatment and recovery goals.
Goals	The goal is to provide provided referrals and linkages to appropriate mental health services.
Anticipated Outcomes	The anticipated outcomes are to provide mental health services to students in Sacramento City Unified School District and Washington Unified School District, as well connect students to community resources.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Haven House
Description	Haven House is an interim care program that offers people experiencing homelessness a safe place to recover after hospitalization. Haven House offers four respite beds for up to 29 days. During their stay, people experiencing homelessness will be provided support to connect with other services. Services include health insurance enrollment, substance abuse and mental health services, and placement in permanent housing. This program addresses multiple prioritized significant health needs, such as access to mental/behavioral/substance abuse services; access to basic needs; and access to quality primary care health services.
Goals	The goal of the program is to provide a safe place for patients to recover following hospitalization and connect patients with a medical home, social support and housing.
Anticipated Outcomes	The anticipated outcome of the ICP is to help people improve their overall health by wrapping them with services and treating the whole person through linkage to appropriate health care, shelter and other social support services.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	West Sacramento Family Resource Center (WSFRC)
Description	West Sacramento Family Resource Center (WSFRC) is located in a low income West Sacramento neighborhood, next to Riverbank Elementary School. Programs and services provided at WSFRC assist immigrants, refugees, homeless and unstably housed families, and other under-resourced parents, children, seniors, and individuals in the community find a safe and nurturing space where they can get hands on personal assistance to access the resources they need in order to improve their lives. They also find a community space that fosters social connection between and among neighbors and other community members. This program addresses multiple prioritized significant health needs, such as injury and disease prevention and management; access to basic needs; active living and healthy eating; access to quality primary care health services.
Goals	The goals of the program are to connect clients to community resources and services, such as tax preparation and assistance services, homeless services and housing assistance services, utility assistance, housing search support and assistance, insurance enrollment, medical services, establish a medical home and receive necessary medical services

	including preventative care. In addition, provide the Nurturing Parenting Program, child development knowledge and parenting skills, free Play School Experience parent/guardian-child preschool classes, supporting parent/guardian-child bonding, school readiness for the children, social connections for the parents and guardians, and developing knowledge of child development. Lastly, the program aims to provide food security services through weekly fresh produce distribution, food pantry, CalFresh enrollment & retention services, and distribution of emergency food vouchers.
Anticipated Outcomes	The anticipated outcomes are that clients will receive hands on personal assistance to access the resources they need in order to improve their lives. They also find a community space that fosters social connection between and among neighbors and other community members.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children/families served, number and types of resources provided, anecdotal stories and other successful linkages.
Name of program/activity/initiative	Communications Strategy for West Sacramento Family Resource Center
Description	The Yolo County Children's Alliance will be transitioning Executive Directors in June,2021 and will update the internal and external communications plan. The purpose of this plan is not only to assist in implementing communication strategies for the transition of Executive Directors, but also to modernize the organization's internal communications, and public-facing communications with clients, partners, the media, and existing and potential donors. This plan would incorporate the Yolo County Children's Alliance brand and most current strategic plan, while outlining a strategy to ensure all communications are consistent throughout the various programs within our organization to provide more effective outreach and awareness, especially for vulnerable and hard to reach populations in Yolo County.
Goals	The goal of the program is to provide more effective outreach and awareness, especially to vulnerable and hard to reach populations in Yolo County.
Anticipated Outcomes	The anticipated outcome is to serve more clients and connect them to supportive services through improved outreach.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number and types of resources provided, anecdotal stories and other successful linkages.
Name of program/activity/initiative	VITA Tax Support
Description	The VITA Tax Support program assists low-income individuals and families with completion of tax documents along with financial literacy education.
Goals	The goal of the program is to help individuals accurately complete tax documents and provide financial literacy education to clients.
Anticipated Outcomes	The anticipated outcomes are more dollars recuperated through accurately completely tax documents and improved financial knowledge.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, amount of funding recuperated for clients, and anecdotal stories.
Name of program/activity/initiative	Brighter Tomorrows Campaign
Description	The Yolo Crisis Nursery Brighter Tomorrows Campaign will build a new, larger home that triples capacity to serve the growing number of Yolo County families and children in crisis after raising $6 million dollars. The

	Nursery is open 24/7 providing emergency respite care for young children and support for families. The objectives are to prevent child abuse and neglect and provide crisis resolution and resources for every Yolo County family that needs our support. This is accomplished through early intervention services offered at the nursery in a safe environment to nurture healthy and resilient children, strengthen parents and preserve families.
Goals	The goals of the program are to prevent child abuse and neglect, as well as connect families to community resources to help preserve families.
Anticipated Outcomes	The anticipated outcomes of the program are to complete construction of the new facility, which will result in increased capacity for safe stays and connection to wrap around services to support families.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Emergency Childcare and Wrap-Around Services for Families in Crisis
Description	The Yolo Crisis Nursery is operating at capacity providing 2,500 safe stays for children experiencing crisis. Sutter Health's funding will support an increase in onsite meals provided to children who are provided a safe stay at the Nursery. In addition, funding will supplement an increased need of essential supplies to families participating in case management services. Families in rural areas will have supplies delivered to them.
Goals	The goals of the program are to increase the number of meals provided to children during safe stays and provide essential supplies, including those in rural communities.
Anticipated Outcomes	The anticipated outcomes of the programs are more meals served to children during safe stays and improved access to essential supplies for families.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Nourish Yolo
Description	Nourish Yolo will help prevent chronic diseases by increasing access to fresh, healthy foods in Yolo County. In addition, the program will increase awareness around the crisis that is food insecurity and create new/expand existing programs across Yolo County to ensure more people have consistent access to the food, education and resources they so desperately need. This program addresses multiple prioritized significant health needs, such as injury and disease prevention and management; access to basic needs; and active living and healthy eating.
Goals	The goal of the program is to provide access to fresh, healthy foods in Yolo County and education through programs.
Anticipated Outcomes	The anticipated outcome is to increase food security, access to fresh foods and education to help prevent chronic diseases.
Metrics Used to Evaluate the program/activity/initiative	Pounds of food distributed, number of people served and anecdotal stories.
Name of program/activity/initiative	Nurture Yolo
Description	Yolo Food Bank will increase storage space to prevent the damage or perish of goods to be utilized for the targeted expansion to rural communities and underserved populations that face greater inequities,

	including: Knights Landing, Madison, Esparto, Dunnigan and Winters. In addition, the home delivery service will be expanded for senior citizens and vulnerable, homebound residents in every portion of the county, especially remote rural areas.
Goals	Increase capacity to service more individuals and families in Yolo County, including expanded services for home delivery services.
Anticipated Outcomes	The anticipated outcome is to increase food security, access to fresh foods and education to help prevent chronic diseases.
Metrics Used to Evaluate the program/activity/initiative	Pounds of food distributed, number of people served and anecdotal stories.
Name of program/activity/initiative	Essential Food Service Worker Initiative
Description	Yolo Food Bank's Food System Worker's Food Assistance Program is conducting research on Spanish speaking clients that work in the food service industry, which have been identified as the majority receiving services through the food bank. When research is completed, a strategy will be developed to meet the nutritional needs of essential food system workers with nutritious, culturally appropriate food thereby dramatically increasing equity and personal dignity.
Goals	Increase capacity to service more individuals and families in Yolo County, focusing on Spanish speaking clients that are working in the food service industry.
Anticipated Outcomes	The anticipated outcome is to increase food security, access to fresh foods and education to help prevent chronic diseases.
Metrics Used to Evaluate the program/activity/initiative	Pounds of food distributed, number of people served and anecdotal stories.

Access to Mental/Behavioral Health and Substance Use Services

Name of program/activity/initiative	Salud Clinic Outdoor Play Area
Description	Newly funded program in 2021. Sutter Health is funding the rebuild of the preschool's outdoor play space at the Salud Clinic in West Sacramento. They recently experienced a tragic fire that rendered the space unusable. The area is used for hands on learning and outdoor play therapy for children of patients receiving treatment through the Perinatal Day Program, which is for pregnant and parenting mothers struggling with substance use issues and is the only program of its kind in Yolo County.
Goals	The goal is to rebuild play area to allow children to experiencing hands on learning and outdoor play therapy while parents receive treatment through the Perinatal Day Program.
Anticipated Outcomes	The anticipated outcomes are to complete the construction of the playground and allow greater access for parents to receive treatment through the Perinatal Day Program.
Metrics Used to Evaluate the program/activity/initiative	Completion of construction, number of individuals served, and anecdotal stories.
Name of program/activity/initiative	Family Poverty Reduction Program
Description	Yolo County is embarking on a very exciting pilot program that will target the lowest income and most vulnerable homeless families in the County with children under the age of 6. The program will provide these families

	intensive case management, housing, health, mental health and employment resources and a living wage basic income stipend that will put each families' income over the California Poverty Measure (CPM) for 2 full years. Each family will be screened for income, existing benefits and family size and will receive a monthly stipend that is at a minimum $1 over the CPM for their family size. Participants for the pilot were identified through the CalWORKS Housing Support Program (Homeless Families) and 65 current families were selected. Each family will essentially be lifted above the CPM for two full years to assist them in breaking the cycle of generational poverty and reaching self-sufficiency. A research team at the University of California Davis will be conducting a full study and evaluation of the program and its results to share with our funders, the larger anti-poverty community and State of California as a possible statewide pilot.
Goals	The goals of the program are to successfully complete a 2 year pilot to show the impact of families living above the California Poverty Measure (CPM) and report out the impact it has on financial, mental, and physical health, and other benefits.
Anticipated Outcomes	The anticipated outcome of the program is a completed 2-year pilot and improved financial, mental, and physical health.
Name of program/activity/initiative	Mobile Medicine Program
Description	The Yolo Street Medicine and Mobile Medical Unit Collaboration consists of partnership between SDH, County of Yolo Health and Human Services Agency, and Dignity Health. The program provides street-based medicine units. The community based provider, CommuniCare Health Center, will provide physical health, behavioral health, and social services to the target populations. In addition funding for the Mobile Medical Unit will help purchase a vehicle (van); and a mobile medical unit.
Goals	The goal is to provide physical health, behavioral health, and social services to individuals living homeless in Yolo County; individuals and families at education, faith and migrant farm community locations who are in need of mobile medical services; people in certain rural areas of Yolo County that are in need of health care services to individuals living homeless in Yolo County.
Anticipated Outcomes	The anticipated outcome is expanded capacity to serve the underserved population with primary care, behavioral/mental health care, and other specialty services.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of appointments provided, types of services provided, anecdotal stories and other successful linkages.
Name of program/activity/initiative	Crisis Now
Description	The Crisis Now program will develop a 24/7 Access/Crisis Call Center, 24/7 Crisis Responders, and a 24/7 Receiving/Sobering Center. Implementation of Crisis Now in Yolo County would improve the way our community meets the needs of individuals in mental health crisis who may otherwise end up in the emergency room, at risk for suicide, and/or involved in the criminal justice system. Further, integrated care results in linkages for follow up services that may prevent crisis reoccurrence. The program would support the 220,408 residents of Yolo County under a No Wrong Door policy- this means there is no utilization management in the field on the part of law enforcement and the facility would accept non-local persons.

Goals	The goals of the program are to meet the needs of individuals in mental health crisis.
Anticipated Outcomes	The anticipated outcomes are improved connection to mental health and supportive services.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of appointments provided, types of services provided, anecdotal stories and other successful linkages.
Name of program/activity/initiative	Plan to Address Homelessness
Description	HPAC Executive Director, working with HPAC Board and homeless service providers, will create an updated plan to address homelessness in Yolo County. Over 100 homeless service providers, as well as community advocates, participate in monthly HPAC governance meetings and will be invited to participate in the updating of the plan. The HPAC Board is comprised of an elected formal board that includes representation from the local governments and a confederation of agencies and non-profit homeless providers, victim service providers, legal services, mental health agencies, law enforcement, persons with lived experience, and community advocates.
Goals	The goals of the program are to complete the updated plan to address homelessness by June 1, 2022.
Anticipated Outcomes	The anticipated outcome is to provide Yolo County and homeless service providers with an updated plan to address homelessness.
Metrics Used to Evaluate the program/activity/initiative	Number of participants, number of events, anecdotal stories, and a completed report.
Name of program/activity/initiative	School Based Mental Health Services
Description	School Based Mental Health Services targets Sacramento City Unified School District (nearly 50,000 students) and Washington Unified School District (over 8,000 students). Student outreach is conducted through education around mental health wellness to reduce stigma related to mental health and promote access to mental health services. Students are provided referrals and linkages to appropriate mental health services. The program includes Family & Youth Partnership, which is peer partner services and support groups designed to inform, educate, support, and empower parents/caregivers to be able to advocate and be fully engaged with their child/youth's educational and social well-being. Access is given to skill building and targeted behavior groups and Sutter Health's funding will cover group costs for students who do not qualify for Medi-Cal. Sutter's funding will also help provide school supplies for low-income students and Life Fund, which offers strategic, targeted assistance to at-risk youth and families by providing financial resources to meet basic needs (i.e. access to food, clothing, housing, and/or transportation) and/or provide educational or social opportunities as youth work toward completing treatment and recovery goals.
Goals	The goal is to provide provided referrals and linkages to appropriate mental health services.
Anticipated Outcomes	The anticipated outcomes are to provide mental health services to students in Sacramento City Unified School District and Washington Unified School District, as well connect students to community resources.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.

Name of program/activity/initiative	Health and Wellness Program
Description	The Health and Wellness Support program provides individuals with mental or physical health support and connection to community resources. The program has the unique ability to serve a wide range of patient needs from navigating services and friendly check-in calls to dealing with more complex issues, like managing a mental health crisis. The goal of early intervention is to give clients a support system by having a live person to speak to when needed and help mitigate stressors before they become difficult to manage. The frequency of check-ins with patients depend on individual needs and can vary from multiple times a week to once per month. The program is completely voluntary and patients can discontinue follow-up services at any point.
Goals	The goal is to provide referred patients mental health support immediately after discharge from the hospital with extended, on-going follow-up calls to help the patient remain stable and continue working on the problems which caused them to escalate into crises originally.
Anticipated Outcomes	The expected outcomes are to maintain the patient's overall well-being and provide appropriate linkages to community resources. This support may divert a crisis, limit the crisis or avoid it altogether.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Haven House
Description	Haven House is an interim care program that offers people experiencing homelessness a safe place to recover after hospitalization. Haven House offers four respite beds for up to 29 days. During their stay, people experiencing homelessness will be provided support to connect with other services. Services include health insurance enrollment, substance abuse and mental health services, and placement in permanent housing. This program addresses multiple prioritized significant health needs, such as access to mental/behavioral/substance abuse services; access to basic needs; and access to quality primary care health services.
Goals	The goal of the program is to provide a safe place for patients to recover following hospitalization and connect patients with a medical home, social support and housing.
Anticipated Outcomes	The anticipated outcome of the ICP is to help people improve their overall health by wrapping them with services and treating the whole person through linkage to appropriate health care, shelter and other social support services.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Promotoras+
Description	The Promotores+ Program provides both direct medical, dental and behavioral health services to individuals in the communities in which they live and work through the extension of the Mobile Medicine Team and referrals for medical, dental, behavioral health and specialty care services. Service areas will include, but not limited to: Woodland, West Sacramento, Esparto, Knights Landing, and Madison, as well as targeted outreach for individuals who speak an Indigenous Language of Mexico.
Goals	The goal is to reach more individuals through increased capacity of the program.

Anticipated Outcomes	The anticipated outcome of the program is to reach 250 individuals annually, and at minimum 30 people monthly through Creando Recursos y Enlaces para Oportunidades (CREO).
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.

Injury and Disease Prevention and Management

Name of program/activity/initiative	Promotoras+
Description	The Promotores+ Program provides both direct medical, dental and behavioral health services to individuals in the communities in which they live and work through the extension of the Mobile Medicine Team and referrals for medical, dental, behavioral health and specialty care services. Service areas will include, but not limited to: Woodland, West Sacramento, Esparto, Knights Landing, and Madison, as well as targeted outreach for individuals who speak an Indigenous Language of Mexico.
Goals	The goal is to reach more individuals through increased capacity of the program.
Anticipated Outcomes	The anticipated outcome of the program is to reach 250 individuals annually, and at minimum 30 people monthly through Creando Recursos y Enlaces para Oportunidades (CREO).
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Healthy Living with Diabetes Program (HLDP)
Description	The Healthy Living with Diabetes Program (HLDP) aims to equip the low-income patients with diabetes management skills and access to the healthy food. There will be an addition of two new Paraprofessional Diabetes Educators (PDEs), a Registered Nurse (RN) who is also a Certified Diabetes Educator (CDE), and a Garden Coordinator to the HLDP team. PDEs will be bilingual, bicultural individuals cross trained as Comprehensive Perinatal Services Program (CPSP) providers. Coverage and coordination of diabetes-related services offered will improve the patient health with particular attention to addressing inequitable outcomes in blood sugar management associated with poverty and ethnicity. There will be targeted efforts to increase access for perinatal patients with diabetes through CenteringPregnancy groups and one-on-one diabetes case management at each site, in addition to implementing strategies to reach more vulnerable populations. Lastly, funding will also assist in the construction of the garden and outdoor classroom and purchase supplementary produce from local farms and the local food bank, which will further educate patients on how they can incorporate sustainable and affordable options at home. This program addresses multiple prioritized significant health needs, such as injury and disease prevention and management; access to basic needs; and active living and healthy eating.
Goals	The goal of the program is to increase patient access to culturally sensitive diabetes education, increase the number of low-income Latino patients with diabetes under control (A1C <9), conduct regularly scheduled classes for gardening, and distribute at least 25,000 pounds of California grown fresh fruits and vegetables, primarily through Group Medical Visits and CenteringPregnancy group visits

Anticipated Outcomes	The anticipated outcomes are to see a significant downward trend in the A1C values among patients receiving greater HLDP intensity (e.g. participating in 4 or more group visits or 3 or more one-on-one education visits). Patients participating in CenteringPregnancy and Sweet Success are anticipated to increase likelihood of giving birth to normal-weight, full-term babies. In addition, during the postpartum period patients are anticipated to return their blood sugar to normal levels, and reduce risk of acquiring diabetes.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided and other successful linkages.
Name of program/activity/initiative	Family Poverty Reduction Program
Description	Yolo County is embarking on a very exciting pilot program that will target the lowest income and most vulnerable homeless families in the County with children under the age of 6. The program will provide these families intensive case management, housing, health, mental health and employment resources and a living wage basic income stipend that will put each families' income over the California Poverty Measure (CPM) for 2 full years. Each family will be screened for income, existing benefits and family size and will receive a monthly stipend that is at a minimum $1 over the CPM for their family size. Participants for the pilot were identified through the CalWORKS Housing Support Program (Homeless Families) and 65 current families were selected. Each family will essentially be lifted above the CPM for two full years to assist them in breaking the cycle of generational poverty and reaching self-sufficiency. A research team at the University of California Davis will be conducting a full study and evaluation of the program and its results to share with our funders, the larger anti-poverty community and State of California as a possible statewide pilot.
Goals	The goals of the program are to successfully complete a 2 year pilot to show the impact of families living above the California Poverty Measure (CPM) and report out the impact it has on financial, mental, and physical health, and other benefits.
Anticipated Outcomes	The anticipated outcome of the program is a completed 2-year pilot and improved financial, mental, and physical health.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Mobile Medicine Program
Description	The Yolo Street Medicine and Mobile Medical Unit Collaboration consists of partnership between SDH, County of Yolo Health and Human Services Agency, and Dignity Health. The program provides street-based medicine units. The community based provider, CommuniCare Health Center, will provide physical health, behavioral health, and social services to the target populations. In addition funding for the Mobile Medical Unit will help purchase a vehicle (van); and a mobile medical unit.
Goals	The goal is to provide physical health, behavioral health, and social services to individuals living homeless in Yolo County; individuals and families at education, faith and migrant farm community locations who are in need of mobile medical services; people in certain rural areas of Yolo County that are in need of health care services to individuals living homeless in Yolo County.

Anticipated Outcomes	The anticipated outcome is expanded capacity to serve the underserved population with primary care, behavioral/mental health care, and other specialty services.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of appointments provided, types of services provided, anecdotal stories and other successful linkages.
Name of program/activity/initiative	Crisis Now
Description	The Crisis Now program will develop a 24/7 Access/Crisis Call Center, 24/7 Crisis Responders, and a 24/7 Receiving/Sobering Center. Implementation of Crisis Now in Yolo County would improve the way our community meets the needs of individuals in mental health crisis who may otherwise end up in the emergency room, at risk for suicide, and/or involved in the criminal justice system. Further, integrated care results in linkages for follow up services that may prevent crisis reoccurrence. The program would support the 220,408 residents of Yolo County under a No Wrong Door policy- this means there is no utilization management in the field on the part of law enforcement and the facility would accept non-local persons.
Goals	The goals of the program are to meet the needs of individuals in mental health crisis.
Anticipated Outcomes	The anticipated outcomes are improved connection to mental health and supportive services.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of appointments provided, types of services provided, anecdotal stories and other successful linkages.
Name of program/activity/initiative	Nourish Yolo
Description	Nourish Yolo will help prevent chronic diseases by increasing access to fresh, healthy foods in Yolo County. In addition, the program will increase awareness around the crisis that is food insecurity and create new/expand existing programs across Yolo County to ensure more people have consistent access to the food, education and resources they so desperately need. This program addresses multiple prioritized significant health needs, such as injury and disease prevention and management; access to basic needs; and active living and healthy eating.
Goals	The goal of the program is to provide access to fresh, healthy foods in Yolo County and education through programs.
Anticipated Outcomes	The anticipated outcome is to increase food security, access to fresh foods and education to help prevent chronic diseases.
Metrics Used to Evaluate the program/activity/initiative	Pounds of food distributed, number of people served and anecdotal stories.
Name of program/activity/initiative	Nurture Yolo
Description	Yolo Food Bank will increase storage space to prevent the damage or perish of goods to be utilized for the targeted expansion to rural communities and underserved populations that face greater inequities, including: Knights Landing, Madison, Esparto, Dunnigan and Winters. In addition, the home delivery service will be expanded for senior citizens and vulnerable, homebound residents in every portion of the county, especially remote rural areas.
Goals	Increase capacity to service more individuals and families in Yolo County, including expanded services for home delivery services.

Anticipated Outcomes	The anticipated outcome is to increase food security, access to fresh foods and education to help prevent chronic diseases.
Metrics Used to Evaluate the program/activity/initiative	Pounds of food distributed, number of people served and anecdotal stories.
Name of program/activity/initiative	Essential Food Service Worker Initiative
Description	Yolo Food Bank's Food System Worker's Food Assistance Program is conducting research on Spanish speaking clients that work in the food service industry, which have been identified as the majority receiving services through the food bank. When research is completed, a strategy will be developed to meet the nutritional needs of essential food system workers with nutritious, culturally appropriate food thereby dramatically increasing equity and personal dignity.
Goals	Increase capacity to service more individuals and families in Yolo County, focusing on Spanish speaking clients that are working in the food service industry.
Anticipated Outcomes	The anticipated outcome is to increase food security, access to fresh foods and education to help prevent chronic diseases.
Metrics Used to Evaluate the program/activity/initiative	Pounds of food distributed, number of people served and anecdotal stories.

Active Living and Healthy Eating

Name of program/activity/initiative	Healthy Living with Diabetes Program (HLDP)
Description	The Healthy Living with Diabetes Program (HLDP) aims to equip the low-income patients with diabetes management skills and access to the healthy food. There will be an addition of two new Paraprofessional Diabetes Educators (PDEs), a Registered Nurse (RN) who is also a Certified Diabetes Educator (CDE), and a Garden Coordinator to the HLDP team. PDEs will be bilingual, bicultural individuals cross trained as Comprehensive Perinatal Services Program (CPSP) providers. Coverage and coordination of diabetes-related services offered will improve the patient health with particular attention to addressing inequitable outcomes in blood sugar management associated with poverty and ethnicity. There will be targeted efforts to increase access for perinatal patients with diabetes through CenteringPregnancy groups and one-on-one diabetes case management at each site, in addition to implementing strategies to reach more vulnerable populations. Lastly, funding will also assist in the construction of the garden and outdoor classroom and purchase supplementary produce from local farms and the local food bank, which will further educate patients on how they can incorporate sustainable and affordable options at home. This program addresses multiple prioritized significant health needs, such as injury and disease prevention and management; access to basic needs; and active living and healthy eating.
Goals	The goal of the program is to increase patient access to culturally sensitive diabetes education, increase the number of low-income Latino patients with diabetes under control (A1C <9), conduct regularly scheduled classes for gardening, and distribute at least 25,000 pounds of California grown fresh fruits and vegetables, primarily through Group Medical Visits and CenteringPregnancy group visits

Anticipated Outcomes	The anticipated outcomes are to see a significant downward trend in the A1C values among patients receiving greater HLDP intensity (e.g. participating in 4 or more group visits or 3 or more one-on-one education visits). Patients participating in CenteringPregnancy and Sweet Success are anticipated to increase likelihood of giving birth to normal-weight, full-term babies. In addition, during the postpartum period patients are anticipated to return their blood sugar to normal levels, and reduce risk of acquiring diabetes.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided and other successful linkages.
Name of program/activity/initiative	West Sacramento Family Resource Center (WSFRC)
Description	West Sacramento Family Resource Center (WSFRC) is located in a low income West Sacramento neighborhood, next to Riverbank Elementary School. Programs and services provided at WSFRC assist immigrants, refugees, homeless and unstably housed families, and other under-resourced parents, children, seniors, and individuals in the community find a safe and nurturing space where they can get hands on personal assistance to access the resources they need in order to improve their lives. They also find a community space that fosters social connection between and among neighbors and other community members. This program addresses multiple prioritized significant health needs, such as injury and disease prevention and management; access to basic needs; active living and healthy eating; access to quality primary care health services.
Goals	The goals of the program are to connect clients to community resources and services, such as tax preparation and assistance services, homeless services and housing assistance services, utility assistance, housing search support and assistance, insurance enrollment, medical services, establish a medical home and receive necessary medical services including preventative care. In addition, provide the Nurturing Parenting Program, child development knowledge and parenting skills, free Play School Experience parent/guardian-child preschool classes, supporting parent/guardian-child bonding, school readiness for the children, social connections for the parents and guardians, and developing knowledge of child development. Lastly, the program aims to provide food security services through weekly fresh produce distribution, food pantry, CalFresh enrollment & retention services, and distribution of emergency food vouchers.
Anticipated Outcomes	The anticipated outcomes are that clients will receive hands on personal assistance to access the resources they need in order to improve their lives. They also find a community space that fosters social connection between and among neighbors and other community members.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children/families served, number and types of resources provided, anecdotal stories and other successful linkages.
Name of program/activity/initiative	Nourish Yolo
Description	Nourish Yolo will help prevent chronic diseases by increasing access to fresh, healthy foods in Yolo County. In addition, the program will increase awareness around the crisis that is food insecurity and create new/expand existing programs across Yolo County to ensure more people have consistent access to the food, education and resources they so desperately need. This program addresses multiple prioritized

	significant health needs, such as injury and disease prevention and management; access to basic needs; and active living and healthy eating.
Goals	The goal of the program is to provide access to fresh, healthy foods in Yolo County and education through programs.
Anticipated Outcomes	The anticipated outcome is to increase food security, access to fresh foods and education to help prevent chronic diseases.
Metrics Used to Evaluate the program/activity/initiative	Pounds of food distributed, number of people served and anecdotal stories.
Name of program/activity/initiative	Nurture Yolo
Description	Yolo Food Bank will increase storage space to prevent the damage or perish of goods to be utilized for the targeted expansion to rural communities and underserved populations that face greater inequities, including: Knights Landing, Madison, Esparto, Dunnigan and Winters. In addition, the home delivery service will be expanded for senior citizens and vulnerable, homebound residents in every portion of the county, especially remote rural areas.
Goals	Increase capacity to service more individuals and families in Yolo County, including expanded services for home delivery services.
Anticipated Outcomes	The anticipated outcome is to increase food security, access to fresh foods and education to help prevent chronic diseases.
Metrics Used to Evaluate the program/activity/initiative	Pounds of food distributed, number of people served and anecdotal stories.
Name of program/activity/initiative	Essential Food Service Worker Initiative
Description	Yolo Food Bank's Food System Worker's Food Assistance Program is conducting research on Spanish speaking clients that work in the food service industry, which have been identified as the majority receiving services through the food bank. When research is completed, a strategy will be developed to meet the nutritional needs of essential food system workers with nutritious, culturally appropriate food thereby dramatically increasing equity and personal dignity.
Goals	Increase capacity to service more individuals and families in Yolo County, focusing on Spanish speaking clients that are working in the food service industry.
Anticipated Outcomes	The anticipated outcome is to increase food security, access to fresh foods and education to help prevent chronic diseases.
Metrics Used to Evaluate the program/activity/initiative	Pounds of food distributed, number of people served and anecdotal stories.

Access to Quality Primary Care Health Services

Name of program/activity/initiative	Family Poverty Reduction Program
Description	Yolo County is embarking on a very exciting pilot program that will target the lowest income and most vulnerable homeless families in the County with children under the age of 6. The program will provide these families intensive case management, housing, health, mental health and employment resources and a living wage basic income stipend that will put each families' income over the California Poverty Measure (CPM) for

	2 full years. Each family will be screened for income, existing benefits and family size and will receive a monthly stipend that is at a minimum $1 over the CPM for their family size. Participants for the pilot were identified through the CalWORKS Housing Support Program (Homeless Families) and 65 current families were selected. Each family will essentially be lifted above the CPM for two full years to assist them in breaking the cycle of generational poverty and reaching self-sufficiency. A research team at the University of California Davis will be conducting a full study and evaluation of the program and its results to share with our funders, the larger anti-poverty community and State of California as a possible statewide pilot.
Goals	The goals of the program are to successfully complete a 2 year pilot to show the impact of families living above the California Poverty Measure (CPM) and report out the impact it has on financial, mental, and physical health, and other benefits.
Anticipated Outcomes	The anticipated outcome of the program is a completed 2-year pilot and improved financial, mental, and physical health.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Culturally Sensitive Palliative Care for Native and Rural Populations, plus Research Study
Description	Culturally Competent and Palliative Care for rural and Native American Communities in Capay Valley. Yolo Hospice was provided $1M grant from Yoche Dehe, which partially funded a 3-year study on rural and native communities in Capay Valley to identify barriers to serious illness and end of life care and to determine how to make culturally sensitive services available to these populations. They are currently going into year-2 of the research side of the project. In year 3, their objective is to implement a culturally sensitive program focusing on acute palliative care services, medication management, and caregiver supportive services in Capay Valley. These will be no-cost services to patients. Final report to be shared with Sutter Hospice to help inform our patient care and the Health Equity Team may partner on the remaining research.
Goals	The goal of the program is to provide more culturally competent training to palliative care staff.
Anticipated Outcomes	The anticipated outcomes are serving more Native American communities in Capay Valley and providing more culturally competent care.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of services provided, type of services provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Promotoras+
Description	The Promotores+ Program provides both direct medical, dental and behavioral health services to individuals in the communities in which they live and work through the extension of the Mobile Medicine Team and referrals for medical, dental, behavioral health and specialty care services. Service areas will include, but not limited to: Woodland, West Sacramento, Esparto, Knights Landing, and Madison, as well as targeted outreach for individuals who speak an Indigenous Language of Mexico.
Goals	The goal is to reach more individuals through increased capacity of the program.

Anticipated Outcomes	The anticipated outcome of the program is to reach 250 individuals annually, and at minimum 30 people monthly through Creando Recursos y Enlaces para Oportunidades (CREO).
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.

System Navigation

Name of program/activity/initiative	Permanent Supportive Housing Project
Description	Sutter Health is partnering with the City of West Sacramento, Mercy Housing California, Yolo County Health and Human Services and Yolo County Housing Authority to help fund the completion of the permanent supportive housing project (PSH). Mercy Housing has developed and operates 134 affordable communities in California with more than 9,190 homes serving lower-income seniors, families, and people who have experienced homelessness. Mercy Housing will develop and manage the 85-unit PSH project with Yolo County Health and Human Services providing the on-site supportive services such as case management and related health services. Yolo County Housing Authority will be a co-developer and has awarded 60 project-based vouchers. The project will aim to expand the available housing for individuals experiencing homelessness; and improve the overall well-being of people experiencing homelessness by targeting four social determinants of health, including housing stability, physical health, behavioral health, and self-sufficiency.
Goals	The goal is to complete the construction of the permanent supportive housing project.
Anticipated Outcomes	The anticipated outcome is to provide permanent supportive housing to individuals in need, as well as connecting clients with supportive services.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided and other successful linkages.
Name of program/activity/initiative	Family Poverty Reduction Program
Description	Yolo County is embarking on a very exciting pilot program that will target the lowest income and most vulnerable homeless families in the County with children under the age of 6. The program will provide these families intensive case management, housing, health, mental health and employment resources and a living wage basic income stipend that will put each families' income over the California Poverty Measure (CPM) for 2 full years. Each family will be screened for income, existing benefits and family size and will receive a monthly stipend that is at a minimum $1 over the CPM for their family size. Participants for the pilot were identified through the CalWORKS Housing Support Program (Homeless Families) and 65 current families were selected. Each family will essentially be lifted above the CPM for two full years to assist them in breaking the cycle of generational poverty and reaching self-sufficiency. A research team at the University of California Davis will be conducting a full study and evaluation of the program and its results to share with our funders, the larger anti-poverty community and State of California as a possible statewide pilot.
Goals	The goals of the program are to successfully complete a 2 year pilot to show the impact of families living above the California Poverty Measure

	(CPM) and report out the impact it has on financial, mental, and physical health, and other benefits.
Anticipated Outcomes	The anticipated outcome of the program is a completed 2-year pilot and improved financial, mental, and physical health.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Crisis Now
Description	The Crisis Now program will develop a 24/7 Access/Crisis Call Center, 24/7 Crisis Responders, and a 24/7 Receiving/Sobering Center. Implementation of Crisis Now in Yolo County would improve the way our community meets the needs of individuals in mental health crisis who may otherwise end up in the emergency room, at risk for suicide, and/or involved in the criminal justice system. Further, integrated care results in linkages for follow up services that may prevent crisis reoccurrence. The program would support the 220,408 residents of Yolo County under a No Wrong Door policy- this means there is no utilization management in the field on the part of law enforcement and the facility would accept non-local persons.
Goals	The goals of the program are to meet the needs of individuals in mental health crisis.
Anticipated Outcomes	The anticipated outcomes are improved connection to mental health and supportive services.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of appointments provided, types of services provided, anecdotal stories and other successful linkages.
Name of program/activity/initiative	Plan to Address Homelessness
Description	HPAC Executive Director, working with HPAC Board and homeless service providers, will create an updated plan to address homelessness in Yolo County. Over 100 homeless service providers, as well as community advocates, participate in monthly HPAC governance meetings and will be invited to participate in the updating of the plan. The HPAC Board is comprised of an elected formal board that includes representation from the local governments and a confederation of agencies and non-profit homeless providers, victim service providers, legal services, mental health agencies, law enforcement, persons with lived experience, and community advocates.
Goals	The goals of the program are to complete the updated plan to address homelessness by June 1, 2022.
Anticipated Outcomes	The anticipated outcome is to provide Yolo County and homeless service providers with an updated plan to address homelessness.
Metrics Used to Evaluate the program/activity/initiative	Number of participants, number of events, anecdotal stories, and a completed report.
Name of program/activity/initiative	School Based Mental Health Services
Description	School Based Mental Health Services targets Sacramento City Unified School District (nearly 50,000 students) and Washington Unified School District (over 8,000 students). Student outreach is conducted through education around mental health wellness to reduce stigma related to mental health and promote access to mental health services. Students are provided referrals and linkages to appropriate mental health services.

	The program includes Family & Youth Partnership, which is peer partner services and support groups designed to inform, educate, support, and empower parents/caregivers to be able to advocate and be fully engaged with their child/youth's educational and social well-being. Access is given to skill building and targeted behavior groups and Sutter Health's funding will cover group costs for students who do not qualify for Medi-Cal. Sutter's funding will also help provide school supplies for low-income students and Life Fund, which offers strategic, targeted assistance to at-risk youth and families by providing financial resources to meet basic needs (i.e. access to food, clothing, housing, and/or transportation) and/or provide educational or social opportunities as youth work toward completing treatment and recovery goals.
Goals	The goal is to provide provided referrals and linkages to appropriate mental health services.
Anticipated Outcomes	The anticipated outcomes are to provide mental health services to students in Sacramento City Unified School District and Washington Unified School District, as well connect students to community resources.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Haven House
Description	Haven House is an interim care program that offers people experiencing homelessness a safe place to recover after hospitalization. Haven House offers four respite beds for up to 29 days. During their stay, people experiencing homelessness will be provided support to connect with other services. Services include health insurance enrollment, substance abuse and mental health services, and placement in permanent housing. This program addresses multiple prioritized significant health needs, such as access to mental/behavioral/substance abuse services; access to basic needs; and access to quality primary care health services.
Goals	The goal of the program is to provide a safe place for patients to recover following hospitalization and connect patients with a medical home, social support and housing.
Anticipated Outcomes	The anticipated outcome of the ICP is to help people improve their overall health by wrapping them with services and treating the whole person through linkage to appropriate health care, shelter and other social support services.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Health and Wellness Program
Description	The Health and Wellness Support program provides individuals with mental or physical health support and connection to community resources. The program has the unique ability to serve a wide range of patient needs from navigating services and friendly check-in calls to dealing with more complex issues, like managing a mental health crisis. The goal of early intervention is to give clients a support system by having a live person to speak to when needed and help mitigate stressors before they become difficult to manage. The frequency of check-ins with patients depend on individual needs and can vary from multiple times a week to once per month. The program is completely voluntary and patients can discontinue follow-up services at any point.

Goals	The goal is to provide referred patients mental health support immediately after discharge from the hospital with extended, on-going follow-up calls to help the patient remain stable and continue working on the problems which caused them to escalate into crises originally.
Anticipated Outcomes	The expected outcomes are to maintain the patient's overall well-being and provide appropriate linkages to community resources. This support may divert a crisis, limit the crisis or avoid it altogether.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	West Sacramento Family Resource Center (WSFRC)
Description	West Sacramento Family Resource Center (WSFRC) is located in a low income West Sacramento neighborhood, next to Riverbank Elementary School. Programs and services provided at WSFRC assist immigrants, refugees, homeless and unstably housed families, and other under-resourced parents, children, seniors, and individuals in the community find a safe and nurturing space where they can get hands on personal assistance to access the resources they need in order to improve their lives. They also find a community space that fosters social connection between and among neighbors and other community members. This program addresses multiple prioritized significant health needs, such as injury and disease prevention and management; access to basic needs; active living and healthy eating; access to quality primary care health services.
Goals	The goals of the program are to connect clients to community resources and services, such as tax preparation and assistance services, homeless services and housing assistance services, utility assistance, housing search support and assistance, insurance enrollment, medical services, establish a medical home and receive necessary medical services including preventative care. In addition, provide the Nurturing Parenting Program, child development knowledge and parenting skills, free Play School Experience parent/guardian-child preschool classes, supporting parent/guardian-child bonding, school readiness for the children, social connections for the parents and guardians, and developing knowledge of child development. Lastly, the program aims to provide food security services through weekly fresh produce distribution, food pantry, CalFresh enrollment & retention services, and distribution of emergency food vouchers.
Anticipated Outcomes	The anticipated outcomes are that clients will receive hands on personal assistance to access the resources they need in order to improve their lives. They also find a community space that fosters social connection between and among neighbors and other community members.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children/families served, number and types of resources provided, anecdotal stories and other successful linkages.
Name of program/activity/initiative	Brighter Tomorrows Campaign
Description	The Yolo Crisis Nursery Brighter Tomorrows Campaign will build a new, larger home that triples capacity to serve the growing number of Yolo County families and children in crisis after raising $6 million dollars. The Nursery is open 24/7 providing emergency respite care for young children and support for families. The objectives are to prevent child abuse and neglect and provide crisis resolution and resources for every Yolo County family that needs our support. This is accomplished through early

	intervention services offered at the nursery in a safe environment to nurture healthy and resilient children, strengthen parents and preserve families.
Goals	The goals of the program are to prevent child abuse and neglect, as well as connect families to community resources to help preserve families.
Anticipated Outcomes	The anticipated outcomes of the program are to complete construction of the new facility, which will result in increased capacity for safe stays and connection to wrap around services to support families.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Emergency Childcare and Wrap-Around Services for Families in Crisis
Description	The Yolo Crisis Nursery is operating at capacity providing 2,500 safe stays for children experiencing crisis. Sutter Health's funding will support an increase in onsite meals provided to children who are provided a safe stay at the Nursery. In addition, funding will supplement an increased need of essential supplies to families participating in case management services. Families in rural areas will have supplies delivered to them.
Goals	The goals of the program are to increase the number of meals provided to children during safe stays and provide essential supplies, including those in rural communities.
Anticipated Outcomes	The anticipated outcomes of the programs are more meals served to children during safe stays and improved access to essential supplies for families.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Center for Caregiver Support
Description	The program offers adult daycare to participants of the caregiver support program while they receive services, such as participating in retreats and education. The trainings will show caregivers how to move someone will no or limited mobility from a bed to a chair, etc. They also plan on offering trainings on how to navigate the system for aging services because it can be often complicated.
Goals	The goals of the program is to provide a support system for caregivers and remove barriers to for access to caregiver trainings.
Anticipated Outcomes	The anticipated outcomes of the program is greater access to trainings for caregivers.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.

Access to Specialty and Extended Care

Name of program/activity/initiative	Culturally Sensitive Palliative Care for Native and Rural Populations, plus Research Study
Description	Culturally Competent and Palliative Care for rural and Native American Communities in Capay Valley. Yolo Hospice was provided $1M grant from Yoche Dehe, which partially funded a 3-year study on rural and native communities in Capay Valley to identify barriers to serious illness and end of life care and to determine how to make culturally sensitive services available to these populations. They are currently going into

	year-2 of the research side of the project. In year 3, their objective is to implement a culturally sensitive program focusing on acute palliative care services, medication management, and caregiver supportive services in Capay Valley. These will be no-cost services to patients. Final report to be shared with Sutter Hospice to help inform our patient care and the Health Equity Team may partner on the remaining research.
Goals	The goal of the program is to provide more culturally competent training to palliative care staff.
Anticipated Outcomes	The anticipated outcomes are serving more Native American communities in Capay Valley and providing more culturally competent care.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of services provided, type of services provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Center for Caregiver Support
Description	The program offers adult daycare to participants of the caregiver support program while they receive services, such as participating in retreats and education. The trainings will show caregivers how to move someone will no or limited mobility from a bed to a chair, etc. They also plan on offering trainings on how to navigate the system for aging services because it can be often complicated.
Goals	The goals of the program is to provide a support system for caregivers and remove barriers to for access to caregiver trainings.
Anticipated Outcomes	The anticipated outcomes of the program is greater access to trainings for caregivers.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.

Increased Community Connections

Name of program/activity/initiative	Permanent Supportive Housing Project
Description	Sutter Health is partnering with the City of West Sacramento, Mercy Housing California, Yolo County Health and Human Services and Yolo County Housing Authority to help fund the completion of the permanent supportive housing project (PSH). Mercy Housing has developed and operates 134 affordable communities in California with more than 9,190 homes serving lower-income seniors, families, and people who have experienced homelessness. Mercy Housing will develop and manage the 85-unit PSH project with Yolo County Health and Human Services providing the on-site supportive services such as case management and related health services. Yolo County Housing Authority will be a co-developer and has awarded 60 project-based vouchers. The project will aim to expand the available housing for individuals experiencing homelessness; and improve the overall well-being of people experiencing homelessness by targeting four social determinants of health, including housing stability, physical health, behavioral health, and self-sufficiency.
Goals	The goal is to complete the construction of the permanent supportive housing project.
Anticipated Outcomes	The anticipated outcome is to provide permanent supportive housing to individuals in need, as well as connecting clients with supportive services.

Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided and other successful linkages.
Name of program/activity/initiative	Promotoras+
Description	The Promotores+ Program provides both direct medical, dental and behavioral health services to individuals in the communities in which they live and work through the extension of the Mobile Medicine Team and referrals for medical, dental, behavioral health and specialty care services. Service areas will include, but not limited to: Woodland, West Sacramento, Esparto, Knights Landing, and Madison, as well as targeted outreach for individuals who speak an Indigenous Language of Mexico.
Goals	The goal is to reach more individuals through increased capacity of the program.
Anticipated Outcomes	The anticipated outcome of the program is to reach 250 individuals annually, and at minimum 30 people monthly through Creando Recursos y Enlaces para Oportunidades (CREO).
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Healthy Living with Diabetes Program (HLDP)
Description	The Healthy Living with Diabetes Program (HLDP) aims to equip the low-income patients with diabetes management skills and access to the healthy food. There will be an addition of two new Paraprofessional Diabetes Educators (PDEs), a Registered Nurse (RN) who is also a Certified Diabetes Educator (CDE), and a Garden Coordinator to the HLDP team. PDEs will be bilingual, bicultural individuals cross trained as Comprehensive Perinatal Services Program (CPSP) providers. Coverage and coordination of diabetes-related services offered will improve the patient health with particular attention to addressing inequitable outcomes in blood sugar management associated with poverty and ethnicity. There will be targeted efforts to increase access for perinatal patients with diabetes through CenteringPregnancy groups and one-on-one diabetes case management at each site, in addition to implementing strategies to reach more vulnerable populations. Lastly, funding will also assist in the construction of the garden and outdoor classroom and purchase supplementary produce from local farms and the local food bank, which will further educate patients on how they can incorporate sustainable and affordable options at home. This program addresses multiple prioritized significant health needs, such as injury and disease prevention and management; access to basic needs; and active living and healthy eating.
Goals	The goal of the program is to increase patient access to culturally sensitive diabetes education, increase the number of low-income Latino patients with diabetes under control (A1C <9), conduct regularly scheduled classes for gardening, and distribute at least 25,000 pounds of California grown fresh fruits and vegetables, primarily through Group Medical Visits and CenteringPregnancy group visits
Anticipated Outcomes	The anticipated outcomes are to see a significant downward trend in the A1C values among patients receiving greater HLDP intensity (e.g. participating in 4 or more group visits or 3 or more one-on-one education visits). Patients participating in CenteringPregnancy and Sweet Success are anticipated to increase likelihood of giving birth to normal-weight, full-term babies. In addition, during the postpartum period patients are

	anticipated to return their blood sugar to normal levels, and reduce risk of acquiring diabetes.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided and other successful linkages.
Name of program/activity/initiative	Salud Clinic Outdoor Play Area
Description	Newly funded program in 2021. Sutter Health is funding the rebuild of the preschool's outdoor play space at the Salud Clinic in West Sacramento. They recently experienced a tragic fire that rendered the space unusable. The area is used for hands on learning and outdoor play therapy for children of patients receiving treatment through the Perinatal Day Program, which is for pregnant and parenting mothers struggling with substance use issues and is the only program of its kind in Yolo County.
Goals	The goal is to rebuild play area to allow children to experiencing hands on learning and outdoor play therapy while parents receive treatment through the Perinatal Day Program.
Anticipated Outcomes	The anticipated outcomes are to complete the construction of the playground and allow greater access for parents to receive treatment through the Perinatal Day Program.
Metrics Used to Evaluate the program/activity/initiative	Completion of construction, number of individuals served, and anecdotal stories.
Name of program/activity/initiative	Mobile Medicine Program
Description	The Yolo Street Medicine and Mobile Medical Unit Collaboration consists of partnership between SDH, County of Yolo Health and Human Services Agency, and Dignity Health. The program provides street-based medicine units. The community based provider, CommuniCare Health Center, will provide physical health, behavioral health, and social services to the target populations. In addition funding for the Mobile Medical Unit will help purchase a vehicle (van); and a mobile medical unit.
Goals	The goal is to provide physical health, behavioral health, and social services to individuals living homeless in Yolo County; individuals and families at education, faith and migrant farm community locations who are in need of mobile medical services; people in certain rural areas of Yolo County that are in need of health care services to individuals living homeless in Yolo County.
Anticipated Outcomes	The anticipated outcome is expanded capacity to serve the underserved population with primary care, behavioral/mental health care, and other specialty services.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of appointments provided, types of services provided, anecdotal stories and other successful linkages.
Name of program/activity/initiative	Plan to Address Homelessness
Description	HPAC Executive Director, working with HPAC Board and homeless service providers, will create an updated plan to address homelessness in Yolo County. Over 100 homeless service providers, as well as community advocates, participate in monthly HPAC governance meetings and will be invited to participate in the updating of the plan. The HPAC Board is comprised of an elected formal board that includes representation from the local governments and a confederation of agencies and non-profit homeless providers, victim service providers,

	legal services, mental health agencies, law enforcement, persons with lived experience, and community advocates.
Goals	The goals of the program are to complete the updated plan to address homelessness by June 1, 2022.
Anticipated Outcomes	The anticipated outcome is to provide Yolo County and homeless service providers with an updated plan to address homelessness.
Metrics Used to Evaluate the program/activity/initiative	Number of participants, number of events, anecdotal stories, and a completed report.
Name of program/activity/initiative	School Based Mental Health Services
Description	School Based Mental Health Services targets Sacramento City Unified School District (nearly 50,000 students) and Washington Unified School District (over 8,000 students). Student outreach is conducted through education around mental health wellness to reduce stigma related to mental health and promote access to mental health services. Students are provided referrals and linkages to appropriate mental health services. The program includes Family & Youth Partnership, which is peer partner services and support groups designed to inform, educate, support, and empower parents/caregivers to be able to advocate and be fully engaged with their child/youth's educational and social well-being. Access is given to skill building and targeted behavior groups and Sutter Health's funding will cover group costs for students who do not qualify for Medi-Cal. Sutter's funding will also help provide school supplies for low-income students and Life Fund, which offers strategic, targeted assistance to at-risk youth and families by providing financial resources to meet basic needs (i.e. access to food, clothing, housing, and/or transportation) and/or provide educational or social opportunities as youth work toward completing treatment and recovery goals.
Goals	The goal is to provide provided referrals and linkages to appropriate mental health services.
Anticipated Outcomes	The anticipated outcomes are to provide mental health services to students in Sacramento City Unified School District and Washington Unified School District, as well connect students to community resources.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Health and Wellness Program
Description	The Health and Wellness Support program provides individuals with mental or physical health support and connection to community resources. The program has the unique ability to serve a wide range of patient needs from navigating services and friendly check-in calls to dealing with more complex issues, like managing a mental health crisis. The goal of early intervention is to give clients a support system by having a live person to speak to when needed and help mitigate stressors before they become difficult to manage. The frequency of check-ins with patients depend on individual needs and can vary from multiple times a week to once per month. The program is completely voluntary and patients can discontinue follow-up services at any point.
Goals	The goal is to provide referred patients mental health support immediately after discharge from the hospital with extended, on-going follow-up calls to help the patient remain stable and continue working on the problems which caused them to escalate into crises originally.

Anticipated Outcomes	The expected outcomes are to maintain the patient's overall well-being and provide appropriate linkages to community resources. This support may divert a crisis, limit the crisis or avoid it altogether.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	West Sacramento Family Resource Center (WSFRC)
Description	West Sacramento Family Resource Center (WSFRC) is located in a low income West Sacramento neighborhood, next to Riverbank Elementary School. Programs and services provided at WSFRC assist immigrants, refugees, homeless and unstably housed families, and other under-resourced parents, children, seniors, and individuals in the community find a safe and nurturing space where they can get hands on personal assistance to access the resources they need in order to improve their lives. They also find a community space that fosters social connection between and among neighbors and other community members. This program addresses multiple prioritized significant health needs, such as injury and disease prevention and management; access to basic needs; active living and healthy eating; access to quality primary care health services.
Goals	The goals of the program are to connect clients to community resources and services, such as tax preparation and assistance services, homeless services and housing assistance services, utility assistance, housing search support and assistance, insurance enrollment, medical services, establish a medical home and receive necessary medical services including preventative care. In addition, provide the Nurturing Parenting Program, child development knowledge and parenting skills, free Play School Experience parent/guardian-child preschool classes, supporting parent/guardian-child bonding, school readiness for the children, social connections for the parents and guardians, and developing knowledge of child development. Lastly, the program aims to provide food security services through weekly fresh produce distribution, food pantry, CalFresh enrollment & retention services, and distribution of emergency food vouchers.
Anticipated Outcomes	The anticipated outcomes are that clients will receive hands on personal assistance to access the resources they need in order to improve their lives. They also find a community space that fosters social connection between and among neighbors and other community members.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children/families served, number and types of resources provided, anecdotal stories and other successful linkages.
Name of program/activity/initiative	Brighter Tomorrows Campaign
Description	The Yolo Crisis Nursery Brighter Tomorrows Campaign will build a new, larger home that triples capacity to serve the growing number of Yolo County families and children in crisis after raising $6 million dollars. The Nursery is open 24/7 providing emergency respite care for young children and support for families. The objectives are to prevent child abuse and neglect and provide crisis resolution and resources for every Yolo County family that needs our support. This is accomplished through early intervention services offered at the nursery in a safe environment to nurture healthy and resilient children, strengthen parents and preserve families.

Goals	The goals of the program are to prevent child abuse and neglect, as well as connect families to community resources to help preserve families.
Anticipated Outcomes	The anticipated outcomes of the program are to complete construction of the new facility, which will result in increased capacity for safe stays and connection to wrap around services to support families.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Emergency Childcare and Wrap-Around Services for Families in Crisis
Description	The Yolo Crisis Nursery is operating at capacity providing 2,500 safe stays for children experiencing crisis. Sutter Health's funding will support an increase in onsite meals provided to children who are provided a safe stay at the Nursery. In addition, funding will supplement an increased need of essential supplies to families participating in case management services. Families in rural areas will have supplies delivered to them.
Goals	The goals of the program are to increase the number of meals provided to children during safe stays and provide essential supplies, including those in rural communities.
Anticipated Outcomes	The anticipated outcomes of the programs are more meals served to children during safe stays and improved access to essential supplies for families.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Culturally Sensitive Palliative Care for Native and Rural Populations, plus Research Study
Description	Culturally Competent and Palliative Care for rural and Native American Communities in Capay Valley. Yolo Hospice was provided $1M grant from Yoche Dehe, which partially funded a 3-year study on rural and native communities in Capay Valley to identify barriers to serious illness and end of life care and to determine how to make culturally sensitive services available to these populations. They are currently going into year-2 of the research side of the project. In year 3, their objective is to implement a culturally sensitive program focusing on acute palliative care services, medication management, and caregiver supportive services in Capay Valley. These will be no-cost services to patients. Final report to be shared with Sutter Hospice to help inform our patient care and the Health Equity Team may partner on the remaining research.
Goals	The goal of the program is to provide more culturally competent training to palliative care staff.
Anticipated Outcomes	The anticipated outcomes are serving more Native American communities in Capay Valley and providing more culturally competent care.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of services provided, type of services provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Center for Caregiver Support
Description	The program offers adult daycare to participants of the caregiver support program while they receive services, such as participating in retreats and education. The trainings will show caregivers how to move someone will no or limited mobility from a bed to a chair, etc. They also plan on offering trainings on how to navigate the system for aging services because it can be often complicated.

Goals	The goals of the program is to provide a support system for caregivers and remove barriers to for access to caregiver trainings.
Anticipated Outcomes	The anticipated outcomes of the program is greater access to trainings for caregivers.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.

Safe and Violence-Free Environment

Name of program/activity/initiative	Brighter Tomorrows Campaign
Description	The Yolo Crisis Nursery Brighter Tomorrows Campaign will build a new, larger home that triples capacity to serve the growing number of Yolo County families and children in crisis after raising $6 million dollars. The Nursery is open 24/7 providing emergency respite care for young children and support for families. The objectives are to prevent child abuse and neglect and provide crisis resolution and resources for every Yolo County family that needs our support. This is accomplished through early intervention services offered at the nursery in a safe environment to nurture healthy and resilient children, strengthen parents and preserve families.
Goals	The goals of the program are to prevent child abuse and neglect, as well as connect families to community resources to help preserve families.
Anticipated Outcomes	The anticipated outcomes of the program are to complete construction of the new facility, which will result in increased capacity for safe stays and connection to wrap around services to support families.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.
Name of program/activity/initiative	Emergency Childcare and Wrap-Around Services for Families in Crisis
Description	The Yolo Crisis Nursery is operating at capacity providing 2,500 safe stays for children experiencing crisis. Sutter Health's funding will support an increase in onsite meals provided to children who are provided a safe stay at the Nursery. In addition, funding will supplement an increased need of essential supplies to families participating in case management services. Families in rural areas will have supplies delivered to them.
Goals	The goals of the program are to increase the number of meals provided to children during safe stays and provide essential supplies, including those in rural communities.
Anticipated Outcomes	The anticipated outcomes of the programs are more meals served to children during safe stays and improved access to essential supplies for families.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.

Access to Functional Needs

Name of program/activity/initiative	School Based Mental Health Services

Description	School Based Mental Health Services targets Sacramento City Unified School District (nearly 50,000 students) and Washington Unified School District (over 8,000 students). Student outreach is conducted through education around mental health wellness to reduce stigma related to mental health and promote access to mental health services. Students are provided referrals and linkages to appropriate mental health services. The program includes Family & Youth Partnership, which is peer partner services and support groups designed to inform, educate, support, and empower parents/caregivers to be able to advocate and be fully engaged with their child/youth's educational and social well-being. Access is given to skill building and targeted behavior groups and Sutter Health's funding will cover group costs for students who do not qualify for Medi-Cal. Sutter's funding will also help provide school supplies for low-income students and Life Fund, which offers strategic, targeted assistance to at-risk youth and families by providing financial resources to meet basic needs (i.e. access to food, clothing, housing, and/or transportation) and/or provide educational or social opportunities as youth work toward completing treatment and recovery goals.
Goals	The goal is to provide provided referrals and linkages to appropriate mental health services.
Anticipated Outcomes	The anticipated outcomes are to provide mental health services to students in Sacramento City Unified School District and Washington Unified School District, as well connect students to community resources.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.

Access to Dental Care and Preventative Services

Name of program/activity/initiative	Promotoras+
Description	The Promotores+ Program provides both direct medical, dental and behavioral health services to individuals in the communities in which they live and work through the extension of the Mobile Medicine Team and referrals for medical, dental, behavioral health and specialty care services. Service areas will include, but not limited to: Woodland, West Sacramento, Esparto, Knights Landing, and Madison, as well as targeted outreach for individuals who speak an Indigenous Language of Mexico.
Goals	The goal is to reach more individuals through increased capacity of the program.
Anticipated Outcomes	The anticipated outcome of the program is to reach 250 individuals annually, and at minimum 30 people monthly through Creando Recursos y Enlaces para Oportunidades (CREO).
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, type of resources provided, anecdotal stories, and other successful linkages.

Needs Sutter Davis Hospital Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Davis Hospital is committed to serving the community by adhering to its mission, using its skills and capabilities, and remaining a strong organization so that it can continue to provide a wide range of community benefits. The implementation strategy does not include specific plans to address the following significant health needs that were identified in the 2022 Community Health Needs Assessment:

N/A

Approval by Governing Board

The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Health Valley Hospitals Board on July 21, 2022.