Sutter Health

Sutter Medical Center, Sacramento

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

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Introduction

The Implementation Strategy Plan describes how Sutter Medical Center, Sacramento, 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 Medical Center, Sacramento 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 2825 Capitol Avenue, Sacramento, CA 95816; and
- In-person at the hospital's Information Desk.

Executive Summary

Sutter Medical Center, Sacramento 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 Medical Center, Sacramento, the following significant community health needs were identified:

1. Access to Mental/Behavioral Health and Substance-Use Services
2. Access to Basic Needs Such as Housing, Jobs, and Food
3. Access to Quality Primary Care Health Services
4. System Navigation
5. Injury and Disease Prevention and Management
6. Health Equity: Equal Access to Opportunities to be Healthy (new, emergent)
7. Active Living and Healthy Eating
8. Safe and Violence-Free Environment
9. Increased Community Connections (new from PHNs)
10. Access to Specialty and Extended Care
11. Access to Functional Needs (transportation and physical mobility)
12. Access to Dental Care and Preventive Services
13. Healthy Physical Environment

The 2022 Community Healthy Needs Assessment conducted by Sutter Medical Center, Sacramento 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 Medical Center, Sacramento. 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 42 one-on-one and group interviews with 87 community health experts, social-service providers, and medical personnel. Further, 57 community residents participated in 11 focus groups across the service area.

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.

Primary and secondary data were analyzed to identify and prioritize significant health needs. This began by identifying 10 potential health needs (PHNs). These PHNs to address were those identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the service area. After these were identified, PHNs were prioritized based on rankings provided by primary data sources. Data were also analyzed to detect emerging health needs beyond those 10 PHNs identified in previous CHNAs.

The full 2022 Community Health Needs Assessment conducted by Sutter Medical Center, Sacramento is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

Sacramento County was the designated area served by the participating hospitals for the 2022 CHNA. This definition of the community served was used because this is the primary geographic area served by the seven nonprofit hospitals that collaborated on this CHNA.

Sacramento County was incorporated in 1850, and much of its rich history was influenced by the discovery of gold in the area in 1848. The county is home to California's capital city, Sacramento. The county includes seven incorporated cities, with the City of Sacramento being the largest. Covering a geographic area of 994 square miles and home to approximately 1.56 million residents, Sacramento County sits at the northern portion of California's Central Valley, situated along the Interstate 5 corridor. The area consists of both urban and rural communities and includes the Sacramento–San Joaquin Delta that connects the Sacramento River to the San Francisco Bay through some 700 miles of winding waterways. Sacramento is often described as a diverse community, and a report ranked the city the fourth most racially and ethnically diverse large city in the US.

Sacramento County has over 30 cities, census-designated places, and unincorporated communities that include neighborhoods with rich heritages such as Oak Park, known as Sacramento's first suburb, to newer communities such as the City of Rancho Cordova, incorporated in 2003. Sacramento County ranks as California's 26th most overall healthy county among the 58 in the state. The area is served by a number of healthcare organizations, including those that collaborated in this assessment.

In this CHNA, two additional ZIP Codes from El Dorado County, a neighboring county east of Sacramento, were included to capture the portion of the community served by Mercy Hospital of Folsom, located near the border of these two counties. With some exceptions, findings described in this report are organized both at the county level and, as detailed later in this report, by designated regions within the 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 Mental/Behavior/Substance-Abuse 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 concurrently. Adequate access to mental, behavioral, and substance-abuse services helps community members obtain additional support when needed.

2. **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 demonstrates 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.

3. **Access to Quality Primary Healthcare Services** – Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and similar. 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.

4. **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. Further, accessing social services provided by government agencies can be an obstacle for those with limited resources such as transportation access and English proficiency.

5. **Injury and Disease Prevention and Management** – Knowledge is important for individual health and well-being, and efforts aimed at 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 focused on reducing cases of injury and infectious disease control (e.g., sexually transmitted infection [STI] prevention, influenza shots) and intensive strategies for the management of chronic diseases (e.g., diabetes, hypertension, obesity, and heart disease) are important for community health improvement.

6. **Health Equity: Equal Access to Opportunities to be Healthy (new, emergent)** – Health equity is defined as everyone having the same opportunity to be as healthy as possible. Health is largely determined by social factors. Some communities have resources needed to be healthy readily available to them, while others do not. Many people experience barriers as the result of policies, practices, systems, and structures that discriminate against certain groups. Individual and community health can be improved by removing or mitigating practices that result in health inequity. While health equity is described as a specific health need in this assessment, it is recognized that equity plays a role in the presence of each health need in a community.

7. **Active Living and Healthy Eating** – Physical activity and eating a healthy diet are extremely 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 are often overloaded with fast food and other establishments where unhealthy food is sold.

8. **Safe and Violence-Free Environment** – Feeling safe in one's home and community are 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. Further, 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.

9. **Increased Community Connections (new from PHNs)** – 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. Further, healthcare and community support services are more effective when they are delivered in a coordinate fashion, where individual organizations collaborate with others to build a network of care.

10. **Access to Specialty and Extended Care** – Extended care services, including specialty care, are services provided in a branch of medicine and focused on the treatment of a specific 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 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.

11. **Access to Functional Needs – Transportation and Physical Disability** – 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 that promote and support a healthy life. Examining the number of people that have a disability is also an important indicator for community health in an effort to ensure that all community members have access to necessities for a high quality of life.

12. **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.

13. **Healthy Physical Environment** – Living in a pollution-free environment is essential for health. Individual health is determined by a number of factors, and some models show that one's living environment, including the physical (natural and built) and sociocultural environment, has more impact on individual health than one's lifestyle, heredity, or access to medical services.

2022 – 2024 Implementation Strategy Plan

The implementation strategy plan describes how Sutter Medical Center, Sacramento 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 Medical Center, Sacramento 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 Mental/Behavior Health and Substance-Use Services
2. Access to Basic Needs Such as Housing, Jobs, and Food
3. Access to Quality Primary Care Health Services
4. System Navigation
5. Health Equity: Equal Access to Opportunities to be Healthy
6. Active Living and Healthy Eating
7. Access to Specialty and Extended Care
8. Healthy Physical Environment

Access to Mental/Behavior Health and Substance-Use Services

Name of program/activity/initiative	Area Wide Mental Health Strategy
Description	The need for mental health services and resources, especially for the underserved, has reached a breaking point across the Sutter Health Valley Operating Unit. Therefore, we are focused on building a comprehensive mental health strategy that integrates key elements such as policy and advocacy, county specific investments, stigma reduction, increased awareness and education, with tangible outreach such as expanded mental health resources to professionals in the workplace, students and school districts and telepsych options to the underserved. In addition, we will identify opportunities to build and foster mental health programs and resources locally in the Sutter Medical Center, Sacramento service area.
Goals	By linking these various strategies and efforts through engaging in statewide partnerships, replicating best practices, and securing innovation grants and award opportunities, we can create a seamless network of mental health care resources so desperately needed in the communities we serve.
Anticipated Outcomes	The anticipated outcome is a stronger mental/behavioral safety net and increased access to behavioral/mental health resources for our community.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, anecdotal stories, types of services/resources provided, and other successful linkages.

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

Name of program/activity/initiative	Short-Term Medical Housing
Description	Provide free short-term housing for patients and families who must leave their own community to seek medical care at Sutter Healthcare Centers and other medical facilities. This unique home-away-from-home experience has brought a compassionate response as well as emotional and financial relief to guests in need. These programs help families to access specialized medical treatment by providing a place to stay at little or sometimes no cost.
Goals	Keeping families with a sick family member together and near the care and resources they need.
Anticipated Outcomes	Families are stronger when they are together. By staying at a short-term medical housing establishment, families can better communicate with their loved one's medical team and keep up with complicated treatment plans when needed. They can also focus on the health of their family member, rather than grocery shopping, cleaning, or cooking meals.
Metrics Used to Evaluate the program/activity/initiative	Number of people/families served, number of resources provided, number of nights stayed.

Name of program/activity/initiative	Serial Inebriate Program
Description	The Serial Inebriate Program (SIP) addresses the health, safety, and housing needs of intoxicated, chronically homeless adults living on the streets of Sacramento. To qualify for SIP, individuals must have been admitted to local EDs, the Comprehensive Alcohol Treatment Center 16 (also known as the "detox" program) or arrested at least 25 times within the previous 12 months, and who pose a danger to themselves or others due to excessive alcohol consumption. During the 90-day stay, clients receive alcohol addiction counseling, and are offered permanent housing through Sacramento Self Help Housing. SIP clients are not only placed in a safe housing environment, but they are also wrapped with services to get on the road to sobriety and connect to health resources they were not aware of during their time on the streets. Additionally, SIP clients are connected with primary and mental health services, to help address their long-term medical needs and place these at-risk patients in permanent medical homes.
Goals	The goal is to get serial inebriates off the streets and into housing and alcohol and drug treatment.
Anticipated Outcomes	The anticipated outcomes are reduced ED visits, reduced arrests, better health and improved sobriety.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories from staff and patients, number of people successfully housed, type of resources provided, reduced arrests and other successful linkages.

Name of program/activity/initiative	Community College Promise Scholarship Program
Description	The Promise Scholarship is targeted to the neediest of these students attending full-time and gives flexible support that can help meet their most important needs. In addition to tuition fees, community college students have other attendance costs that stand in the way of

	postsecondary success (books, transportation, housing, student fees, lab equipment, supplies, childcare expenses, etc.), but they have less access to financial aid. 56% of Los Rios students are low income (approx. 40,000) nearly 32% live below the poverty line, and 13% are homeless.
Goals	The Promise Scholarship aims to remove the barriers that prevent students from achieving college success. By removing barriers, students have a greater chance of completing their degrees and entering the workforce ready to succeed.
Anticipated Outcomes	These scholarships will really help bridge the gap for students. They will meet the needs that fall outside the traditional lines of what existing aid programs will cover and help students complete their degrees and enter the workforce ready to succeed.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories from students.

Access to Quality Primary Care Health Services

Name of program/activity/initiative	Ongoing Clinic Investments
Description	With access to care, including primary, mental health and specialty care continuing to be a major priority area in the SMCS health service area, we will continue to make strategic investments in our local FQHC partners to increase clinic capacity and services offered. Creative collaborations and innovative opportunities with our clinic partners will continue to evolve with the needs of the community.
Goals	The goal is to expand access to care, especially for underserved populations who have barriers to receiving proper medical care.
Anticipated Outcomes	The anticipated outcome is expanded capacity to serve the underserved population with primary care, behavioral/mental health care, and dental 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	Emergency Department Navigator (ED Navigator)
Description	The ED Navigator serves as a visible ED-based staff member. Upon referral from a Sutter employee (and after patient agreement), ED Navigators attend to patients in the ED and complete an assessment for T3 case-management services. Upon assessment, the ED Navigator determines and identifies patient needs for community-based resources and/or case-management services, such as providing a patient linkage to a primary care provider and establishing a medical home.
Goals	The goal of the ED Navigator is to connect patients with health and social services, and ultimately a medical home, as well as other programs (like T3) when appropriate.
Anticipated Outcomes	The anticipated outcome of the ED Navigator is reduced ED visits, as patients will have a medical home and access to social services, in turn, reducing their need to come to the ED for non-urgent reasons and making the patient healthier overall.

Metrics Used to Evaluate the program/activity/initiative	The ED Navigator program has proven to be effective in improving access to care for the underserved community. SMCS will continue to evaluate the impact of the ED Navigator on a quarterly basis, by tracking the number of people served, recidivism rates, number of linkages to other referrals/ services and other indicators. We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories, type of resources provided, number of patients referred to T3 and other successful linkages.

Name of program/activity/initiative	Health Navigation: Reducing Barriers to Care
Description	The Sacramento Health Navigator Program expands health navigation services in Sacramento County and connects thousands of low-income residents to affordable health care coverage.
Goals	The overall goal of the project is to establish medical homes, thereby reducing dependence on emergency room systems of care.
Anticipated Outcomes	The community needs addressed by this project, all of which support the under-insured and uninsured, include: 1) access to primary care, 2) access to preventive care, and 3) access to dental care.
Metrics Used to Evaluate the program/activity/initiative	The plan to evaluate will follow the same process as many of our other community benefit program with bi-annual reporting and partner meetings to discuss/track effectiveness of each program within this strategy. We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories, types of services/resources provided and other successful linkages.

Name of program/activity/initiative	Interim Care Program (ICP)
Description	A collaborative of the four health care systems and WellSpace Health, Volunteers of America and Sacramento County, the Sacramento Interim Care Program (ICP) is a respite-care shelter for homeless patients discharged from hospitals. The ICP wraps people with health and social services, while giving them a place to heal. Started in 2005, the ICP links people in need to vital community services while giving them a place to heal. The clients who are enrolled in the ICP are homeless adult individuals who otherwise would be discharged to the street or cared for in an inpatient setting only. The program is designed to offer clients up to six weeks during which they can focus on recovery and developing a plan for their housing and care upon discharge. This innovative community partnership provides temporary respite housing that offer homeless men and women a place to recuperate from their medical conditions, link them to vital community services, and provide them a place to heal.
Goals	The ICP seeks to 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	The ICP program has proven to be effective in improving access to care for the underserved community. SMCS will continue to evaluate the impact of ICP on a quarterly basis, by tracking the number of people served, recidivism rates, number of linkages to other referrals/ services and other indicators. We will look at metrics including (but not limited to)

	number of people served, number of resources provided, hospital usage post program intervention, type of resources provided and other successful linkages.
Name of program/activity/initiative	Interim Care Program Plus (ICP+)
Description	SMCS offers an “expanded ICP” ICP+ aimed to meet the needs of patients with more complex needs and acute health issues. The program offers short-term (60-90 days) respite center serving homeless individuals post-hospitalization. Caters to individuals with higher medical acuity. Offers intensive case mgmt., access to LVNs & CNAs, medication educ., transportation, & referrals.
Goals	ICP+ seeks to 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	We will look at metrics including (but not limited to) number of people served, number of resources provided, hospital usage post program intervention, type of resources provided and other successful linkages.
Name of program/activity/initiative	Triage, Transport, Treatment (T3)
Description	T3 provides case management services for people who frequently access the SMCS EDs for inappropriate and non-urgent needs, by connecting vulnerable patients to vital resources such as housing, primary care, mental and behavioral health services, transportation, substance abuse treatment and other key community resources. By linking these patients to the right care, in the right place, at the right time and wrapping them with services, we see a drastic improvement to the health and overall quality of life for this often underserved, patient population.
Goals	The goal of T3 is to wrap patients with health and social services, and ultimately a medical home.
Anticipated Outcomes	The anticipated outcome of T3 is reduced ED visits, as patients will have a medical home and access to social services, in turn, reducing their need to come to the ED for non-urgent reasons and making the patient healthier overall.
Metrics Used to Evaluate the program/activity/initiative	The T3 program has proven to be effective in improving access to care for the underserved community. SMCS will continue to evaluate the impact of T3 on a quarterly basis, by tracking the number of people served, recidivism rates, number of linkages to other referrals/ services and other indicators. We will look at metrics including (but not limited to) number of people served, number of resources provided, hospital usage post program intervention, type of resources provided and other successful linkages.
Name of program/activity/initiative	Triage, Transport, and Treatment Plus (T3+)
Description	T3+ is like T3, except patients are identified in an inpatient setting and are often more complex. The T3+ navigator follows patients after discharge and works with Sutter Health staff to provide a follow-up health plan, tele-health, pain management, etc. All of this occurs while the T3+ navigators address the patient’s other needs (including housing,

	insurance enrollment, etc) and ensure a connection is made to primary and preventive care to reduce further hospitalization.
Goals	The goal of T3+ is to wrap patients with health and social services, and ultimately a medical home.
Anticipated Outcomes	The anticipated outcome of T3+ is to successfully connect patients with a medical home and social services, in turn, managing any long-term health ailments and making the patient healthier overall.
Metrics Used to Evaluate the program/activity/initiative	The T3+ program has proven to be effective in improving access to care for the underserved community. SMCS will continue to evaluate the impact of T3+ on a quarterly basis, by tracking the number of people served, recidivism rates, number of linkages to other referrals/ services and other indicators. We will look at metrics including (but not limited to) number of people served, number of resources provided, hospital usage post program intervention, type of resources provided and other successful linkages.

Name of program/activity/initiative	Street Nurse
Description	Street Nurse works alongside our local community navigators. This increases opportunities to connect more homeless individuals to immediate medical care, necessary follow-up treatment and eventually a primary and behavioral health home to address the long-term healthcare needs for this underserved population. The Street Nurse has become a direct conduit from the community navigators to programs like ICP and ED Navigators.
Goals	The goal of the street nurse is to connect with patients in their environment (often homeless patients, on the street) provide them with health advice and certain services, then work with community partners to wrap patients with health and social services, and ultimately a medical home.
Anticipated Outcomes	The anticipated outcome of the street nurse is to successfully connect patients with a medical home and social services, in turn, getting patients off the street and making the patient healthier overall.
Metrics Used to Evaluate the program/activity/initiative	The street nurse has proven to be effective in improving access to care for the underserved community. SMCS will continue to evaluate the impact of T3+ on a quarterly basis, by tracking the number of people served, recidivism rates, number of linkages to other referrals/ services and other indicators. We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories from staff and patients, type of resources provided and other successful linkages.

System Navigation

Name of program/activity/initiative	Community Navigators
Description	Community Navigators connects with homeless individuals. The Community Navigator slowly builds relationships with these people and helps wrap them with services, such as housing, a medical home, a PCP/mental health provider, alcohol and drug treatment and other social services. The Community Navigator ensures a continuum of care for homeless patients both within the walls of the hospital and out in the community.

Goals	This effort seeks to provide homeless individuals with a medical home, linkages to health and social resources and a successfully connection to housing/shelter.
Anticipated Outcomes	The anticipated outcomes is a lower number of homeless people in the greater Sacramento region.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories from staff and patients, number of people successfully housed, number of successful referrals to primary, mental/behavioral health care and/or alcohol and drug treatment, type of resources provided and other successful linkages.

Name of program/activity/initiative	Pediatric Navigation
Description	Pediatric navigation provides health navigation services, including but not limited to assistance with scheduling timely discharge appointments of newborns, adding newborns to Medi-Cal case, plan selection/changes to assigned provider or health plan, primary dental or vision care appointments, transportation services, interpreting services, education on health coverage and nutrition program, and referrals to other resources.
Goals	The goal of Pediatric Navigation is to provide newborns with health and social services.
Anticipated Outcomes	The anticipated outcomes are to successfully connect newborns with a primary care provider and social services, in turn, helping to inform and educate caregivers and families about how to access services, work with providers and manage the various aspects of special needs caregiving
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories from staff and patients, type of resources provided and other successful linkages.

Health Equity: Equal Access to Opportunities to be Healthy

Name of program/activity/initiative	World Relief Refugee Women's Integration Program
Description	Over 13,000 refugees have arrived in northern California in the past five years. The overarching objective is to support successful resettlement and improved behavioral health outcomes for Afghan women and their families in Sacramento. This program will fill the service gap by providing comprehensive mental health and psychosocial supportive services within existing refugee resettlement programs. By using a culturally safe place-based approach the mental health of service users will improve, with flow on impacts to their families and communities.
Goals	The goal is to help support successful resettlement and improved behavioral health outcomes for Afghan women and their families in Sacramento. Improved understanding of mental health (learning to identify and name stressors, understanding the effect of resettlement and trauma, learning what local resources are available): - Increase knowledge and skills to implement health seeking behaviors and coping skills - Reduced stigmatization around mental health and help seeking behavior - Increased ability to identify quality culturally responsive mental health resources - Increase uptake and engagement in mental health supports

	- Improved ability to recover from trauma and stress - Reduced negative impact of trauma and stress in daily life
Anticipated Outcomes	The program will serve 700 individuals, with the benefits flowing out to client households, impacting over 2,000 individuals' total.
Metrics Used to Evaluate the program/activity/initiative	Program documentation such as attendance records, program logs, staff notes, and client case files will provide accurate data on the number, type, frequency and duration of client access and engagement. This data will be collected on an ongoing basis and used to continually improve program implementation.
Name of program/activity/initiative	Sacramento LGBT Center
Description	The goals of this organization will support increased access for LGBTQ+ people to preventive sexual health and mental health support, homeless and at-risk LGBTQ+ youth support services, youth development activities, and cultural competency education.
Goals	To create a region where LGBTQ people can focus on all aspects of their health and well-being. Hundreds of LGBTQ+ youth experiencing homelessness who will have access to food, clothing, survival supplies, showers, transportation, life skills development, mental health respite, crisis intervention, counseling, case management, emergency shelter and transitional housing on a pathway to self-reliance
Anticipated Outcomes	We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories from staff and patients, type of resources provided and other successful linkages.
Metrics Used to Evaluate the program/activity/initiative	The goals of this organization will support increased access for LGBTQ+ people to preventive sexual health and mental health support, homeless and at-risk LGBTQ+ youth support services, youth development activities, and cultural competency education.

Active Living and Healthy Eating

Name of program/activity/initiative	Food Literacy Center Program
Description	To teach elementary children in low-income schools cooking and nutrition to improve our health, environment, and economy.
Goals	To reach 700 elementary students during free 14-week afterschool programs. Provide hands-on cooking & nutrition classes covering topics such as fiber, sugar, and fruit & vegetable appreciation. Improve children's attitude through repeated exposure to new foods through tasting education. Improve children's behavior by repeating skills until they become habits, including sending recipes home to replicate with their families and training them to ask for veggies.
Anticipated Outcomes	Improve children's knowledge toward healthy food to improve their attitude and develop the habit of eating healthy.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children served, active schools, anecdotal stories, and other successful program impacts.
Name of program/activity/initiative	Health Education and Physical Fitness Program for Youth
Description	We will invest in a comprehensive children's wellness program focusing on nutrition, fitness, and mental wellness. The on-site school program, geared toward 5th and 6th grade students, will teach students easy ways

	to incorporate healthy choices into daily living. The curriculum is designed to improve overall health in a fun and meaningful way.
Goals	To teach children and their families healthy lessons about fitness, physical activity, and the importance of nutritious eating.
Anticipated Outcomes	The anticipated outcome of this program is teaching children and their families how to live a healthier and more active lifestyle, creating lifelong habits.
Metrics Used to Evaluate the program/activity/initiative	Number of children/families served, active schools, anecdotal stories and other successful program impacts.

Access to Specialty and Extended Care

Name of program/activity/initiative	SPIRIT
Description	The Sacramento Physicians' Initiative to Reach out, Innovate and 14 Teach (SPIRIT) program recruits and places physician volunteers in community clinics to provide free medical services to our region's uninsured. The SPIRIT program also provides physician volunteers and case management for surgical procedures, including hernia and cataract repair, at local hospitals and ambulatory surgery centers that wish to donate services.
Goals	The overall goal of the project is to provide uninsured patients with outpatient surgeries they otherwise couldn't afford.
Anticipated Outcomes	Patients will live happier, healthier and more productive lives.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, type of surgeries provided, anecdotal stories and other successful linkages.

Name of program/activity/initiative	School-Based Health Clinic
Description	Del Paso Heights has been identified in our Community Health Needs Assessment as one of Sacramento County's most underserved communities. Coupled with high rates of uninsured residents, health and economic disparities, many residents have little access to primary health care and supportive services. Neighborhood Wellness in collaboration with Sacramento Native American Health Clinic created a School-Based Health Clinic (SBHC) at Grant Union High School, the pulse of Del Paso Heights. The School-Based Health Clinic will provide medical, mental/behavioral, dental, and vision care directly at the school where young people spend the majority of their time. SBHC will provide a medical home for students who would not otherwise have access to care. Neighborhood Wellness will provide Pediatric ACEs and Related Life Event Screening, healing circles, provide sustainable outreach combined with clinical, data analysis/assessment, and finance expertise.
Goals	Improved overall mental and physical health of Grant Union High Students that will also have a positive impact on their school attendance, academic engagement and performance, behavior, and opportunities for matriculation beyond high school.
Anticipated Outcomes	Increase utilization of the SBHC for childhood trauma that includes household dysfunction of drug, sexual and physical abuse, abandonment for outside referral with full support from the Foundation. Through

	individual sessions with a Licensed Clinical Social Worker (LCSW); group "teen talk" healing circles guided by Marriage and Family Therapists (MFT), LCSWs and Foundation staff; school public service announcements on mental health and mentorship, will address the challenges of intergenerational trauma, neighborhood violence, gang affiliation, suicidal and violent ideation, depression and overall stress and anxiety.
Metrics Used to Evaluate the program/activity/initiative	Number of youth/students served, number of services and resources provided, anecdotal stories, type of resources provided and other successful linkages.

Healthy Physical Environment

Name of program/activity/initiative	Clean Air Partnership
Description	CAP is a joint project of Breathe California Sacramento Region, the Sacramento Metro Chamber of Commerce, Valley Vision, and others to help the Sacramento region meet clean air standards that protect health, promote economic growth, and support equity.
Goals	CAP provides regional leadership to influence public policy centered on air quality and greenhouse gases. CAP's work centers on programs that help minimize smog-forming emissions from vehicles, which are the dominant source of the capital region's air pollution.
Anticipated Outcomes	Expand and maintain a regional air quality coalition of business, public health, government, transportation, and community leaders focused on reducing air emissions and advancing air quality and health benefits.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of communities served, policies enacted, and reported air quality indicators like AQI, PM 2.5, NO2, and Ozone levels.

Needs Sutter Medical Center, Sacramento Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Medical Center, Sacramento 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:

1. **Injury and Disease Prevention and Management**: While many of our programs expand access to primary care, in turn, connecting patients with disease prevention, management and treatment resources, this is not a primary focus in the SMCS.
2. **Safe and Violence-Free Environment:** SMCS plans to identify partnerships and strengthen relationships with organizations soon to collaborate on initiatives to address safe and violence free environments in Sacramento Counties.
3. **Increased Community Connections:** While many of our programs already increase community connections, SMCS is not specifically investing in programs aimed to do this work.
4. **Access to Functional Needs (transportation and physical mobility):** While many of our programs already provide transportation in expanding access to primary care, SMCS is not specifically investing in programs aimed to do this work.
5. **Access to Dental and Preventive Services:** While many of our programs expand access to primary care, in turn, connecting patients with preventive services, is not a primary focus.

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.