Sutter Health

Sutter Roseville Medical Center

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

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Table of Contents

Introduction

The Implementation Strategy Plan describes how Sutter Roseville Medical Center, 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 Roseville Medical Center 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 1 Medical Plaza Dr, Roseville, CA 95661; and
- In-person at the hospital's Information Desk.

Executive Summary

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

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

The 2022 Community Healthy Needs Assessment conducted by Sutter Roseville Medical Center 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 Roseville Medical Center. 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. Furthermore, 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 33 community health experts, social service providers, and medical personnel. Furthermore, 59 community residents or community service provider organizations participated in 4 focus groups across the service area. Finally, 69 community service providers responded to a Community Service Provider (CSP) survey asking about health need identification and prioritization.

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. Furthermore, 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 SRMC'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 Roseville Medical Center is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

The definition of the community served was the primary service area of SRMC, located in Roseville, California. The service area was defined by 21 ZIP Codes that stretch over Placer, Sacramento, and Sutter Counties. This service area was designated because the majority of patients served by SRMC resided in these ZIP Codes.

Though located in Placer County, the hospital serves a diverse population across both Sacramento and Placer Counties. Situated in Roseville along the I-80 corridor that runs from the San Francisco Bay area to Reno, Nevada and beyond, SRMC sits near the border of these two counties. There were 11 ZIP codes included in the service area in Placer County (one ZIP code is shared with Sutter County) and contain communities such as Granite Bay, Lincoln, Loomis, Penryn, Rocklin, Roseville, and Sheridan. In Sacramento County there were 10 ZIP Codes included in the assessment, and these encompassed communities such as Antelope, Carmichael, Citrus Heights, Folsom, North Highlands, and Orangevale. Collectively, the SRMC service area is home to 725,725 residents.

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[1] 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

[1] McLeod, S. 2020. Maslow's Hierarchy of Needs. Retrieved 31 Jan 2022 from http://www.simplypsychology.org/maslow.html.

security, education, and social support systems, influence individual health as much as health behaviors and access to clinical care.

2. **Access to Mental/Behavior/Substance-Abuse Services** – I 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. **Access to Quality Primary Healthcare 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.

4. **Access and Functional Needs** – Functional needs refers to needs related to 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.

5. **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.

6. **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

7. **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. 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.

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. **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.

10. **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.

11. **Access to Dental Care and Preventative 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 Roseville Medical Center 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 Roseville Medical Center 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/Behavior/Substance-Abuse Services
3. Access to Quality Primary Healthcare Services
4. Access and Functional Needs
5. Injury and Disease Prevention and Management
6. Active Living and Healthy Eating
7. Access to Specialty and Extended Care

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

Name of program/activity/initiative	Meals on Wheels
Description	Food distribution program to deliver meals to vulnerable homebound Placer County seniors (ages 60+).
Goals	Ensure low-income, Placer County seniors are food secure
Anticipated Outcomes	Provide meals to an estimated 445 homebound seniors annually.
Metrics Used to Evaluate the program/activity/initiative	Number of seniors served; number of meals delivered to homebound seniors (5 meals per week per senior)

Access to Mental/Behavior/Substance-Abuse Services

Name of program/activity/initiative	School Wellness Centers
Description	Wellness Centers are on-campus mental health resources and provider sites where students and families can access prevention, early intervention, intensive, and crisis mental health services and referrals. In addition, school staff can access the program for the purposes of training, consultation and increased mental health literacy.
Goals	Increase mental wellness in schools and connect students and families to the appropriate resources for support.
Anticipated Outcomes	Improved mental health outcomes at the individual level, school level and county level.
Metrics Used to Evaluate the program/activity/initiative	• Improved average daily attendance • Increased academic performance • Reduced suspensions and expulsions • Improved student and family mental health • Improved social emotional competence • Reduced student psychiatric hospitalizations and crisis evaluations (5150s) • Increased knowledge among county and community mental health providers of school-based supports • Increased knowledge among school staff of county and community mental health services

Access to Quality Primary Healthcare Services

Name of program/activity/initiative	Care Transitions Team
Description	This team at SRMC will include a transitions nurse (RN) and support staff (LVN) who are employed by an FQHC but work in the hospital. The RN and LVN will work directly with SRMC care coordination staff to discuss medical appointments, specialty referrals, and special needs/timing of appointments, to help underinsured and uninsured patients access the appropriate follow-up care and resources when they leave the hospital. In addition, this team will be complemented by a peer intake staff member who will work in the community to provide patients complex case management once they are discharged. This team will not only make home visits (or for patients experiencing homelessness, visits to the parks/streets) but will also provide medical assessments, transport

	patient's to medical appoints, connect clients with housing and provide other services as needed.
Goals	Our goal will be to support a more successful management of underserved, complex patients post hospital discharge.
Anticipated Outcomes	We expect more patients to receive follow-up care post discharge from SRMC, and less visits to the emergency department because patients will be receiving preventative care in a primary care setting and managing their chronic conditions with appropriate specialty care.
Metrics Used to Evaluate the program/activity/initiative	Number of individuals served, number of follow-up appointments scheduled, percentage of appointments kept, number of subsequent visits to the emergency department, number of referrals to support services such as housing, transportation and insurance enrollment, and anecdotal stories.

Name of program/activity/initiative	Promotora Program
Description	The Promotora program provides culturally sensitive support to Spanish speaking patients in need of health and social services. Case management wraparound services provided by the Promotora often transcend the patient and extend to the entire family to ensure they have necessary resources. This investment provides health care access and services to the Latino community, focusing on serving recent immigrants and monolingual Spanish-speaking families who face greater challenges and barriers to receiving services.
Goals	Our goal is to increase access to primary care, preventative care, and services for the underinsured and uninsured, and ultimately help them establish a medical home.
Anticipated Outcomes	The anticipated outcome of the Promotora is reduced hospital usage, 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	Number of people served, number of resources provided, anecdotal stories, type of resources provided and other successful linkages.

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 SRMC 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	Comprehensive Management Team (CMT)
Description	The WellSpace Health CMT program provides case management services for people who frequent the emergency departments for non-urgent needs. We support this vulnerable population with vital resources such as income (SSI/GA) , primary care, mental and behavioral health services, transportation, substance abuse treatment and other key community resources.
Goals	1. Reduce the frequency of individuals utilizing high cost systems of care 2. Coordinate and link clients to a medical and behavioral health home 3. Provide wraparound case management services to the under-served 4. Educate and assist clients with additional community resources
Anticipated Outcomes	By linking these patients to the appropriate care and wraparound services, we expect to see a drastic improvement to the health and overall quality of life for this often undeserved, patient population.
Metrics Used to Evaluate the program/activity/initiative	Number of clients served; shelter obtained; transitional shelter or permanent housing obtained; basic needs met; enrollment into income assistance; establishment with a PCP or mental health care provider.

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

Name of program/activity/initiative	Interim Care Program
Description	Offered in partnership with a nonprofit homeless shelter, the Placer Interim Care Program (ICP) is a respite-care shelter for homeless patients discharged from the hospital. The ICP wraps people with health and social services, while giving them a place to heal. 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.
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	Number of people served, number of resources provided, hospital usage post program intervention, type of resources provided, and other successful linkages.

Access and Functional Needs

Name of program/activity/initiative	Transportation Program for Seniors
Description	This investment will provide non-emergency medical transportation on an advance reservation, shared-ride basis for eligible residents of Placer County. Because we know scheduling and keeping non-emergency medical appointments is essential to preventative health this program will

	provide transportation to and from medical appointments for Placer County's underserved, vulnerable and elderly population, who are unable to access necessary medical care, due to transportation constraints.
Goals	Our goal is to provide transportation assistance for seniors and disabled individuals to consistently attend their medical appointments.
Anticipated Outcomes	This program will result in thousands of rides to and from medical appointments each year, for people who might not otherwise have the resources to travel to these important appointments.
Metrics Used to Evaluate the program/activity/initiative	Number of people served and number of rides provided.

Injury and Disease Prevention and Management

Name of program/activity/initiative	Pediatric Cancer Navigators
Description	Navigators provide customized supportive services to families as they navigate the complexities of their childhood cancer journey. As appropriate to each family served, these family-centered support services may include: case management, financial assistance, links to community resources, informal emotional support, meal and fuel vouchers, other travel/transportation assistance, peer support, bereavement support, and social support/outings for parents, youth, and siblings. Family Navigators provide on-going support and resources based on each family's unique needs.
Goals	The goal is to help families eliminate stressors and potential barriers so that their attention can be focused on their child.
Anticipated Outcomes	Childhood cancer families will have increased access to high-quality healthcare, social services, financial assistance and other vital resources during this life-threatening crisis.
Metrics Used to Evaluate the program/activity/initiative	Number of families served, resource referrals, services provided, case management outcomes, and anecdotal stories.

Access to Specialty and Extended Care

Name of program/activity/initiative	Maternal-Infant Support
Description	Working with the County Department of Public Health, we a public health nurse (PHN) will work cooperatively with the maternal-infant units at Sutter Roseville Medical Center (SRMC), including Labor and Delivery, Neonatal Intensive Care, Pediatrics and Postpartum. The PHN is on campus 2-3 days per week, attends NICU rounds once a week, and visits all units at least twice a week to retrieve referrals from the unit binders and conference with staff as appropriate. Referrals are sent to all counties represented by patient families. If referred families accept services offered, they will receive community support as they transition home.
Goals	The goal is to improve the health of prenatal and postpartum women and infants born at SRMC through childhood immunization education, outreach and promotion of breastfeeding, and improving family transition to home by connecting families to community resources and services.

Anticipated Outcomes	We will provide at-risk families who are pregnant, postpartum, or have high risk infants with outreach to help them transition at discharge to a supporting community.
Metrics Used to Evaluate the program/activity/initiative	Number of families served, resource referrals, services provided, case management outcomes, and anecdotal stories.

Active Living and Healthy Eating

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.

Safe and Violence Free Environment

Name of program/activity/initiative	ACES Education, Prevention and Treatment Coalition
Description	The Sierra Community Medical Foundation (SCMF) will offer free education and prevention workshops, offer initial evaluations, assessments and referrals for treatment. Additionally, SCMF will offer medical education, behavioral health services, housing, basic life skills, referrals for housing, employment and training and educational aide. Mental health first aiders and navigators will be utilized to ensure coordination of screening, treatment, aftercare/follow up for additional necessities. Behavioral services will be used to include training to learn about (ACEs), toxic stress, increased confusion of life, divorce, hyperactivity, mental health screening, risk assessment, and evidence-based care to effectively intervene on toxic stress.
Goals	Develop a coalition for the community supported the education, training, business development and community agencies being better prepared to address ACE's. Secondly, ACE coalition supported agencies to utilize referral providers to assist in serving their clients with other service needs such as housing and job placement, physician encounters
Anticipated Outcomes	Improved collaboration so that hospitals, public, private and community agencies are all working together to increase education and awareness around ACEs as well as a more coordinated response.
Metrics Used to Evaluate the program/activity/initiative	Number of children/families served; number of individuals served; number and type of referrals made to medical and/or social supports.

Needs Sutter Roseville Medical Center Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Roseville Medical Center 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. **Increased Community Connections** – Given limited time and resources and our focus on other priority needs, we will not be addressing increased community connections during this implementation cycle.
2. **Healthy Physical Environment** – Given limited time and resources and our focus on other priority needs, we will not be addressing healthy physical environment during this implementation cycle.
3. **Access to Dental Care and Preventative Services** – We do not currently have plans to implement dental programs however we will be supporting other partnerships, especially those for individuals experiencing homelessness, where they will offer referrals to dental.

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.