Sutter Health

Sutter Solano Medical Center

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

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FACILITY LICENSE #110000082
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Introduction

The Implementation Strategy Plan describes how Sutter Solano Medical Center (SSMC), 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 Solano 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 300 Hospital Dr, Vallejo, CA 94589; and
- In-person at the hospital's Information Desk.

Executive Summary

Sutter Solano Medical Center 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 Solano 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/Behavioral Health and Substance-Use Services
3. Injury and Disease Prevention and Management
4. Access to Quality Primary Care Health Services
5. Access to Functional Needs
6. Access to Specialty and Extended Care
7. Increased Community Connections
8. Active Living and Healthy Eating
9. Safe and Violence-Free Environment
10. Healthy Physical Environment

The 2022 Community Healthy Needs Assessment conducted by Sutter Solano 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 Solano 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. 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 17 community health

experts, social-service providers, and medical personnel. Further, 16 community residents participated in three 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 12 potential health needs (PHNs). These PHNs were 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 12 PHNs identified in previous CHNAs.

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

Definition of the Community Served by the Hospital

The definition of the community served included the primary service area of the hospital, the City of Vallejo, California, and surrounding communities as defined by six ZIP Codes—94503, 94510, 94589, 94590, 94591, and 94592. This is the designated service area because the majority of patients served by SSMC resided in these ZIP Codes. Considered a North San Francisco Bay community, Vallejo is an incorporated city in Solano County. The service area included one ZIP Code, 94503 (American Canyon), located in Napa County. The total population of the service area was 173,55.

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 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.

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 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.

4. **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.

5. **Access and Functional Needs** – 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.

6. **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.

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 to foster a healthy community.

8. **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.

9. **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. 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. **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 Solano 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 Solano 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/Behavioral Health and Substance-Use Services
3. Injury and Disease Prevention and Management
4. Access to Quality Primary Care Health Services
5. Active Living and Healthy Eating
6. Safe and Violence-Free Environment

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

Name of program/activity/initiative	On the Move
Description	VOICES, the largest of initiative of On the Move, has worked for over 15 years to empower underserved, system-involved youth, ages 16-24, by utilizing holistic services and building a loving community and establishing a solid foundation for a healthy future. At the core of VOICES are youth-led programs designed to address the independent living, housing, education, employment, and wellness needs of transition-age youth. VOICES' one-of-a-kind Youth Engagement Model focuses on empowering each youth, integrating resources and services, and working with the entire community to address the barriers that youth face as they leave systems of care.
Goals	Provide outreach and navigation services to 350 transition-age youth in Solano County who are homeless or at high risk of homelessness to: identify needs, develop relationships, provide referrals to needed services and connect them to the VOICES Center as a safe and stable place for them to access additional resources.
Anticipated Outcomes	• 350 youth will develop trusting relationship with VOICES Youth Advocates and be connected to VOICES services. • 85% of youth reached through street-based outreach efforts will engage in VOICES services.

Metrics Used to Evaluate the program/activity/initiative	To assess program and participant success, VOICES has implemented AirTable, a web-based automated data information and evaluation system to track and monitor the participant's required data elements including educational achievement, employment, wages, permanency, housing and health services. AirTable tracks program effectiveness through a combination of quantitative and qualitative data measurements including individual assessments, dose and intensity of services utilized, youth feedback and outcomes achieved. Monthly, VOICES staff perform a "data audit" which ensures that all applicable information is being collected and utilized in program evaluation. Ultimately, the data collected allows VOICES to ascertain the impact of staff and programs on participants both individually and collectively.

Name of program/activity/initiative	4th Second UpHousing
Description	4th Second's UpHousing Project seeks to develop the steps that support the climb up the ladder of housing stability. An emergency effort was catalyzed in direct response to people being displaced from Vallejo's Project Roomkey. Hope Village, a planned low barrier safe camping site, was developed to offer an emergency shelter option while supporting a pathway towards stable housing. However, circumstances changed and the City of Vallejo instead offered additional funding to support alternative shelter options. Therefore, this emergency phase of the UpHousing Project evolved into a low barrier Transitional Housing Program at hotels and studio apartments, coupled with providing upgraded shelter and health and safety services at existing camping sites. Whether from tents, hotel rooms or studio apartments, 4th Second and its coalition of partners provide wrap-around services to promote health and safety while working to transition individuals into permanent and stable housing.
Goals	Support a dedicated housing navigator specifically focused on moving people into stable housing. Support basic needs and housing gap costs to promote health and safety and support the successful transition of participants to stable housing.
Anticipated Outcomes	At least three Uphousing participants will be successfully placed in stable housing per month.
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.

Name of program/activity/initiative	Community Health Workers
Description	The Community Health Worker Program expands health navigation services in Solano 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.

Access to Mental/Behavioral 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. This is why 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 and telepsych options to the underserved. In addition, we will identify opportunities to build and foster mental health programs and resources locally in the SRMC 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 have the ability to 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.

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 SSMC 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.

Injury and Disease Prevention Management

Name of program/activity/initiative	Mobile Diabetes Education Center
Description	The Mobile Diabetes Education Center will deliver care to the most vulnerable residents of Solano County and provide direct diabetes prevention programs and diabetes education services. The mobile diabetes clinic will provide not only diabetes screening for members of

	the community who may not otherwise have adequate access to healthcare but also education to the public about their risk factors, thus aiming to prevent diabetes and prediabetes in their lives.
Goals	Delivering primary health services to the underserved and connecting them to resources for ongoing care, as well as providing diabetes testing and education.
Anticipated Outcomes	The anticipated outcome of the mobile clinic is that hundreds of underserved individuals will have access to diabetes education and resources, helping them identify, manage, and treat their diabetes.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of services/resources provided, anecdotal stories from staff and patients, type of services/resources provided and other successful linkages.

Name of program/activity/initiative	Pharmacist-Led Post Hospitalization Surveillance Initiative
Description	To provide pharmacist-led chronic disease and medication management services through home and telehealth visits. Getting to know individual patients, who have socioeconomically disadvantage backgrounds behind their diagnoses to enhance the personalized healthcare delivery approaches for chronic disease management.
Goals	Delivering primary health services to the underserved and connecting them to resources for ongoing care, as well as providing diabetes testing and education.
Anticipated Outcomes	The anticipated outcome is to drive behavioral changes in support of chronic disease management through strengthening knowledge foundation on chronic conditions and medications, improve clinical management of the identified chronic medical conditions and enhance self-efficacy in chronic disease management.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of services/resources provided, anecdotal stories from staff and patients, type of services/resources provided and other successful linkages.

Access to Quality Primary Care Health Services

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 determines the type of resources and support this patient needs. Upon assessment, the ED Navigator 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 community programs 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. SSMC 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 and other successful linkages.
Name of program/activity/initiative	Triage, Treatment, and Transport Plus (T3+)
Description	T3+ patients are identified in an inpatient setting and are often battle complex health and social issues. 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 in Solano County. SSMC is currently implementing this best practice and once implemented will evaluate the impact 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	Shelter Solano, INC
Description	Shelter Solano provides a place to discharge and connect homeless patients, who are traditionally underserved residents, with resources and support. SSMC, along with other local health providers, provide this program to some of Solano County's most vulnerable residents. This program links homeless adults to vital community services while giving them a place to heal, as well as medical follow up and case management.
Goals	The program seeks to connect patients with a medical home, social support, and housing.
Anticipated Outcomes	The anticipated outcome is to help people improve their overall health by wrapping them with services and treating the whole person through linkage to appropriate health care.
Metrics Used to Evaluate the program/activity/initiative	SSMC will continue to evaluate the impact of the respite program 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.

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 elementary 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.

Name of program/activity/initiative	Shoes for Seniors
Description	Fit Seniors with a Pair of Walking Shoes to encourage them to stay active. The Florence Douglas Center in partnership with Solano County District 1 Supervisor Erin Hannigan will reach out to seniors in the area to fit them with a pair of walking shoes with the grant money supplied.
Goals	Shoes for Seniors Program encourages Citizens 50+ to Walk to for fitness and to stay active. Upon registration for a pair of shoes the participants complete a registration form with their contact information, age group and how often one is walking 30 minutes a day now and set a walking goal.
Anticipated Outcomes	Hold Shoe Fit Events at the Florence Douglas Center or Senior Living Communities in Vallejo and fitting 225 Seniors with Shoes during the grant period.
Metrics Used to Evaluate the program/activity/initiative	Number of seniors served, and shoe walking events held.

Safe and Violence-Free Environment

Name of program/activity/initiative	Advance Peace Vallejo
Description	Advance Peace (AP) interrupts cyclical and retaliatory gun violence in urban neighborhoods by providing transformational opportunities to individuals at the center of firearm hostilities. Through its Peacemaker Fellowship® strategy (an evidence-based gun violence prevention model), AP provides developmental and healing centered services, supports and opportunities to those suspected to be actively involved in recurrent firearm activity.
Goals	Increased Community safety and reduction of gun violence in Vallejo; Fellow participants have improved ability to seek life-affirming experiences and opportunities that increases personal health and wellbeing; Increased network of public and community-based social, health, and economic services network with requisite capacity and

	competency to support and deliver optimal outcomes with fellowship population in Vallejo.
Anticipated Outcomes	Advance Peace Vallejo will serve up to 70 Peacemaker Fellows over the initial 3-year period of strategy implementation. A minimum of 210 individual community members will be engaged through this process.
Metrics Used to Evaluate the program/activity/initiative	The University of California at Berkeley, Center for Global Healthy Communities serves as the independent evaluator of the local strategy, capturing and analyzing data points, measuring individual and communal impacts. The UCB learning & evaluation team provides a variety of data collection and analysis tools (including a mobile App) that support local staff and Fellows in capturing program inputs, including engagement logs, pre-post program surveys, staff and facilitator logs, community surveys.

Needs Sutter Solano Medical Center Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Solano 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. **Access to Functional Needs:** While many of our programs already increase access to functional needs, SSMC is not specifically investing in programs aimed to do this work.
2. **Access to Specialty and Extended Care:** While many of our programs already increase access to specialty and extended care, SSMC is not specifically investing in programs aimed to do this work.
3. **Increased Community Connections:** While there are currently no increasing community connection SSMC community benefit programs in the SSMC HSA, we do fund programs/organizations and efforts that address this need through our sponsorship program.
4. **Healthy Physical Environment:** While this is an important issue, this is not something that we are able to greatly affect through community benefit; therefore, we are focusing our resources elsewhere, especially given that regional community partners and local jurisdictions are working on these vital issues.

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.