

Sutter Health

Sutter Tracy Community Hospital

2019 – 2021 Community Benefit Plan

Responding to the 2019 Community Health Needs Assessment

Submitted to the Office of Statewide Health Planning and Development May 2022

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Note: This community benefit plan is based on the hospital’s implementation strategy, which is written in accordance with Internal Revenue Service regulations pursuant to the Patient Protection and Affordable Care Act of 2010. This document format has been approved by OSHPD to satisfy the community benefit plan requirements for not-for-profit hospitals under California SB 697.

Introduction

The Implementation Strategy Plan describes how Sutter Tracy Community Hospital, a Sutter Health affiliate, plans to address significant health needs identified in the 2019 Community Health Needs Assessment (CHNA). The document describes how the hospital plans to address identified needs in calendar (tax) years 2019 through 2021.

The 2019 CHNA and the 2019 - 2021 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 Tracy Community Hospital welcomes comments from the public on the 2019 Community Health Needs Assessment and 2019 - 2021 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 Sutter Tracy Community Hospital, ATTN: Brooke Galas, 1420 N. Tracy Boulevard, Tracy, CA 95376; and
- In-person at the hospital's Information Desk.

About Sutter Health

Sutter Health is the 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.

Through the Sutter Tracy Community Hospital 2019 Community Health Needs Assessment process the following significant community health needs were identified:

1. Mental Health
2. Economic Security
3. Obesity/Healthy Eating, Active Living/Diabetes
4. Violence/Injury Prevention
5. Access to Care
6. Substance Abuse/Tobacco
7. Asthma
8. Oral Health
9. Climate and Health

The 2019 Community Healthy Needs Assessment conducted by Sutter Tracy Community Hospital is publicly available at www.sutterhealth.org.

2019 Community Health Needs Assessment Summary

The Sutter Tracy Community Hospital 2019 Community Health Needs Assessment (CHNA) presents a comprehensive picture of community health that encompasses the conditions that impact health in San Joaquin County. The overall goal of the CHNA is to inform and engage local decision-makers, key stakeholders, and the community-at-large in efforts to improve the health and well-being of all San Joaquin County residents. From data collection and analysis to the identification of prioritized needs, the development of the 2019 CHNA report has been an inclusive and comprehensive process guided by a Core Team planning group and broadly representative Steering Committee, with input from hundreds of community residents. This collaborative effort stems from a desire to address local needs and a dedication to improving the health of everyone in the community.

Conducting a CHNA every three years has been a California requirement for nonprofit hospitals for more than 20 years and is now a national requirement as well as a requirement for Public Health Accreditation. San Joaquin County's CHNA is unique in that all of its non-profit hospitals, the local health department and key stakeholders join together to support one countywide assessment. The process in 2019 included interviews with 11 key informants, 31 focus group discussions with 349 diverse community residents, and data analysis of over 120 indicators, creating a robust picture of the issues affecting people's health where they live, work, and play.

The 2019 CHNA process applied a social determinants of health framework and examined San Joaquin County's social, environmental, and economic conditions that impact health in addition to exploring factors related to diseases, clinical care, and physical health. Analysis of this broad range of contributing factors resulted in identification of the top health needs for the county. The CHNA report places particular emphasis on the health issues and contributing factors that impact vulnerable populations that disproportionately have poorer health outcomes across multiple health needs. It explored disparities for

populations residing in specific geographic areas referred to as “Priority Neighborhoods”, as well as disparities among the county’s diverse ethnic populations. These analyses will inform intervention strategies to promote health equity. Through a comprehensive process combining findings from demographic and health data as well as community leader and resident input, nine health needs were identified.

The full 2019 Community Health Needs Assessment conducted by Sutter Tracy Community Hospital is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

San Joaquin County is one of California’s fastest growing counties, it includes seven cities, many small towns, and a number of rural farm and ranching communities. The county residents are diverse, including Latino, African American, Caucasian, and Asian/Pacific Islander populations.

Each hospital participating in the San Joaquin County CHNA defines its hospital service area to include all individuals residing within a defined geographic area surrounding the hospital. For this joint CHNA, the hospital partners chose San Joaquin County as the primary service area for their hospitals. The table below shows the key demographics for this service area:

Race/ethnicity		Socioeconomic Data	
Total Population	745,424	Living in poverty (<100% federal poverty level)	17.8%
Asian	16.7%	Children in poverty	24.9%
Black	8.2%	Unemployment	11.7%
Hispanic/Latino	41.6%	Uninsured population	11.7%
Native American/Alaska Native	2.0%	Adults with no high school diploma	22.0%
Pacific Islander/Native Hawaiian	0.8%		
Multiple races	5.3%		
White	31.8%		

Source: US Census, 2017

Significant Health Needs Identified in the 2019 CHNA

The following significant health needs were identified in the 2019 CHNA, listed in order of highest priority to lowest:

1. **Mental Health** – Maintaining mental health is as important as physical health and is essential to one’s well-being. Access to mental health care services can equip people with the necessary skills to cope with and move on from daily stressors and life’s difficulties, allowing for improved personal wellness, meaningful social relationships, and contributions to communities or society. Deaths by suicide, drug overdose and alcohol poisoning combined are higher in San Joaquin County when compared to the state average. Primary data indicates there is a perception of limited access to providers and culturally competent services. Poor mental health was also linked to stigma, low incomes, substance abuse, and homelessness.
2. **Economic Security** – Economic security contributes to good health. It facilitates access to healthcare services, healthy eating, and other factors that play a role in overall wellbeing. San Joaquin County benchmarks poorly compared to the state on many economic security indicators and there are a significant number of ethnic/racial disparities within the county. Black and Latino populations are among those most impacted by poverty. Unemployment is also higher in the County relative to the state. Homelessness and housing instability, lack of employment, poor recovery post-recession, transportation access and substance abuse are connected with economic security and were mentioned as important issues by key informants and in the focus groups.

3. **Obesity/Healthy Eating, Active Living/Diabetes** – A lifestyle that includes eating healthy and physical activity improves overall health, mental health, and cardiovascular health, thus reducing costly and life-threatening health outcomes such as obesity and diabetes. Obesity rates and diabetes prevalence were higher in San Joaquin County as compared to the state. Physical inactivity is higher among youth and adults in San Joaquin County compared to the state, and disparities are higher for Latino and Black youth in particular. Poverty, lack of access to healthy food and safe places for physical activity, and easy access to unhealthy foods were frequently mentioned as barriers in primary data and confirmed by secondary data.
4. **Violence/Injury Prevention** – Safe communities contribute to overall health and well-being. Safe communities promote community cohesion and economic development, and provide more opportunities to be active and improve mental health while reducing untimely deaths and serious injuries. Non-Hispanic Whites and Blacks are disproportionately impacted by motor vehicle crash deaths. Injury deaths and violent crime rates are both higher in San Joaquin County compared to the state. Key informants and focus group participants linked violence and injury prevention to poor lighting, loose dogs, traffic and drug use. Poverty and the economy's impact on jobs were mentioned in primary data as well.
5. **Access to Care** – Access to high quality, culturally competent, affordable healthcare and health services is essential to the prevention and treatment of morbidity and increases the quality of life, especially for the most vulnerable. In San Joaquin County, residents are more likely to be enrolled in Medicaid or other public insurance, which is a factor related to overall poverty. Latinos are most likely to be uninsured. Secondary data revealed that poor access to affordable health insurance and the lack of high-quality providers, including urgent care and mental health, impact access to care. Language and cultural barriers, including poor language access, were also discussed by key informants and in the focus groups.
6. **Substance Abuse/Tobacco** – Reducing and treating substance abuse (including alcohol, opioids, marijuana, methamphetamines and tobacco) improves the quality of life for individuals and their communities. Tobacco use is the most preventable cause of death, with second hand smoke exposure putting people around smokers at risk for the same respiratory diseases as smokers. Substance abuse is linked with community violence, sexually transmitted infections, and teen pregnancies. Impaired driving deaths are higher in San Joaquin County than the state. Marijuana, methamphetamine, tobacco and alcohol use were frequently mentioned in primary data, as was the intersection of substance abuse, homelessness and poverty, and mental illness. Although opioids were not mentioned specifically in primary data, key informants discussed challenges associated with drug use in general.
7. **Asthma** – Prevention and management of asthma by reducing exposures to triggers such as tobacco smoke and poor air quality, improves quality of life and productivity as well as reduces the cost of care. Asthma prevalence and the asthma hospitalization rate are greater in San Joaquin County than in the state. Focus group participants discussed allergies, unsafe air from farming, and bad smelling air as factors impacting this health need.
8. **Oral Health** – Tooth and gum diseases are associated with poverty, an unhealthy diet that includes excessive sugar consumption, and oral tobacco use, and can lead to multiple health problems. Access to oral health services is a challenge for many vulnerable populations as it can be difficult to find affordable, convenient, and culturally/linguistically appropriate dental care. San Joaquin County performs similarly to the rest of California when it comes to oral health outcomes. Insufficient insurance coverage and high out of pocket costs, as well as a lack of high quality dental care providers, were mentioned as key concerns by key informants and focus groups.
9. **Climate and Health** – Climate change poses a threat for the health and well-being of current and future generations. Climate change has been linked to vector-borne disease, health related issues, and respiratory diseases. Clean air and water are necessary for health, but rapid climate change contributes to increased drought and poor air quality. Unsafe drinking water and poor air

quality were mentioned in focus groups. Traffic pollution and farming are factors that contribute to this health need.

For the purposes of the CHNA, health needs are defined as including requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities). Requisites may include addressing financial and other barriers to care as well as preventing illness, ensuring adequate nutrition, or addressing social, behavioral, and environmental factors that influence health in the community. Health needs were identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data. The following criteria were used:

- It fits the definition of a “health need” as described above.
- It was confirmed by multiple data sources (i.e., identified in both secondary and primary data).
- Indicator(s) related to the health need performed poorly against a defined benchmark (e.g., state average).
- It was chosen as a community priority. Prioritization was based on the frequency with which key informants and focus groups mentioned the need. The final list included only those that at least three key informants and focus groups identified as a need.

The following methods were used:

- A health needs identification table was developed which included all core and related indicators that benchmarked poorly to the state. Race and ethnicity data were reviewed (when available) to identify all indicators for which disparities existed. The number of groups experiencing disparities for a given indicator was noted and addressed during prioritization. Primary data were reviewed and health needs that were not mentioned by 3 or more key informants/focus groups during primary data collection were not included as a health need.
- While Indicators for HIV/AIDS/STDs, Maternal and Infant Health, CVD/Stroke, and Cancers had at least one indicator that performed poorly against the state average, they were not included as health needs for the 2019 CHNA because they were not mentioned with frequency in the primary data collection.

The following process was conducted to rank the health needs into highest, medium and lower priority:

- Older Adult Survey: A brief survey was developed specifically for older adults who are congregate senior meal program and food pantry clients.
- Tracy Ranking Meeting: A 90-minute meeting was held with community residents of Tracy, the 22 participants were recruited by the Tracy Family Resource Center, which hosted the meeting.
- CHNA Steering Committee Ranking Meeting: This two-hour meeting was attended by 48 Steering Committee members.
- Multi-voting Process: In Tracy and for the Steering Committee, a multi-voting method was used to prioritize the nine identified health needs as highest, medium or lower priority. Participants considered the prioritization matrix and criteria in making their decisions.

Participants took part in two rounds of voting to prioritize the nine health needs. For the first round, participants voted for their top three priority health needs. The three needs that received the most votes were identified as highest priority. The same voting process was used for round two: participants voted for their top three priorities among the remaining six health needs. The three that received the most votes

were identified as medium priority health needs. The remaining needs were identified as lower priority health needs.

2019 – 2021 Implementation Strategy Plan

The implementation strategy plan describes how Sutter Tracy Community Hospital plans to address significant health needs identified in the 2019 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 2019 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 Tracy Community Hospital initiatives that may not be described herein, but which together advance the hospital's commitment to improving the health of the communities it serves. Each year, programs are evaluated for effectiveness, the need for continuation, discontinuation, or the need for enhancement. Depending on these variables, programs may change to continue focus on the health needs listed below.

1. Mental Health
2. Economic Security
3. Obesity/Healthy Eating, Active Living/Diabetes
4. Access to Care
5. Violence/Injury Prevention

Mental Health

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 tele psych options to the underserved.
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.
Outcomes	<p>In 2021, the mental health strategy helped with the following initiatives:</p> <ul style="list-style-type: none"> • Launch the 988 crisis line going live on July 26, 2022 • Pass SB803 for peer certification. • Secure funding for SB71/Bring CA Home in amount of \$2 billion over two years and an unspecified amount future funding. • Advocate for funding for board and care with the County Behavioral Health Directors Association and other organizations serving people living with severe mental illness and/or substance use disorder. Resulting in securing \$803 million, with program details still to be fleshed out. • Propose Children and Youth Initiative and assist Secretary Ghaly to develop what became one of the Governor's signature budget achievements: \$4.5 billion over five years to meet the behavioral health needs of children.
Name of program/activity/initiative	Family Wellness Prevention and Early Intervention Program – Catholic Charities
Description	The PEI Family Wellness Program Provides short-term counseling to individuals who are low income or who are under-served by offering multi-lingual culturally appropriate counseling services in San Joaquin and Stanislaus Counties. The target populations for these services are adults and teens who are at risk of mental health services and LatinX populations experiencing mild to moderate depression, anxiety, grief, and other mental health disorders. Services are available to all individuals regardless of race, age, gender, religion, ethnicity, economic status, or sexual orientation. The program also provides community workshops and presentations in Spanish and English through partnership with businesses, churches, non-profit organizations, schools and other organizations. Topics focus on mental health awareness, prevention & early intervention, stigma reduction, access to resources, and suicide prevention.
Goals	The PEI Family Wellness Program will provide brief individual counseling sessions and mental health presentations and workshops in an effort to improve mental health outcomes in San Joaquin County (Stockton, Manteca, Tracy, and Ripon) and Stanislaus County (Modesto). A target of 100 unduplicated individuals will receive counseling sessions resulting in a minimum of 480-720 hours of counseling. Our overall goal is to provide accessible brief counseling sessions through multiple delivery locations, ensure all individuals served have a treatment plan, and

	receive 6-12 counseling sessions or case management services as appropriate.
Outcomes	<ul style="list-style-type: none"> Jan-June 2021: Served 61 individuals; 334 counseling sessions; 23 referrals to other services.

Economic Security

Name of program/activity/initiative	McHenry House
Description	<p>The McHenry House Family Crisis Intervention Program supports families experiencing homelessness through:</p> <ul style="list-style-type: none"> Steady full-time employment; a client needs to actively seek and secure employment within 2 weeks of entering McHenry House (if they are not employed at the time of admittance). Save 90% of their income to cover the 1st months' rent and deposit. Children must be enrolled in school within 3 days of entering McHenry House, with mandatory attendance of the nightly Homework Club to learn. Due to the COVID-19 pandemic we were forced to do distant learning and still help the children residents of the shelter. Mandatory attendance twice a month of a 2-hour counseling session that addresses: stress management, substance abuse issues, parenting and coping skills, contributing to becoming self-sufficient and to the success of their children in school. The counselor was available by phone to the adult clients due to the COVID-19 pandemic. We are hoping that in the near future to go back to the in person sessions. Adult clients are drug tested as they move in and randomly as needed, if the test is positive the adults will be required to attend NA/AA three times a week and bring proof of attendance.
Goals	<p>Funds for the operation of the shelter and to continue providing free service to the homeless families we serve.</p> <ul style="list-style-type: none"> To continue with the Homework Club that promotes education, improving grades and school attendance for children ages 3-17 years old. To maintain and continue to offer the Counseling sessions on: parenting issues, stress management and substance abuse, as well as offering the Nutrition Workshop, that teaches the families how to eat healthy in order to prevent Heart Disease, Obesity & Diabetes.
Outcomes	<ul style="list-style-type: none"> Jan-June 2021: Served 85 families, 11,889 services provided including 2,969 bed nights. McHenry House Tracy Family Shelter offered an opportunity to families to have a safe place to live while they turned their situation around by securing employment, saving their money and finding a place of their own to live. McHenry House can provide shelter for 6 families daily for a period of 8-10 weeks. On average, this means that we can house approximately 45-50 families per year, depending on how long a family stays.
Name of program/activity/initiative	HOPE Family Ministries

Description	Program that will equip families in all areas of life; helping to minimize the trauma of being dislocated while strengthening and empowering them to become occupationally and residentially independent.
Goals	To serve at least 250 individuals including adult and children in finding permanent housing and provide job skills and preparation so that our families will learn to become residentially and occupationally independent of our help.
Outcomes	<ul style="list-style-type: none"> Jan-June 2021: Served 152 individuals including 37 families, 165,381 services provided; 877 service referrals.
Name of program/activity/initiative	Recuperative Care – Gospel Center Rescue Mission
Description	Gospel Center Rescue Mission (GCRM) Recuperative Care program offers a 24/7 shelter for people in need of recuperation from acute (short term) or exacerbation of a chronic illness. Services provided are non-medical care at a level that would be expected from a competent family member. Average Length of stay is 30 days.
Goals	During stay, guiding individuals towards lifestyle change for the better of their existing health conditions. Encouraging interaction with campus New Life Program Students for possibility of transition to life change upon Recuperative Care discharge if they meet qualifications. Helping client apply for and acquire Social Service documents such as: ID, SS Card, Birth Certificate, General Assistance, Social Security, Food Stamps, etc..... If applicable, assist with submitting documentation necessary to acquire stable housing, Board & Care, Assisted Living, etc...
Outcomes	This program was only supported in 2021. During the first half of 2021, it was our goal to reach a minimum of 125 individuals and help them with resources that would help them become residentially and occupationally independent; we reached 152 individuals surpassing our goal. We have helped to refer many more individuals to mental health care than any year before and are proud that we are able to assist our families with this support so successfully. Lastly we have found permanent housing for 42% of the individuals who we served.
Name of program/activity/initiative	Modified Recuperative Care and Emergency Shelter – Tracy Community Connections Center
Description	Tracy CCC's Modified Recuperative Care & Emergency Shelter Program provides case management and temporary, motel-based shelter to persons experiencing homelessness who are in need of a place to recover after being discharged from our local Sutter Hospital as well as temporary, motel-based emergency shelter for persons either experiencing homelessness or who are at risk of homelessness to better connect them with shelter, housing and supportive services. Sutter also provides support for our shower and laundry programs and for operations and outreach.
Goals	<p>To provide:</p> <ul style="list-style-type: none"> Provide case management by 3 case managers, Monday-Friday, 8:00am-4:30pm Recuperative Care 24 hours, seven days a week Showers and hygiene supplies with our mobile shower unit twice per week, Mondays at and Thursdays at New Heart Church Laundry services to the homeless at a local laundromat manned by volunteers. Emergency shelter, food, clothing and hygiene supplies to homeless individuals being discharged from the hospital.

	<ul style="list-style-type: none"> Housing solutions, emergency shelter, outreach supplies (via Operation Helping Hands), food, client assistance, transportation and automobile repair for homeless individuals in the community
Outcomes	<ul style="list-style-type: none"> Jan-June 2021: Served 276 individuals, 1,581 services provided, 1,448 service referrals. TCCC has showers and laundry services available to the homeless twice a week, as well as Community Medical Center, coming out to our Mobile Showers on Mondays to provide flu shots, and address other medical concerns for the homeless individuals. This has been exceedingly successful. The new temporary location for our shower program is central to other essential services that provide basic needs like public transportation, food, and it is in the vicinity of one of the larger homeless encampments in Tracy, making it easy for the homeless to get to TCCC.

Obesity/Healthy Eating, Active Living/Diabetes

Name of program/activity/initiative	Boys & Girls Club's Health, Well-Being, and Inclusion Program
Description	Triple Play is a program that addresses the health, wellness and fitness needs of the youth in the Boys & Girls Clubs community including youth with disabilities. Youth receive regular physical activity, access to fresh fruits/vegetables and daily healthy meals.
Goals	Program Goals (1): In 12 months 80% (112/140) of participants will engage in physical activity FIVE days a week with CDC goal of 60 minutes of activity per day. (2): In 12 months 80% (12/15) of regular attending Inclusion youth will engage in physical activity for 3 days per week. (3): In 12 months 80% (112/140) of participants will have access to clean water and 3 or more fruits and vegetables per day.
Outcomes	<ul style="list-style-type: none"> Jan-June 2021 – Served 140 children and youth; 1,000 services to connect them to basic needs; "During Zoom, members became aware that other members were eating healthy snacks and due to positive dialogue of the benefits of eating healthy foods and encouraging members to be their best selves, all members on the chat Intentionally began to eat healthy snacks". -Lisa Frymyer, Central Unit Director Member's endurance during Triple Play improved. One member became very proud that he could complete the work-out after a couple of weeks. He said "wow I worked out the entire time without stopping".-Central Member
Name of program/activity/initiative	Tracy Family Resource Center
Description	<ul style="list-style-type: none"> The Tracy Family Resource Center (TFRC) helps families build protective factors including child development knowledge, parent/youth resilience, and access to concrete supports primarily through parent skill building, resource referral, and working with other organizations to improve service access. The TFRC focuses its work around five categories of service: outreach, healthcare, parenting classes and resources, counseling, and housing safety and security.
Goals	<ul style="list-style-type: none"> The mission of the Community Partnership for Families of San Joaquin (CPFSJ) is to provide tools, resources, and connections to help families improve their quality of life. CPFSJ's TFRC works

	<p>with the public and private sector to help families achieve the following goals:</p> <ol style="list-style-type: none"> 1. Engage parents, youth, and appropriate service provider(s) in a multi-disciplinary step-by-step approach to untangling interrelated crises and risks, while also building protective factors that help prevent future crises. 2. Involve families and youth in building nurturing and thriving neighborhoods and communities 3. Connect low-income and under-served families with community resources that help prevent crisis.
Outcomes	<ul style="list-style-type: none"> • Jan-June 2021: 1,032 individuals served; 275 services provided; 862 service referrals; 95,835 pounds of food distributed.

Access to Care

Name of program/activity/initiative	Community Medical Centers Care Link Program
Description	Care Link will improve access to healthcare for homeless patients during the grant period by providing no-cost medical care, and follow-up appointments to medical, dental and other services at CMC clinic sites.
Goals	<p>Provide medical care to homeless individuals through the Care Link program, including providing follow-up medical, dental, behavioral health and case management services. Increase the number of uninsured patients linked to Medi-Cal eligibility and enrollment assistance.</p> <p>Provide case management to at least 50 individuals, making referrals and connections for enabling services.</p>
Outcomes	<ul style="list-style-type: none"> • 2021: 605 total outreaches; 2,637 total encounters including nearly 1,000 COVID tests. Total of 308 new patients reached who had never been seen at a CMC clinic.
Name of program/activity/initiative	Catholic Charities Homecoming Program
Description	Homecoming Program, is a transitional care program that bridges the gap between a hospital discharge and a strong recovery. The program assists at-risk patients to return home with increased stability through services that include follow-up care with primary physicians and case management.
Goals	Actively provide care management and services to patients discharged from the hospital as they return home to help stabilize and achieve optimal recovery.
Outcomes	<ul style="list-style-type: none"> • Jan-June 2021: 17 individuals served including 37 services provided; 91 referrals to other services. • Transitional Care Specialist received a referral from a social worker at Sutter Tracy Community Hospital. The patient lives with her sister but the family reported that they were overwhelmed with the new healthcare diagnosis. A phone call was placed to the patient's sister to inform her of the program services available to assist. Both the patient and his sister were agreeable to the services. According to the client "it was the help that we were looking for". Transitional Care Specialist conducted the initial phone screening interview and completed the program intake form to determine the needs associated with this case. A referral was placed to All Ways Caring for the patient to receive four weeks of homemaking services. This service assist clients at home with light housekeeping, laundry, transportation and

meal prepping. All Ways Caring also provides assistance for the family, such as respite care. The client was also referred to the Linkages program and submitted to the San Joaquin County Human Services Agency for the patient to receive long-term case management and assistance with resources needed. Referral to IHSS was completed and submitted for the patient to receive long-term caregiving services through the San Joaquin County Human Services Agency. An E-mail was submitted to MedData to follow up on patient's Medi-Cal transfer out of county status. A new Medi-Cal application was submitted and the patient was able to obtain local Medi-Cal benefits. By providing the client these services, we were able to improve his health and well-being. The client has avoided any new readmissions and is appreciative of services provided by the Homecoming Program.

- The Homecoming Project received a referral for an 88 year old female with a history of chest pains. Patient lives alone and lacked transportation and family support. Transitional Care Specialist (TCS) contacted client to inform her of program services and client was appreciative of services being provided. TCS was able to complete phone screening and obtain necessary information to assist client. Client was referred to All Ways Caring to receive up to four weeks of services which will assist at home with any light housekeeping and transportation needs. Client was also referred to Catholic Charities - Senior Assisted Transportation program to provide long term transportation assistance. Client did not have a reliable source of transportation to obtain her medications so TCS was able to coordinate services with Rx Express to have medications delivered to client's home. In order to access long term case management services, client was referred to Linkages with the San Joaquin County Human Services Agency. The client was closely monitored by our TCS for four weeks and determined that her social and health obstacles were vanishing due to the improvement of social/ health aspects. The client is now independent and able to maintain a healthy lifestyle.

Violence/Injury Prevention

Name of program/activity/initiative	Tracy Seniors Association COVID Prevention
Description	TSA's COVID Relief Project was designed to bring groceries and hard to find paper and cleaning items to low income seniors during the Stay at Home orders. This population are extremely vulnerable to the COVID virus and should not go out to the store where crowds gather. Most are unable to drive and depend on public transportation that is not running during the shutdown or is running on a limited schedule. Having someone bring them the items they need to supplement other food distribution like Brown Bag is crucial.
Goals	To prevent keep low income seniors from contracting the COVID virus and reduce hospitalization by keeping them safe at home and supplied with the necessities to thrive.
Outcomes	<ul style="list-style-type: none"> • Jan-June 2021: 137 individuals served; 39 direct services provided.

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- The impact was immediate - seniors were so grateful and it helped them to remain safe home during the Stay at Home order as they didn't need to go out to get food and supplies. We offered to schedule and transport seniors to get their COVID shot during this period - the seniors that took advantage of our help to schedule and transport to get the vaccine were homebound without family to help; we believe that without the COVID relief program they may have been unvaccinated and possibly even hospitalized.
 - TSA achieved our goal to provide food, paper products and sanitizing products to low income seniors during the COVID crisis where there were Stay at Home orders. The program grew from 125 to 137 seniors attributed to word of mouth. While contacting our list of seniors to arrange monthly supply delivery, we identified that some seniors that were unable to make their own COVID vaccination appointments or obtain transportation to the appointments. We were able to expand the program to also include reserving COVID vaccination appointments and providing transportation to those that needed it. We were able to help approximately 22 seniors out of our list of 137 get their COVID vaccinations.
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Needs Sutter Tracy Community Hospital Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Tracy Community Hospital is committed to serving the community by adhering to its mission, using its skills and capabilities, and remaining a strong organization so that it can continue to provide a wide range of community benefits. The implementation strategy plan does not include specific plans to address the following significant health needs that were identified in the 2019 Community Health Needs Assessment for the following reasons:

1. **Substance Abuse and Tobacco** – While our strategy does not directly focus on substance abuse and tobacco, this is an area that will be addressed through our investments in access to care and economic security. Many individuals experiencing homelessness or at-risk of becoming homeless are also grappling with mental health and substance abuse issues, so through programs such as street outreach, homeless shelters, and recuperative care, we will likely be connecting individuals to the appropriate substance abuse referrals as needed.
2. **Asthma** – Asthma is not specifically addressed in our implementation plan as an area of focus, but we recognize its prevalence in San Joaquin County and many of our other strategies will seek to address this chronic condition. Through our investments in access to care, we will seek to identify individuals with asthma and connect them with a primary care provider so that they can appropriately manage their condition.
3. **Oral Health** – Although the hospital does not have a specific strategy to address this component of overall health, it does intend to indirectly address the priority finding through the various other interventions as mentioned in this report. Many of the strategies in this plan look to provide whole-person care, and will offer referrals to oral health care resources to individuals as necessary.
4. **Climate and Health** – Due to limited resources and ability to impact environmental policies, the hospital does not intend to directly address this health issue at this time.

Approval by Governing Board

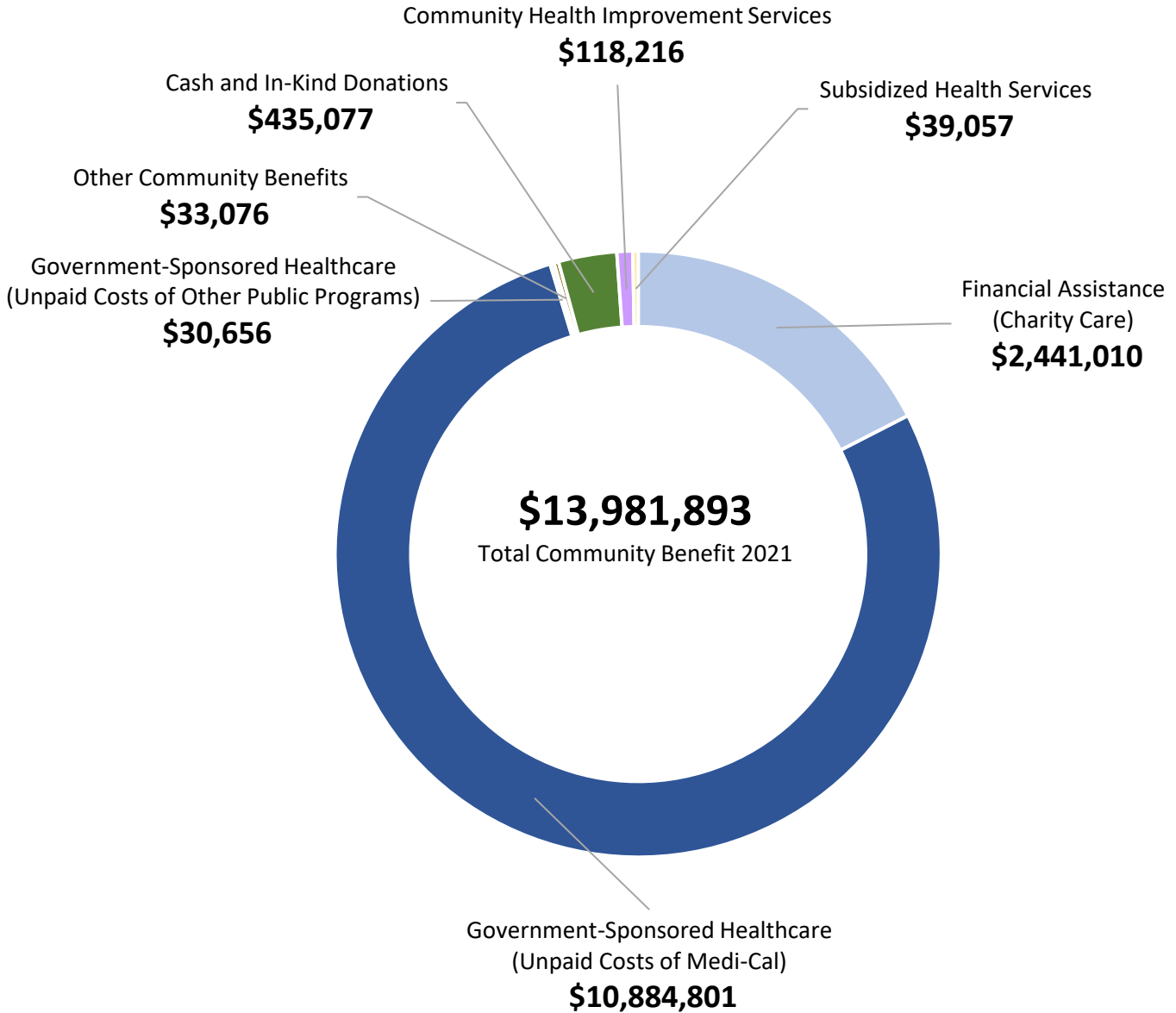
The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Health Valley Hospitals Board on November 21, 2019.

Appendix: 2021 Community Benefit Financials

Sutter Health hospitals and many other healthcare systems around the country voluntarily subscribe to a common definition of community benefit developed by the Catholic Health Association. Community benefits are programs or activities that provide treatment and/or promote health and healing as a response to community needs.

Community benefit programs include traditional charity care which covers healthcare services provided to persons who meet certain criteria and cannot afford to pay, as well as the unpaid costs of public programs treating Medi-Cal and indigent beneficiaries. Costs are computed based on a relationship of costs to charges. Additional community benefit programs include the cost of other services provided to persons who cannot afford healthcare because of inadequate resources and are uninsured or underinsured, cash donations on behalf of the poor and needy as well as contributions made to community agencies to fund charitable activities, training health professionals, the cost of performing medical research, and other services including health screenings and educating the community with various seminars and classes, and the costs associated with providing free clinics and community services. Sutter Health affiliates provide some or all of these community benefit activities.

Sutter Tracy Community Hospital 2021 Total Community Benefit & Unpaid Costs of Medicare



2021 unpaid costs of Medicare were \$13,189,389