# Sutter Health

Sutter Medical Center, Sacramento

2016 – 2018 Implementation Strategy
Responding to the 2016 Community Health Needs Assessment

2825 Capitol Avenue, Sacramento, CA 95816
FACILITY LICENSE #30000102
www.sutterhealth.org

## Table of Contents

## Introduction

The implementation strategy describes how Sutter Medical Center, Sacramento (SMCS), a Sutter Health affiliate, plans to address significant health needs identified in the 2016 Community Health Needs Assessment (CHNA). The document describes how the hospital plans to address identified needs in calendar (tax) years 2016 through 2018.

The 2016 CHNA and the 2016 - 2018 implementation strategy were undertaken by the hospital to understand and address community health needs, and in accordance with the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

The implementation strategy 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 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.

SSMCS welcomes comments from the public on the 2016 Community Health Needs Assessment and 2016 – 2018 implementation strategy. Written comments can be submitted:

- By emailing the Sutter Health System Office Community Benefit department at SHCB@sutterhealth.org;
- Through the mail by sending to 2700 Gateway Oaks, Suite 2200, Sacramento, CA 95833 ATTN: Community Benefit and
- In-person at the hospital's Information Desk.

### About Sutter Health

SSMCS is affiliated with Sutter Health, a not-for-profit network of hospitals, physicians, employees and volunteers who care for more than 100 Northern California towns and cities. Together, we're creating a more integrated, seamless and affordable approach to caring for patients.

The hospital's mission is to enhance the well-being of people in the communities we serve through a not-for-profit commitment to compassion and excellence in health care services. Over the past five years, Sutter Health has committed nearly $4 billion to care for patients who couldn't afford to pay, and to support programs that improve community health. Our 2015 commitment of $957 million includes unreimbursed costs of providing care to Medi-Cal patients, traditional charity care and investments in health education and public benefit programs. For example:

- In 2015, Sutter Health invested $712 million more than the state paid to care for Medi-Cal patients. Medi-Cal accounted for 20 percent of Sutter Health's gross patient service revenues in 2015. Sutter Health hospitals proudly serve more Medi-Cal patients in our Northern California service area than any other health care provider.
- As the number of insured people grows, hospitals across the U.S. continue to experience a decline in the provision of charity care. In 2015, Sutter Health's investment in charity care was $52 million.
- Throughout our health care system, we partner with and support community health centers to ensure that those in need have access to primary and specialty car. We also support children's

health centers, food banks, youth education, job training programs and services that provide counseling to domestic violence victims.

Every three years, Sutter Health hospitals participate in a comprehensive and collaborative Community Health Needs Assessment, which identifies local health care priorities and guides our community benefit strategies. The assessments help ensure that we invest our community benefit dollars in a way that targets and address real community needs.

For more facts and information about Sutter Medical Center, Sacramento, visit www.sutterhealth.org.

## 2016 Community Health Needs Assessment Summary

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs of the community served by Sutter Medical Center, Sacramento. The priorities identified in this report help to guide the hospital's community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets requirements of the Patient Protection and Affordable Care Act and California Senate Bill 697 that not-for-profit hospitals conduct a community health needs assessment at least once every three years.

This report documents the processes, methods, and findings of the CHNA conducted in partnership with SMCS. Building on federal and state requirements, the objective of the 2016 CHNA was to identify and prioritize community health needs and identify resources available to address those health needs, with the goal of improving the health status of the community at large and for specific locations and/or populations experiencing health disparities.

The CHNA was completed as a collaboration of the four major health systems in the Greater Sacramento region: Sutter Health, Kaiser Permanente, Sutter Health and UC Davis Health System. Together, the CHNA Collaborative represented 15 hospitals in the Sacramento Region. The CHNA Collaborative project was conducted over a period of eighteen months, beginning in January 2015 and concluding in June 2016.

The following research questions were used to guide the 2016 CHNA:

1. What is the community or hospital service area (HSA) served by each hospital in the CHNA Collaborative?
2. What specific geographic locations within the community are experiencing social inequities that may result in health disparities?
3. What is the health status of the community at large as well as of particular locations or populations experiencing health disparities?
4. What factors are driving the health of the community?
5. What are the significant and prioritized health needs of the community and requisites for the improvement or maintenance of health status?
6. What are the potential resources available in the community to address the significant health needs?

To meet the project objectives, a defined set of data collection and analytic stages were developed. Data collected and analyzed included both primary or qualitative data, and secondary or quantitative data. To determine geographic locations affected by social inequities, data were compiled and analyzed at the census tract and ZIP code levels as well as mapped by GIS systems. From this analysis as well as an initial preview of the primary data, Focus Communities were identified within the HSA. These were defined as geographic areas (ZIP codes) within the SMCS HSA that had the greatest concentration of social inequities that may result in poor health outcomes. Focus Communities were important to the overall CHNA methodology because they allowed for a place-based with which to consider health disparities in the SMCS HSA.

To assess overall health status and disparities in health outcomes, indicators were developed from a variety of secondary data sources (see Appendix B in full CHNA report). These "downstream" health

outcome indicators included measures of both mortality and morbidity such as mortality rates, emergency department visit and hospitalization rates. They also included risk behaviors such as smoking, poor nutrition and physical activity. Health drivers/conditions or "upstream" health indicators included measures of living conditions spanning the physical environment, social environment, economic and work environment, and service environment. This also included the indicators on social inequities that were used for the determination of Focus Communities. Overall, more than 170 indicators were included in the CHNA.

Community input and primary data on health needs were obtained via interviews with service providers and community key informants and through focus groups with medically underserved, low-income, and minority populations. Transcripts and notes from interviews and focus groups were analyzed to look for themes and to determine if a health need was identified as significant and/or a priority to address. Primary data for SMCS included 45 key informant interviews with 56 participants and 20 focus groups conducted with 228 participants including community members and service providers. A complete list of key informant interview data sources is available in Appendix F and a complete list of focus group data is available in Appendix G in the full CHNA report.

The full 2016 Community Health Needs Assessment conducted by Sutter Medical Center, Sacramento is available at www.sutterhealth.org.

### Definition of the Community Served by the Hospital

The hospital service area (HSA) is defined as the geographic area (by ZIP code) in which Sutter Medical Center, Sacramento and Sutter Center for Psychiatry receives its top 80% of discharges.

The SMCS HSA is located in Northern California and has approximately 1 million residents. The area is considerably diverse in population, economic stability (income and poverty), and insurance status. The population of the SMCS HSA makes up approximately 2.68% of all residents in the State of California. The majority of the population count for the HSA comes from residents living in Sacramento County. Population counts at the ZIP code level varied from 240 residents in ZIP code 95837 (Sacramento International Airport) to 74,154 residents in ZIP code 95823 (Fruitridge). The median age at the ZIP code level ranged from 26.2 years in 95832 (South Meadowview) to 53.3 years in 95612 (Southeastern Yolo). The median income by ZIP code for the HSA ranged significantly from approximately $29,771 in 95824 (Parkway) to $81,076 in 95819 (East Sac/River Park), a range of $51,305 per year.

In an attempt to understand the extent of and location of the medically underserved, low income and minority populations living in the SMCS HSA, specific indicators were examined. The percent of population living in poverty in the SMCS HSA was greater than both the Sacramento and Yolo County and state percentages. The SMCS HSA ZIP code with the highest percent of population in poverty was 95824 (Parkway) at 36.7%, compared to the lowest percent poverty in ZIP code 95830 (East Florin Road) at 4.1%. The percent of residents uninsured was lowest in Yolo County as compared to the SMCS HSA, Sacramento County and the state percent benchmarks. The ZIP code with the highest percent uninsured was 95824 (Parkway) at 24.7% and the lowest percent was 4.7% in ZIP code 95830 (East Florin Road). The SMCS HSA percent of minority residents was 58.7%, lower than state rate of 60.3%, but higher than both the Sacramento County (52.1%) and Yolo County (50.6%) percentages. An examination of areas throughout the county revealed a large variation in the degree of diversity, or percent minority. ZIP code 95832 (Meadowview) showed a percent of minority populations at 85.6%. This percent is drastically different from the ZIP code of 95837 (Sacramento International Airport) which only had 15.0% minority residents.

Census data showed that Whites/Caucasians make up the highest percent of residents in the SMCS HSA, followed by Hispanics/Latinos and Asians.

### Significant Health Needs Identified in the 2016 CHNA

The following significant health needs were identified in the 2016 CHNA:

1. Access to Behavioral Health Services

2. Active Living and Healthy Eating
3. Access to High Quality Health Care and Services
4. Disease Prevention, Management and Treatment
5. Basic Needs (Food Security, Housing, Economic Security, Education)
6. Safe, Crime and Violence Free Communities
7. Affordable and Accessible Transportation
8. Pollution-Free Living and Work Environments

In order to identify and prioritize the significant health needs, the quantitative and qualitative data were synthesized and analyzed according to established criteria outlined later in this report. This included identifying eight potential health need categories based upon the needs identified in the previously conducted CHNA, the grouping of indicators in the Kaiser Permanente Community Commons Data Platform (CCDP), and a preliminary review of primary data. Indicators within these categories were flagged if they compared unfavorably to State benchmarks or demonstrated racial/ethnic disparities according to a set of established criteria. Eight potential health needs were validated as significant health needs for the service area. The data supporting the identified significant health needs can be found in the Prioritized Description of Significant Health Needs section of this report. The resources available to address the significant health needs span several counties and were compiled by using the resources listed in the 2013 CHNA reports as a foundation, and then verifying and expanding these resources to include those referenced through community input. Additional information regarding resources is found in the Resources section and a comprehensive list of potential resources to address health needs is located in Appendix H in the full CHNA report.

### 2016 – 2018 Implementation Strategy

The implementation strategy describes how SMCS plans to address significant health needs identified in the 2016 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 2016 CHNA.

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

1. Access to Behavioral Health Services
2. Active Living and Healthy Eating
3. Access to High Quality Health Care and Services
4. Basic Needs (Food Security, Housing, Economic Security, Education)

**ACCESS TO BEHAVIORAL HEALTH 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. |
| **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. |
| **Plan to Evaluate** | We will work with our partners to create specific evaluation metrics for each program within this strategy. The plan to evaluate will follow the same process of our other community benefit program with bi-annual reporting and partner meetings to discuss/track effectiveness of each program within this strategy. |
| **Metrics Used to Evaluate the program/activity/initiative** | We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories, types of services/resources provided and other successful linkages. |

| | |
|---|---|
| **Name of program/activity/initiative** | Suicide Prevention Follow Up Program |
| **Description** | The Emergency Department Suicide Prevention Follow Up Program is designed to prevent suicide during a high-risk period, and post discharge, provide emotional support, and continue evidence based risk assessment and monitoring for ongoing suicidality. That includes personalized safe plans, educational and sensitive outreach materials about surviving a suicide attempt and recovery, 24-hour access to WellSpace Health's Suicide Prevention Crisis lines, and referrals to community-based resources for ongoing treatment and support. |
| **Goals** | The goal of the Suicide Prevention program is to wrap patients with services and support following a suicide attempt or suicidal ideation. |
| **Anticipated Outcomes** | The anticipated outcome of the suicide prevention follow up program is to decrease instances of suicide reattempts or ideations. |
| **Plan to Evaluate** | SMCS will continue to evaluate the impact of the suicide prevention program on a quarterly basis, by tracking the number of people served, number of linkages to other referrals/ services and other indicators. |
| **Metrics Used to Evaluate the program/activity/initiative** | We will look at metrics including (but not limited to) number of people served, number of resources provided, suicide attempts post program intervention, type of resources provided and other successful linkages. |

| | |
|---|---|
| **Name of program/activity/initiative** | Triage Navigator |

| | |
|---|---|
| **Description** | The Triage Navigator has become an important part of the ED and Psych Response Team at SMCS, and a vital resource for patients suffering from a mental health crisis. The Triage Navigator connects with complex patients who are not only battling mental health issues, but also have countless other challenges around substance abuse, homelessness, poverty and other health problems. The Triage Navigator, through the offering of specialized, wrap-around services, is making a positive impact on the lives of patients. |
| **Goals** | The goal of the Triage Navigator is to provide a linkage between our underserved population and behavioral/mental health resources. |
| **Anticipated Outcomes** | The anticipated outcome of this program is more underserved patients connected with the mental health resources they so desperately need. |
| **Plan to Evaluate** | The Triage Navigator program has proven to be effective in improving access to care for the underserved community. SMCS will continue to evaluate the impact of the Triage Navigator on a quarterly basis, by tracking the number of people served, anecdotal stories from patients and staff, number of linkages to other referrals/ services and other indicators. |
| **Metrics Used to Evaluate the program/activity/initiative** | We will look at metrics including (but not limited to) number of people served, number of resources provided, type of resources provided and other successful linkages. |

**ACTIVE LIVING AND HEALTHY EATING**

| | |
|---|---|
| **Name of program/activity/initiative** | Sacramento Food Bank Services Capacity Building |
| **Description** | The Food Bank Services Capacity Building Project increases the number of people gaining access to fresh fruits and produce, the number of families fed, the pounds of healthy food distributed, and the number of partner agencies in the Sacramento Food Bank & Family Services' food distribution network. |
| **Goals** | The community needs addressed by this project include: poverty, food access and wellness (nutrition and physical activity). |
| **Anticipated Outcomes** | The anticipated outcome is an increased number of people receiving healthy food and expanded partnerships for the Sacramento Food Bank. |
| **Plan to Evaluate** | 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. |
| **Metrics Used to Evaluate the program/activity/initiative** | We will look at metrics including (but not limited to) number of people served, pounds of food provided, types of food provided, anecdotal stories and other successful linkages. |

| | |
|---|---|
| **Name of program/activity/initiative** | Early Interventions Focused on Health/Fitness |
| **Description** | We fund many partners that focus on early childhood health and wellness, including physical activity, nutrition, education and the arts. Some of those programs, but may not be limited to in the future include, Soil Born Farms (community farms/healthy eating), American River Parkway (Foundation Campfire site, aimed to bring thousands of children to River Bend Park for healthy, active experiences), Sacramento Ballet (Providing community performances and school assemblies in schools/communities in underserved communities, to ensure kids are exposed to the arts and movement) and the Crocker Art Museum (programs for underserved children), |

| | |
|---|---|
| **Goals** | The goals of these programs is to expose underserved children to the importance of physical activity, healthy habits, movement and the arts. |
| **Anticipated Outcomes** | Without these programs/partners, many of the underserved children who participate wouldn't otherwise have the opportunity to enjoy these lessons and experiences. The anticipated outcomes are children who are more knowledgeable about the importance of healthy eating, physical activity and overall wellness. |
| **Plan to Evaluate** | 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. |
| **Metrics Used to Evaluate the program/activity/initiative** | We will look at metrics including (but not limited to) number of children served, number/types of services/experiences/lessons provided, anecdotal stories and other successful linkages. |

**ACCESS TO HIGH QUALITY HEALTH CARE AND SERVICES**

| | |
|---|---|
| **Name of program/activity/initiative** | Educational Campaign |
| **Description** | In partnership with Sacramento Covered, we will launch of an educational, "health literacy" campaign to increase access to primary care and its utilization. The navigators will provide one-on-one coaching to access services and ensure all patients have health coverage.<br><br>The partnership will also include linkAges, a database of community resources, and a tool for community health workers and patient navigators to improve health and well-being outcomes for low income and ethnically diverse communities. They will be able to build individual profiles in linkAges to capture non-medical determinants of health and then use the linkAges community platform to connect families and individuals to local resources.<br><br>Such critical everyday needs as learning English, tutoring math and science, giving a ride to the pharmacy, helping with yard work, etc. will be accessible through linkAges. In addition, extended needs such as nutrition, transportation, housing, case management and vocational training will all be manageable when the technology is up and running. |
| **Goals** | The overall goal of the project is to educate people about their health insurance and local health resources. |
| **Anticipated Outcomes** | By educating people and encouraging them to take their healthcare into their own hands, we will help connect people to medical homes, appropriate medical care and the resources they need to live a healthier life. |
| **Plan to Evaluate** | 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. |
| **Metrics Used to Evaluate the program/activity/initiative** | We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories, types of services/resources provided and other successful linkages. |

| | |
|---|---|
| **Name of program/activity/initiative** | ED Navigator |
| **Description** | The ED Navigator is an employee of WellSpace Health and serves as a visible ED-based staff member. Upon referral from a Sutter employee (and after patient agreement), ED Navigators attend to patients in the ED |

| | |
|---|---|
| | and complete an assessment for T3 case-management services. Upon assessment, the ED Navigator determines and identifies patient needs for community-based resources and/or case-management services, such as providing a patient linkage to a primary care provider and establishing a medical home. |
| **Goals** | The goal of the ED Navigator is to connect patients with health and social services, and ultimately a medical home, as well as other programs (like T3) when appropriate. |
| **Anticipated Outcomes** | The anticipated outcome of the ED Navigator is reduced ED visits, as patients will have a medical home and access to social services, in turn, reducing their need to come to the ED for non-urgent reasons and making the patient healthier overall. |
| **Plan to Evaluate** | The ED Navigator program has proven to be effective in improving access to care for the underserved community. SMCS will continue to evaluate the impact of the ED Navigator on a quarterly basis, by tracking the number of people served, recidivism rates, number of linkages to other referrals/ services and other indicators. |
| **Metrics Used to Evaluate the program/activity/initiative** | We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories, type of resources provided, number of patients referred to T3 and other successful linkages. |

| | |
|---|---|
| **Name of program/activity/initiative** | Free Mammography Screenings |
| **Description** | Throughout the month of October, Sutter Diagnostic Imaging centers across the Valley OU provide free digital screening mammograms to uninsured women in honor of National Breast Cancer Awareness Month. The goal of this outreach effort was to not only provide free screenings to underinsured women in our communities, but it also serves as an opportunity to provide women with information on health and insurance resources. Free mammograms are offered in various locations, at various times, including in Sacramento County, to ensure as many women as possible were able to take advantage of this effort. In addition, a packet of follow up resources was created in the event that a participant had an abnormal screening, as well as insurance enrollment services. |
| **Goals** | The goal of the screening events are to provide free mammograms for women who otherwise wouldn't have access to one. |
| **Anticipated Outcomes** | The anticipated outcome of the screenings is to provide free mammograms for uninsured women and ensure they have supportive resources and connection to care if results come back abnormal. |
| **Plan to Evaluate** | SMCS will continue to evaluate the impact of our Free Mammography Screenings on an annual basis, by tracking the number of people served and additional services provided, like linkages to primary care and insurance. We will also reexamine this program to ensure it evolves with the needs of the community. |
| **Metrics Used to Evaluate the program/activity/initiative** | We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories and other successful linkages. |

| | |
|---|---|
| **Name of program/activity/initiative** | Health Navigator Program |
| **Description** | In partnership with Sacramento Covered, the Sacramento Health Navigator Program expands health navigation services in Sacramento |

| | |
|---|---|
| | County and connects thousands of low-income residents to affordable health care coverage. |
| **Goals** | The overall goal of the project is to establish medical homes, thereby reducing dependence on emergency room systems of care. |
| **Anticipated Outcomes** | The community needs addressed by this project, all of which support the under-insured and uninsured, include: 1) access to primary care, 2) access to preventive care, and 3) access to dental care. |
| **Plan to Evaluate** | 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. |
| **Metrics Used to Evaluate the program/activity/initiative** | We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories, types of services/resources provided and other successful linkages. |

| | |
|---|---|
| **Name of program/activity/initiative** | Interim Care Program (ICP) |
| **Description** | A collaborative of the four health care systems and WellSpace Health, Volunteers of America and Sacramento County, the Sacramento Interim Care Program (ICP) is a respite-care shelter for homeless patients discharged from hospitals. The ICP wraps people with health and social services, while giving them a place to heal.<br><br>Started in 2005, the ICP links people in need to vital community services while giving them a place to heal. The clients who are enrolled in the ICP are homeless adult individuals who otherwise would be discharged to the street or cared for in an inpatient setting only. The program is designed to offer clients up to six weeks during which they can focus on recovery and developing a plan for their housing and care upon discharge. This innovative community partnership provides temporary respite housing that offer homeless men and women a place to recuperate from their medical conditions, link them to vital community services, and provide them a place to heal.<br><br>WellSpace Health, Sacramento's Federally Qualified Health Center, provides on-site nursing and social services to support clients in their recuperation and help them move out of homelessness. The WellSpace case manager links clients with mental health services, substance abuse recovery, housing workshops and provides disability application assistance.<br><br>In addition to the ICP program, launching in the fall of 2016, SMCS will also offer an "expanded ICP" aimed to meet the needs of patients with more complex needs and acute health issues. This program will primarily serve patients in Sacramento, with 2 beds available for Yolo and Placer county residents. All "out of county" patients will be wrapped with services from their county of origin so they can return to their "home county" when healed. |
| **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. |
| **Plan to Evaluate** | The ICP program has proven to be effective in improving access to care for the underserved community. SMCS will continue to evaluate the |

| | |
|---|---|
| | impact of ICP on a quarterly basis, by tracking the number of people served, recidivism rates, number of linkages to other referrals/ services and other indicators. |
| **Metrics Used to Evaluate the program/activity/initiative** | We will look at metrics including (but not limited to) number of people served, number of resources provided, hospital usage post program intervention, type of resources provided and other successful linkages. |

| | |
|---|---|
| **Name of program/activity/initiative** | Mobile Clinic |
| **Description** | In a joint effort between two Federally Qualified Health Clinics, WellSpace and Golden Valley Health Centers will deliver care to the most vulnerable residents of Sacramento and Stanislaus Counties. Initial services in will include, pediatric health and dental screenings, and women's health services. Launching in 2016, this innovative approach to health care is built on a sustainable model, and additional funding will allow the clinic to expand services in both service areas to reach more people where they are. |
| **Goals** | Delivering primary health services to the underserved and connecting them to resources for ongoing care, it the goal of the Mobile Clinic |
| **Anticipated Outcomes** | The anticipated outcome of the mobile clinic is that at least 1,000 people will be served each year and provide with primary care to the underserved. |
| **Plan to Evaluate** | SMCS will continue to evaluate the impact of the mobile clinic on a quarterly basis, by tracking the number of people served, number/type of services provided, number of linkages to other referrals/services and other indicators. |
| **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** | Ongoing Clinic Investments |
| **Description** | With access to care, including primary, mental health and specialty care continuing to be a major priority area in the SMCS HSA, we will continue to make strategic investments in our local FQHC partners to increase clinic capacity and services offered. Current investments have been provided to WellSpace Health, Peach Tree and Sacramento Native American Health Clinic (for dental), but this list will continue to grow and evolve over the next three years. |
| **Goals** | The goal is to expand access to 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. |
| **Plan to Evaluate** | 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 investments within this strategy. |
| **Metrics Used to Evaluate the program/activity/initiative** | We will look at metrics including (but not limited to) number of people served, number of appointments provided, types of services provided, anecdotal stories and other successful linkages. |

| | |
|---|---|
| **Name of program/activity/initiative** | Triage, Transport, Treat (T3) |
| **Description** | T3 provides case management services for people who frequently access the SMCS EDs for inappropriate and non-urgent needs, by connecting vulnerable patients to vital resources such as housing, primary care, mental and behavioral health services, transportation, substance abuse treatment and other key community resources. By linking these patients to the right care, in the right place, at the right time and wrapping them with services, we see a drastic improvement to the health and overall quality of life for this often underserved, patient population. |
| **Goals** | The goal of T3 is to wrap patients with health and social services, and ultimately a medical home. |
| **Anticipated Outcomes** | The anticipated outcome of T3 is reduced ED visits, as patients will have a medical home and access to social services, in turn, reducing their need to come to the ED for non-urgent reasons and making the patient healthier overall. |
| **Plan to Evaluate** | The T3 program has proven to be effective in improving access to care for the underserved community. SMCS will continue to evaluate the impact of T3 on a quarterly basis, by tracking the number of people served, recidivism rates, number of linkages to other referrals/ services and other indicators. |
| **Metrics Used to Evaluate the program/activity/initiative** | We will look at metrics including (but not limited to) number of people served, number of resources provided, hospital usage post program intervention, type of resources provided and other successful linkages. |

| | |
|---|---|
| **Name of program/activity/initiative** | T3+ |
| **Description** | T3+ is similar to T3, except patients are identified in an inpatient setting and are often more complex. The T3+ navigator follows patients after discharge and works with Sutter Health staff to provide a follow-up health plan, tele-health, pain management, etc. All of this occurs while the T3+ navigators address the patient's other needs (including housing, insurance enrollment, etc) and ensure a connection is made to primary and preventive care to reduce further hospitalization**.** |
| **Goals** | The goal of T3+ is to wrap patients with health and social services, and ultimately a medical home. |
| **Anticipated Outcomes** | The anticipated outcome of T3+ is to successfully connect patients with a medical home and social services, in turn, managing any long term health ailments and making the patient healthier overall. |
| **Plan to Evaluate** | The T3+ program has proven to be effective in improving access to care for the underserved community. SMCS will continue to evaluate the impact of T3+ on a quarterly basis, by tracking the number of people served, recidivism rates, number of linkages to other referrals/ services and other indicators. |
| **Metrics Used to Evaluate the program/activity/initiative** | We will look at metrics including (but not limited to) number of people served, number of resources provided, hospital usage post program intervention, type of resources provided and other successful linkages. |

| | |
|---|---|
| **Name of program/activity/initiative** | SPIRIT |
| **Description** | The Sacramento Physicians' Initiative to Reach out, Innovate and |

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

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

**BASIC NEEDS (FOOD SECURITY, HOUSING, ECONOMIC SECURITY, EDUCATION)**

| | |
|---|---|
| **Name of program/activity/initiative** | Community Navigator |
| **Description** | The Community Navigator works in the .25 mile radius around SMCS and connects with homeless individuals. The Community Navigator slowly builds relationships with these people and helps wrap them with services, such as housing, a medical home, a PCP/mental health provider, alcohol |

| | |
|---|---|
| | and drug treatment and other social services. The Community Navigator is integrated with both the Street Nurse and the SMCS ED, Case Management and Social Work staff, to ensure a continuum of care for homeless patients both within the walls of the hospital and out in the community. |
| **Goals** | This effort seeks to provide homeless individuals with a medical home, linkages to health and social resources and a successfully connection to housing/shelter. |
| **Anticipated Outcomes** | The anticipated outcomes is a lower number of homeless people in the greater Sacramento region. |
| **Plan to Evaluate** | SMCS will continue to evaluate the impact of the community navigator program on a quarterly basis, by tracking the number of people served, number of people successfully housed, number of medical homes established, number of linkages to other referrals/services and other indicators. |
| **Metrics Used to Evaluate the program/activity/initiative** | We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories from staff and patients, number of people successfully housed, number of successful referrals to primary, mental/behavioral health care and/or alcohol and drug treatment, type of resources provided and other successful linkages. |

| | |
|---|---|
| **Name of program/activity/initiative** | Coordinated Exit |
| **Description** | Sacramento Steps Forward (SSF) utilizes a three-step housing crisis resolution system as a strategy to end homelessness in the Sacramento region. This system is based on a Housing First model that provides people with a continuum of care. The Coordinated Exit program is designed to move individuals and families out of homelessness as efficiently and as quickly as possible by placing them in emergency, transitional, or permanent housing while concurrently wrapping them with other supportive services. These services often include access to health care, coordination of social services, enrollment in employment programs and other client-centered support services to maintain ongoing stability and break the cycle of homelessness. |
| **Goals** | This effort seeks to place homeless people in permanent housing, while addressing other issues like health needs, etc. |
| **Anticipated Outcomes** | The anticipated outcomes is lower number of homeless people in the greater Sacramento region. |
| **Plan to Evaluate** | SMCS will continue to evaluate the impact of the coordinated exit program on a quarterly basis, by tracking the number of people served, number of people successfully housed, number of linkages to other referrals/services and other indicators. |
| **Metrics Used to Evaluate the program/activity/initiative** | We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories from staff and patients, number of people successfully housed, type of resources provided and other successful linkages. |

| | |
|---|---|
| **Name of program/activity/initiative** | Serial Inebriate Program |
| **Description** | The Serial Inebriate Program (SIP) addresses the health, safety, and housing needs of intoxicated, chronically homeless adults living on the streets of Sacramento. To qualify for SIP, individuals must have been admitted to local EDs, the Comprehensive Alcohol Treatment Center |

| | |
|---|---|
| | (also known as the “detox” program) or arrested at least 25 times within the previous 12 months, and who pose a danger to themselves or others due to excessive alcohol consumption.<br><br>During the 90-day stay, clients receive alcohol addiction counseling, and are offered permanent housing through Sacramento Self Help Housing. SIP clients are not only placed in a safe housing environment, but they are also wrapped with services to get on the road to sobriety and connect to health resources they were not aware of during their time on the streets. Additionally, SIP clients are connected with primary and mental health services, to help address their long-term medical needs and place these at-risk patients in permanent medical homes. |
| **Goals** | The goal is to get serial inebriates off the streets and into housing and alcohol and drug treatment. |
| **Anticipated Outcomes** | The anticipated outcomes are reduced ED visits, reduced arrests, better health and improved sobriety. |
| **Plan to Evaluate** | SMCS will continue to evaluate the impact of the SIP program on a quarterly basis, by tracking the number of people served, number of people successfully housed, number of people successfully enrolled in drug and alcohol treatment programs, number of linkages to other referrals/services and other indicators. |
| **Metrics Used to Evaluate the program/activity/initiative** | We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories from staff and patients, number of people successfully housed, type of resources provided, reduced arrests and other successful linkages. |

| | |
|---|---|
| **Name of program/activity/initiative** | Way Up |
| **Description** | MedZone and Oak Park Smart are two major elements of the Way Up initiative.<br><br>MedZone, a collaboration with UC Davis Medical Center, Sutter Health, Kaiser Permanente, and Dignity Health is WayUP’s cornerstone workforce development and employment initiative. The initiative is a strategic tool for community economic development to foster a vibrant and healthy neighborhood that results in a thriving local economy, an educated local workforce and jobs for local residents.<br><br>Oak Park Smart is a place-based network of Oak Park schools and educational facilities that promotes positive achievements of its schools in the community, and provides a springboard for coordinated education-focused initiatives. |
| **Goals** | The goal of MedZone is threefold: To continue improvement of the Oak Park community; catalyzing the health industry by supporting the profitability of the enterprises that are part of the MedZone; and workforce development consisting of new jobs and necessary educational and training opportunities that provide local residents access to careers in the health sector.<br><br>The goals of Oak Park Smart are to develop a vibrant collaboration between public, public charter, and private schools in Oak Park so they share best practices; leverage resources, and support the success of teachers and students; bolster community pride through a coordinated branding strategy; engage students through experiential learning |

| | |
|---|---|
| | opportunities; launch effective, community-inclusive educational initiatives; and strengthen relationships among stakeholders in Oak Park through community. |
| **Anticipated Outcomes** | The anticipated outcome of the Way Up effort is to revitalize the Oak Park community, in turn, bringing economic development to an economically depressed area and bolstering the educational offerings and support for local students. |
| **Plan to Evaluate** | SMCS will continue to evaluate the impact of the Way Up initiatives on a biannual basis, by tracking the number of people/kids served, number of linkages to other referrals/services, number of new jobs created/businesses brought to Oak Park and other indicators. |
| **Metrics Used to Evaluate the program/activity/initiative** | We will look at metrics including (but not limited to) number of people served, economic impact information (if available), anecdotal stories, type of resources provided to local kids and other successful linkages. |

**SAFE, CRIME AND VIOLENCE FREE COMMUNITIES**

| | |
|---|---|
| **Name of program/activity/initiative** | Violence Prevention Navigator |
| **Description** | WEAVE's Violence Prevention Navigator Program focuses resources on a violence prevention navigator to leverage WEAVE's specialized expertise in serving victims of domestic violence, sexual assault and human trafficking. The program incorporates strategies identified in the Continuum of Care Strategic Plan to End Homeless, and integrates with law enforcement and the medical community to provide specialized response services to victims. The program also helps WEAVE leadership identify and implement internal policy changes to better align WEAVE's response model with existing community efforts and other community service providers. |
| **Goals** | This help victims of domestic violence, sexual assault and human trafficking. |
| **Anticipated Outcomes** | The anticipated outcome is a better support system for victims and improved response models. |
| **Plan to Evaluate** | SMCS will continue to evaluate the impact of the violence prevention navigator program on a biannual basis, by tracking the number of people served, number of linkages to other referrals/services and other indicators. |
| **Metrics Used to Evaluate the program/activity/initiative** | We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories from staff and patients, type of resources provided and other successful linkages. |

**Plans Not to Address**

No hospital can address all of the health needs present in its community. Sutter Medical Center, Sacramento is committed to serving the community by adhering to its mission, using its skills and capabilities, and remaining a strong organization so that it can continue to provide a wide range of community benefits. The implementation strategy does not include specific plans to address the following significant health needs that were identified in the 2016 Community Health Needs Assessment:

1. Disease Prevention, Management and Treatment: While many of our programs expand access to primary care, in turn, connecting patients with disease prevention, management and treatment resources, this is not a primary focus in the SMCS HSA.

2. Affordable and Accessible Transportation: We are continuously looking for opportunities to provide collaborative transportation options to the underserved communities; however, we have not yet found the perfect fit in Sacramento County. Although we don't have current plans to address transportation, there is always a chance that one may develop in the years ahead.

3. Pollution-Free Living and Work Environments: 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 like SACOG, the Cleaner Air Partnership and others, are working on these vital issues.

### Approval by Governing Board

The implementation strategy was approved by the Sutter Health Valley Area Board on 17, November, 2016.