

Sutter Health

Sutter Roseville Medical Center

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

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Introduction

The implementation strategy describes how Sutter Roseville Medical Center (SRMC), 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.

SRMC 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

SRMC 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 care. 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 SRMC, 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 Roseville Medical Center and Sutter Auburn Faith Hospital (SRMC/SAFH). 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 SRMC. 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: Dignity 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 SRMC/SAFH 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 lens with which to consider health disparities in the HSA.

To assess overall health status and disparities in health outcomes, indicators were developed from a variety of secondary data sources (see Appendix B). 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 SRMC/SAFH included 38 key informant interviews with 58 participants and 11 focus groups conducted with 88 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 SRMC is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

The community or hospital service area (HSA) is defined as the geographic area (by ZIP code) in which the hospital receives its top 80% of discharges.

The Sutter Roseville Medical Center/Sutter Auburn Faith Hospital HSA is located in Northern California and has nearly 700,000 residents. As Tables 1 and 2 show, the area is diverse in population, economic stability (income and poverty), and insurance status. Table 1 shows the total population count, the median age and the median income of all 41 ZIP codes in the SRMC/SAFH HSA compared to the state and county benchmarks. Table 2 provides information on the presence of medically underserved, low income, and minority residents in all 41 ZIP codes in the SRMC/SAFH HSA compared to the state and county benchmarks.

The population of the SRMC/SAFH HSA makes up nearly 2% of all residents in the State of California. The majority of the population count for the SRMC/SAFH HSA comes from residents living in Placer County. Twenty-two of the 41 ZIP codes that make up the SRMC/SAFH HSA are located in Placer County; ten ZIP codes are located in Sacramento County, three ZIP codes are located in El Dorado County, two ZIP codes are located in Yuba County and one ZIP code is located in Nevada County. Population counts at the ZIP code level varied from 88 residents in ZIP code 95715 (Emigrant Gap) to 53,452 residents in ZIP code 95747 (Roseville).

The median age of the SRMC/SAFH HSA at the ZIP code level ranged from 21.5 years in 95736 (Weimar) to 62.4 years in 95714 (Dutch Flat). The median income by ZIP code for the SRMC/SAFH HSA ranged significantly from approximately \$36,967 in 95841 (North Highlands) to \$127,736 in 95746 (Granite Bay), a range of almost \$90,000 dollars a year. In an attempt to understand the extent of and location of the medically underserved, low income and minority populations living in the SRMC/SAFH HSA, specific indicators were examined.

The percent of population living in poverty for the SRMC/SAFH HSA was 11.8%, much greater than the Placer County benchmark, but lower than both the Sacramento County benchmark and state benchmark. The ZIP code in the SRMC/SAFH HSA with the highest percent of population in poverty was 95841 (North Highlands) with 27.9% of its population living below 100% Federal Poverty Level, compared to the lowest percent of population in poverty in 95714 (Dutch Flat) and 95715 (Emigrant Gap), both with 0% of their populations living in poverty. The percent of uninsured residents in the SRMC/SAFH HSA was 12.1%, higher than the percent uninsured in Placer County, but lower than both the state and Sacramento County percentages. The ZIP code with the highest percent uninsured was 95736 (Weimar) with 36.3%, while ZIP code 95715 (Emigrant Gap) had 0% of its population in poverty. The percent of minority residents in the SRMC/SAFH HSA was 27.4%, which is higher than the Placer County percent minority, but lower than the Sacramento County and state percentages of minority. An examination of the ZIP codes in the SRMC/SAFH HSA revealed a large variation in the degree of diversity, or percent minority. The highest percent minority in the SRMC/SAFH HSA was found in 95736 (Weimar) with 48.9% and the

lowest percent minority in the SRMC/SAFH HSA was found in 95715 (Emigrant Gap), with 0% of its population classified as minority.

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. Access to High Quality Health Care and Services
3. Active Living and Healthy Eating
4. Disease Prevention, Management and Treatment
5. Safe, Crime and Violence Free Communities
6. Basic Needs (Food Security, Housing, Economic Security, Education)
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 then verifying and expanding these resources to include those referenced through community input. Additional information regarding resources is found below in the Resources section and a comprehensive list of potential resources to address health needs is located in Appendix H in the full report.

2016 – 2018 Implementation Strategy

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

The prioritized significant health needs the hospital will address are:

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

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	SRMC 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.

ACCESS TO HIGH QUALITY HEALTH CARE AND SERVICES

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 Navigator 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. SRMC 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 Placer 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	SRMC 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	Interim Care Program (ICP)
Description	<p>Offered in partnership with The Gathering Inn, the Placer Interim Care Program (ICP) is a respite-care shelter for homeless patients discharged from the hospital. The ICP wraps people with health and social services, while giving them a place to heal.</p> <p>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.</p>
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. SRMC 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	Ongoing Clinic Investments and Programs
Description	<p>With access to care, including primary, mental health and specialty care continuing to be a major priority area in the SRMC 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, the Auburn Renewal Center and Chapa De, all located in Placer County, but this list will continue to grow and evolve over the next three years.</p> <p>We are also working on collaborative programs with our clinic partners, such as a Community Diabetes course, which will be offered in partnership with Chapa De, the Auburn Renewal Center and Latino</p>

	Leadership Council. Creative collaborations and innovative opportunities with our clinic partners will continue to evolve with the needs of the community.
Goals	The goal is to expand access to care.
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	Promotora Program and CREER en TU Salud
Description	<p>The Promotora program provides culturally sensitive support to Spanish speaking patients in need of health and social services. Case management wraparound services provided by the Promotora often transcend the patient and extend to the entire family to ensure they have necessary resources.</p> <p>The Sutter CREER project provides health care access and services to the Latino community. This project focuses on serving recent immigrants and monolingual Spanish-speaking families who face greater challenges and barriers to receiving services. Using the Promotora Model, the Latino Leadership Council addresses mental health, education, and youth development areas. The community needs this project aims to address include: 1) access to primary care, 2) access to preventative care, and 3) access to services for the underinsured and uninsured.</p>
Goals	The goal of the Promotora is to connect patients with health and social services, and ultimately a medical home.
Anticipated Outcomes	The anticipated outcome of the Promotora is reduced hospital usage, as patients will have a medical home and access to social services, in turn, reducing their need to come to the ED for non-urgent reasons and making the patient healthier overall.
Plan to Evaluate	The Promotora program has proven to be effective in improving access to care for the underserved, Spanish speaking community. SRMC will continue to evaluate the impact of the Promotora on a quarterly basis, by tracking the number of people served, hospital usage post program intervention, 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 and other successful linkages.

Name of program/activity/initiative	Triage, Transport, Treat (T3) Foothills
Description	T3 Foothills provides case management services for people who frequently access the SRMC 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. SRMC 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	Transitions Nurse
Description	The Transition Nurse working from the WellSpace Health Roseville Community Health Center manages the Sutter dedicated line for Sutter Health's case managers, providers, WellSpace Health T3 team, and ED Navigators. The Transition Nurse gathers clinical information necessary to schedule appropriate and timely appointments for ED and hospital discharge patients. In addition, the nurse provides triage to Open Access appointments and assists providers with wound care, INR management, and patient education for disease management.
Goals	The goal of the Transitions Nurse is to assist in scheduling timely appointments for patients needing care at the Roseville WellSpace Health Clinic. The Transitions Nurse serves as the "warm handoff" between SRMC Case Management/Social Work and WellSpace Health Community Clinic staff.
Anticipated Outcomes	The anticipated outcome of the Transitions Nurse is better care coordination between Sutter Health and WellSpace Health around shared patients, specifically underserved and complex patients.
Plan to Evaluate	The Transitions Nurse has proven to be a valuable resource for staff and patients. SRMC 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, appointments provided, anecdotal stories about complex cases and other successful linkages.

ACTIVE LIVING AND HEALTHY EATING

Name of program/activity/initiative	Fit Quest
Description	FitQuest Program is a comprehensive children's wellness program focusing on nutrition, fitness, and mental wellness. The on-site school program, geared toward 5th and 6th grade students, teaches students easy ways to incorporate healthy choices into daily living. The curriculum is designed to improve overall health in a fun and meaningful way.

Goals	The goal of FitQuest is to teach children and their families healthy lessons about fitness, physical activity and the importance of nutritious eating.
Anticipated Outcomes	The anticipated outcome of this program is continued success in teaching children and their families beneficial lessons that will last a lifetime, creating overall healthier people.
Plan to Evaluate	SRMC will continue to evaluate the impact of the FitQuest program on a quarterly basis, by tracking the number of children/families reached, types of activities/lessons taught and other indicators.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children/families served, active schools, anecdotal stories and other successful program impacts.

Name of program/activity/initiative	Go Noodle
Description	Go Noodle (formerly Health Teacher) is an early education physical and mental wellness program offered to schools throughout Placer County. This impactful and easy to use program helps kids channel their physical and emotional energy for good, through quick in-classroom lessons, which are easily integrated into classroom curriculum. GoNoodle's short desk-side physical activities help teachers manage their classroom and improve student performance. These activities focus on both physical and mental wellness.
Goals	The goal of Go Noodle is to get kids moving throughout the school day to improve their physical and mental wellbeing.
Anticipated Outcomes	The outcome of this successful program is teachers throughout Placer County utilizing this program, which now reaches hundreds of students each school year.
Plan to Evaluate	SRMC will continue to evaluate the impact of the Go Noodle program on a quarterly basis, by tracking the number of teachers using this resource, number of kids reached, number of minutes of activities and other indicators.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of students and teachers served, active schools, anecdotal stories and other successful program impacts.

Name of program/activity/initiative	Recreation and Respite
Description	<p>The Recreation and Respite Adult Day Program is designed to offer a change of pace and sense of independence to seniors with physical or memory impairments, as well as support for their caregivers. The Adult Day Program is a planned program of activities designed to promote well-being through social and health related services. Participants take part in physical activities, mentally stimulating activities (arts and crafts), social interaction and fed nutritious meals.</p> <p>The staff is supported by its valuable team of volunteers and completed by personal care aides. R & R meets in various locations throughout Roseville, Auburn and Lincoln to reach the maximum amount of seniors in need. In 2010, the R&R program expanded and transportation is now offered through Health Express to ensure those who benefit the most from the program will continue to access.</p>

Goals	The goal of the Recreation and Respite program is to provide a social, physical and mentally stimulated environment for seniors with physical or memory impairments.
Anticipated Outcomes	The outcome of this successful program is hundreds of seniors and their caregivers participating in the Recreation and Respite program every year, which improves their quality of life.
Plan to Evaluate	SRMC will continue to evaluate the impact of the Recreation and Respite program on a quarterly basis, by tracking the number of people served, anecdotal stories 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, anecdotal stories and other successful program impacts.

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

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, specifically in Sacramento, Yolo and Placer Counties. 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	SRMC 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.

AFFORDABLE AND ACCESSIBLE TRANSPORTATION

Name of program/activity/initiative	Health Express
Description	Health Express provides non-emergency medical transportation on an advance reservation, shared-ride basis for eligible residents of Placer County. Scheduling and keeping non-emergency medical appointments is essential to maintaining quality of life, preventing injury, and treating illness. The Health Express partnership provides transportation to and from medical appointments for Placer County's underserved, vulnerable and

	<p>elderly population, who are unable to access necessary medical care, due to transportation constraints. This program is publicized throughout Placer County to encourage use.</p> <p>In order to increase access to health care services for Placer County seniors, disabled, and underserved populations, the Health Express was expanded in 2007 to include a larger population and provide last resort medically related transportation services within most of Placer county.</p>
Goals	The goal of Health Express is to provide rides to and from medical appointments for seniors and disabled residents of Placer County.
Anticipated Outcomes	The outcome of the Health Express program is thousands of rides to and from medical appointments each year, for people who might not otherwise have the resources to travel to these important appointments.
Plan to Evaluate	SRMC will continue to evaluate the impact of Health Express on a biannual basis, by tracking the number of people served and number of rides provided.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served and number of rides provided.

Needs Sutter Roseville Medical Center Plans Not to Address

No hospital can address all of the health needs present in its community. SRMC 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 SRMC/SAFH HSA; however, we're in the process of developing community diabetes education courses.
2. **Safe, Crime and Violence Free Communities:** This is primarily a law enforcement issue and not something that SRMC has the expertise to effectively address.
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.