

Sutter Health

Sutter Delta Medical Center

2019 – 2021 Implementation Strategy Plan Responding to the 2019 Community Health Needs Assessment

3901 Lone Tree Way Antioch, CA 94509 Facility License #140000258 www.sutterhealth.org

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Introduction

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

The 2019 CHNA and the 2019 - 2021 Implementation Strategy Plan were undertaken by the hospital to understand and address community health needs, and in accordance with state law and the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

The Implementation Strategy Plan addresses the significant community health needs described in the CHNA that the hospital plans to address in whole or in part. The hospital reserves the right to amend this Implementation Strategy Plan as circumstances warrant. For example, certain needs may become more pronounced and merit enhancements to the described strategic initiatives. Alternately, other organizations in the community may decide to address certain community health needs, and the hospital may amend its strategies and refocus on other identified significant health needs. Beyond the initiatives and programs described herein, the hospital is addressing some of these needs simply by providing health care to the community, regardless of ability to pay.

Sutter Delta Medical Center welcomes comments from the public on the 2019 Community Health Needs Assessment and 2019 - 2021 Implementation Strategy Plan. Written comments can be submitted:

- By emailing the Sutter Health System Office Community Benefit department at SHCB@sutterhealth.org;
- Through the mail using the hospital's address at 3012 Summit Street, 3rd Floor, Oakland, CA 94609, ATTN: Community Benefit; and
- In-person at the hospital's Information Desk.

Executive Summary

Sutter Delta Medical Center is affiliated with Sutter Health, a not-for-profit public benefit corporation that is the parent of various entities responsible for operating health care facilities and programs in Northern California, including acute care hospitals, medical foundations and home health and hospice, and other continuing care operations. Together with aligned physicians, our employees and our volunteers, 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 notfor-profit commitment to compassion and excellence in health care services.

Over the past five years, Sutter Health and its affiliates have committed nearly \$4 billion to care for patients who couldn't afford to pay, and to support programs that improve community health. Our 2018 commitment of \$734 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 2018, Sutter invested \$435 million more than the state paid to care for Medi-Cal patients. Medi-Cal accounted for nearly 19 percent of Sutter's gross patient service revenues in 2018.
- Throughout Sutter, we partner with and support community health centers to ensure that those in need have access to primary and specialty care. Sutter also supports 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 affiliated hospitals participate in a comprehensive and collaborative Community Health Needs Assessment, which identifies significant community health needs and guides

our community benefit strategies. The assessments help ensure that Sutter invests its community benefit dollars in a way that targets and addresses real community needs.

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

- 1. Behavioral Health
- 2. Economic Security
- 3. Housing and Homelessness
- 4. Healthcare Access and Delivery
- 5. Education and Literacy
- 6. Healthy Eating/Active Living
- 7. Community and Family Safety
- 8. Transportation and Traffic
- 9. Climate/Natural Environment

The 2019 Community Healthy Needs Assessment conducted by Sutter Delta Medical Center is publicly available at www.sutterhealth.org.

2019 Community Health Needs Assessment Summary

Sutter Delta Medical Center conducted its 2019 Community Health Needs Assessment (CHNA) collaboratively with local hospitals serving Contra Costa County, which included John Muir Health and Kaiser Permanente. The CHNA was completed by Actionable Insights (AI), LLC, an independent local research firm.

The Hospitals began the third CHNA cycle in 2018 with the goal to collectively gather community feedback, understand existing data about health status, and prioritize local health needs. Community input was obtained during the summer and fall of 2018 through key informant interviews with local health experts and focus groups with community leaders, residents, and representatives. Secondary data were obtained from the Community Commons data platform and other online sources such as the California Department of Public Health and the U.S. Census Bureau. Data were available for Contra Costa County and, in many cases, for hospitals' service areas specifically. Significant health needs were identified and prioritized in early 2019, described further below.

The full 2019 Community Health Needs Assessment conducted by Sutter Delta Medical Center is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

The Internal Revenue Service defines the community served as individuals who live within the hospital's service area. This includes all residents in a defined geographic area and does not exclude low-income or underserved populations.

Sutter Delta Medical Center is located in the city of Antioch in Eastern Contra Costa County. Sutter Delta Medical Center's hospital service area includes six zip codes surrounding the hospital and its neighboring communities. As previously noted, the medical center collaborated on the 2019 CHNA with other healthcare facilities serving the Eastern Contra Costa County region. Thus, the local data gathered for the assessment represent residents across the service areas of the participating hospitals, which include Antioch, Bay Point, Brentwood, Byron, Discovery Bay, Knightsen, Oakley, and Pittsburg.

The map below (Figure 1) on the next page shows the alignment of the Eastern Contra Costa County region with Sutter Delta Medical Center's service area.

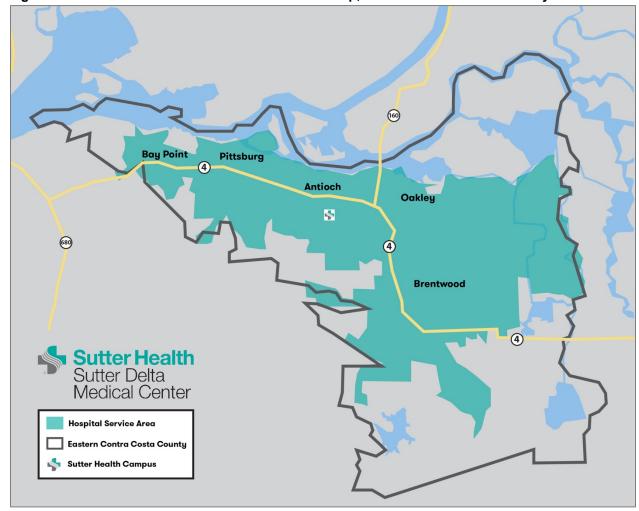


Figure 1. Sutter Delta Medical Center Service Area Map, Eastern Contra Costa County

The U.S. Census estimates a population of 318,900 in the Eastern Contra Costa County region. Close to 13% of residents in poverty, a higher proportion than in Contra Costa County overall. In addition, 18% of children live below the poverty line, again exceeding the county statistic. Eastern Contra Costa County is highly diverse. About 36% of residents are White, about 35% of residents are Latinx and about 13% are African American; residents of multiple races account for 5% of residents. In addition, nearly one in four Contra Costa County residents is foreign-born.

¹ U.S. Census Bureau. (2017). American Community Survey, 5-Year Estimates, 2013-17.

² The term "Latinx" is employed as a gender-neutral way to refer to Latin American and Hispanic individuals of any race.

Significant Health Needs Identified in the 2019 CHNA

The following significant health needs were identified in the 2019 CHNA:

- 1. Behavioral Health. Behavioral health, which includes mental health and substance use, is one of the health needs for which the community expressed strongest concerns in focus groups and interviews. Depression and stress were the most common issues raised. Mental health statistics for children and youth suggest a need for increased focus on addressing the issue and ethnic disparities exist across multiple behavioral health indicators for youth. Further, a significantly larger proportion of adults in the county, compared to the state, need help for mental health issues. Focus group participants and key informant interviewees also discussed the cooccurrence of mental health and substance use conditions.
- 2. Economic Security. Economic environments are important determinants of population health and economic security was one of the top priorities of the community. Key informant interviewees and focus group participants discussed food insecurity, risk of homelessness, and employment. Residents emphasized that local jobs often do not pay enough to afford the high cost of living. The percentage of older adults in Contra Costa County living in poverty has been increasing and the percentages of the local population enrolled in government assistance programs are substantially higher than state averages. In addition, disparities exist between ethnic groups in educational attainment, the rate of uninsured individuals, and people living in poverty.
- 3. Housing and Homelessness. Access to safe, affordable, and stable housing is associated with physical and mental health and well-being. Maintaining safe and healthy housing ranked high as a community priority. The median rent in the county is significantly higher than the state average and has been increasing, as has the proportion of children living in crowded housing. Poor housing quality is associated with childhood asthma prevalence and asthma-related emergency room visits; child and youth asthma diagnoses and hospitalizations are significantly higher in Contra Costa County than the state benchmark.
- 4. Healthcare Access and Delivery. The community expressed strong concerns about this health need, including the affordability of care and the lack of access to specialists, especially for Medi-Cal patients. Poor access to healthcare is associated with higher rates of many health conditions due to lack of preventive screenings and early treatment. A smaller proportion of Contra Costa County residents have a usual source for primary care, and a larger proportion have delayed or had difficulty obtaining care, compared to the Healthy People 2020 aspirational goals³. Additionally, the ratio of Federally Qualified Health Centers to residents is significantly worse locally than the state benchmark.
- 5. Education and Literacy. The relationship of educational attainment, employment, wages, and health have been well documented; limited literacy is correlated with low educational attainment. The community discussed concerns regarding education and academic achievement. The proportion of fourth graders who are reading at or above proficiency is significantly lower than the state average. In addition, ethnic disparities are evident in the proportion of students that pass the high school exit exam and high school graduation rates.
- 6. Healthy Eating/Active Living. This health need is comprised of access to food and recreation. food insecurity (also identified in Economic Security), diabetes, obesity, nutrition, diet, and fitness. There are fewer grocery stores and produce vendors per capita in the region compared to the state. A greater proportion of local youth are physically inactive compared to the state average; the community cited a lack of safe public spaces and community centers where residents can

³ Healthy People is an endeavor of the U.S. Department of Health and Human Services that has provided 10-year national

objectives for improving the health of Americans based on scientific data spanning 30 years. Healthy People sets national objectives, which serve as or targets for improvement. The most recent set of objectives are for the year 2020; year 2030 objectives are currently under development.

- engage in recreational activities and exercise. In addition, the rate of diabetes hospitalization among children and youth in Contra Costa County is above the state average.
- 7. Community and Family Safety. With regard to intentional injury, the community most frequently talked about domestic violence, violent crime, and unsafe neighborhoods. Children and youth were the populations about which participants expressed the most concern; issues included online and in-person bullying, being victims of violence, and acting out trauma. Some participants also indicated that human trafficking is a growing problem in Antioch. With regard to accidents, Contra Costa County's rates of children and youth being hospitalized for both poisoning and traumatic injury (intentional and unintentional) significantly exceed state benchmarks. Furthermore, the rate of fatalities from firearms (intentional or unintentional) also surpasses the state average.
- 8. Transportation and Traffic. The community discussed transportation as a barrier to seeing the doctor and getting to work and expressed frustration with the limitations and costs of public transportation, particularly BART, which is not widely accessible in Eastern Contra Costa County. A significantly smaller proportion of residents live within half a mile of a public transit stop compared to other state residents. Commutes by car can also wear on local residents; a significantly greater proportion of the region's commuters drive alone to work more than 60 minutes in each direction.
- 9. Climate/Natural Environment. Feedback from the community about the environment primarily concerned poor air quality, which was attributed to pollution and identified as a driver of asthma. Residents indicated that local refineries were a cause of air pollution. Road network density contributes to greater traffic, which can increase air pollution, and Eastern Contra Costa County has a significantly higher density of roads than the state average.

Health Need Identification

Health needs were identified by synthesizing primary qualitative research (community input) and quantitative (secondary) data, and then filtering those needs against the following set of criteria:

- 1. Meets the definition of a "health need," defined as a poor health outcome and its associated health driver, or a health driver associated with a poor health outcome where the outcome itself has not yet arisen as a need.
- 2. At least two data sources were consulted.
- 3. a. Prioritized by at least half of key informant interviewees or focus groups.
 - b. If not (a), three or more direct indicators fail the benchmark by ≥5% or show a ≥0.5 standard deviation.
 - c. If not (b), four or more indicators must show ethnic disparities of ≥5% or a ≥ 0.5 standard deviation.

Health Need Prioritization

In February 2019, Sutter Health, John Muir Health, and Kaiser Permanente convened a meeting with key leaders in Contra Costa County to prioritize the identified health needs. The following criteria were selected by the health systems in advance and considered by participants during the prioritization process.

- Clear disparities or inequities. This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, language, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.
- Community priority. This refers to the extent to which the community prioritizes the issue over
 other issues about which it has expressed concern during the CHNA primary data collection
 process. This criterion was ranked by Actionable Insights based on the frequency with which the
 community expressed concern about each health outcome during the CHNA primary data
 collection.
- Magnitude/scale of the need. This refers to the number of people affected by the health need.

- *Multiplier effect*. This refers to the idea that a successful solution to the health need has the potential to solve multiple problems.
- Severity of need. This refers to how severe the health need is (such as its potential to cause death or disability) and its degree of poor performance against relevant benchmarks.

Meeting participants individually ranked the health needs according to their interpretation of the criteria. Rankings were then averaged across all participants to obtain a final rank order of the health needs. Sutter Delta Medical Center then selected the top four health needs prioritized through this collaborative process to address in its 2019-2021 Implementation Strategy Plan.

2019 – 2021 Implementation Strategy Plan

The implementation strategy plan describes how Sutter Delta Medical Center plans to address significant health needs identified in the 2019 Community Health Needs Assessment and is aligned with the hospital's charitable mission. The strategy describes:

- Actions the hospital intends to take, including programs and resources it plans to commit;
- Anticipated impacts of these actions and a plan to evaluate impact; and
- Any planned collaboration between the hospital and other organizations in the community to address the significant health needs identified in the 2019 CHNA.

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

- 1. Behavioral Health
- 2. Economic Security
- 3. Housing and Homelessness
- 4. Healthcare Access and Delivery

Behavioral Health

	Investments made through grants and sponsorships are decided annually and based on community health need. Sutter Delta Medical Center (SDMC) seeks to promote behavioral health, in part, by supporting the provision of behavioral health programs, including those focused on the effective delivery of promotion and preventive interventions. Childhood and youth are opportune ages for promotion and preventive behavioral health interventions; schools are promising settings from which to prioritize these age groups and offer opportunities to engage the broader school community, including staff
	in part, by supporting the provision of behavioral health programs, including those focused on the effective delivery of promotion and preventive interventions. Childhood and youth are opportune ages for promotion and preventive behavioral health interventions; schools are promising settings from which to prioritize these age groups and offer opportunities to engage the broader school community, including staff
	and administrators, parents and caregivers, and students. ⁴ Further, SDMC supports workforce development strategies, which are critical to ensuring that present and future behavioral health needs of the community can be met. Additionally, enhancing the coordination of primary and behavioral healthcare in a clinical setting and improving access to wraparound resources that support health and well-being are approaches to behavioral healthcare services that Sutter Delta Medical Center supports.
	Sutter Delta Medical Center invests in organizations, programs, and initiatives that work to address behavioral health. The Antioch Unified School District's Mental Health and Wellness Initiative provides one example, among others, of an effort to address this health need by building the capacity of the broader school community to address behavioral health through training and systems change.
	Selected executed grants will be reported at year end.
;	Youth and adult residents are aware of and easily able to access appropriate behavioral health resources and services through sustainable, prevention-focused interventions
	Increased knowledge of behavioral health resources and services, including promotion and preventive approaches
	Improved access to behavioral health resources and services, including promotion and preventive approaches
	Number of persons served
the program/activity/initiative	Number of classes/workshops provided
	Number connected to mental health services
	Number of persons case-managed
	Additional metrics to be determined, based on organization/initiative supported. For example, Percent of staff reporting an increase in understanding of preventive mental health resources
	Percent reduction in student referrals

⁴ Healthy People 2020. Mental health and mental disorders. Retrieved August 8, 2019, from https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders

Economic Security

Name of program/activity/initiative	Investments in Economic Security
Description	Investments made through grants and sponsorships are decided annually and based on community health need.
	Financial health is associated with physical and mental health. Sutter Delta Medical Center works to promote economic security, in part, by supporting the provision of job training and workforce development, financial education and coaching, as well as the connection to income supports, such as food security and child care programs, for low-income youth and adult residents. Establishing long-term financial well-being requires a multi-faceted approach; Sutter Delta Medical Center partners with programs that connect their clients to bundled services such as job training, financial coaching, and access to wraparound resources that support health and well-being in collaboration with multi-sector partners. Supporting access to quality educational opportunities, from early childhood through higher education, is also critical to promoting financial security.
	Sutter Delta Medical Center invests in organizations, programs, and initiatives that work to address economic security. Examples of organizations within the hospital service area that support low-income residents in working towards financial security by providing job training, placement, and wraparound services in collaboration with other nonprofits in Contra Costa County are Loaves and Fishes of Contra Costa (offers a Culinary Arts Program for individuals interested in the culinary industry and experiencing barriers to employment) and Opportunity Junction (offers a Job Training and Placement Program for low-income residents launch to administrative careers), and others.
	Selected executed grants will be reported at year end.
Goals	Residents achieve financial security through increased income or other resources and/or improved financial management practices
Anticipated Outcomes	Improved knowledge, skills, and experience to support financial security and/or employability
	Increased access to educational and/or stable employment opportunities
	Attainment and retention of new employment opportunities or increased stability and/or wages of existing employment
Metrics Used to Evaluate the program/activity/initiative	Number of persons served
	Number connected to social services
	Number of classes/workshops provided
	Additional metrics to be determined, based on organization/initiative supported. For example, Percent of participants that graduate from the program
	Percent of program participants that secure employment
	Percent of program participants that retain employment (measured within a defined time period)
	Percent of program participants that enroll in additional educational opportunities

Housing and Homelessness

program/activity/initiative Description Investments made through grants and spons and based on community health need. Sutter Delta Medical Center (SDMC) works thomelessness, in part, by partnering with organized management, navigation, and support service currently experiencing, or exiting homelessness instability. Programs that prevent homelessness through strategies such as facilitating access.	
homelessness, in part, by partnering with org management, navigation, and support servic currently experiencing, or exiting homeless instability. Programs that prevent homelessn	orships are decided annually
housing assistance, and employment support are also important preventive approaches. ⁵ is multi-sectoral issue; Sutter Delta Medical organizations that convene and participate ir between governmental and nonprofit organizand delivery and/or in developing long-terms.	ganizations that provide case es to individuals at risk of, ess and/or housing ess and housing instability to affordable housing, ets for low-income residents, Housing and homelessness Center partners with a collaborative efforts eations in service outreach
Sutter Delta Medical Center invests in organ initiatives that work to address housing and house the Costa Health Services' Coordinated Outread (CORE) program is one example of a program hospital service area that works with individual homelessness to assess housing and service connection to shelter and support services.	nomelessness. The Contra h, Referral, and Engagement m, among others, within the als experiencing
Selected executed grants will be reported at	year end.
Goals Residents have access to safe, affordable, a resources that provide the conditions necess	
Anticipated Outcomes Provide information and support that, when a individuals from entering the homeless systematics.	
Support transitions from homelessness to int	erim housing arrangements
Provides linkages to health, behavioral healt services that support housing needs	h, benefits and other
Provide hygiene, clothing, basic needs (e.g., health and wellness	food, water) that promote
Metrics Used to Evaluate Number of persons served	
program/activity/initiative Number of encounters	
Number of people connected to social service	es
Number of people connected to mental healt	h services
Number of persons housed in shelters	
Number connected to permanent or tempora	ry housing
Additional metrics to be determined, based of supported.	n organization/initiative

⁵ United States Interagency Council on Homelessness. Home, together: Federal strategic plan to prevent and end homelessness. Retrieved from https://www.usich.gov/resources/uploads/asset_library/Home-Together-Federal-Strategic-Plan-to-Prevent-and-End-Homelessness.pdf

Healthcare Access and Delivery

Investments made through grants and sponsorships are decided annually and based on community health need. Sutter Delta Medical Center (SDMC) addresses healthcare access and delivery, in part, by partnering with community-based organizations that develop, expand, and promote affordable, culturally, and linguistically appropriate health services for uninsured and underinsured patients. This includes support for initiatives that improve access to primary care, which can offer a usual source of care, preventive care, early detection and treatment of disease, and chronic disease management. Additionally, enhancing the coordination of primary and behavioral healthcare in a clinical setting is an approach to care delivery that SDMC supports. Primary care has also been identified as an important setting in which to address the social determinants of health, and SDMC works with organizations that connect patients to additional wraparound resources that promote health and well-being, such as food and housing assistance and employment supports. SDMC invests in organizations, programs, and initiatives that work to address healthcare access and delivery. Examples of clinics within the hospital service area that improve access to primary care and connections to wraparound resources to uninsured and underinsured patients are La Clínica and RotaCare Pittsburg Free Medical Clinic at St. Vincent de Paul, and others. Selected executed grants will be reported at year end. To improve community health by expanding access to healthcare for uninsured and underinsured populations Improve access to primary healthcare services for low-income patients increase the percentage of primary care physician appointments that are scheduled and kept Metrics Used to Evaluate the program/activity/initiative Number of patients seen by a primary care physician appointments that are scheduled and kept Number of primary care physician appointments made Percent of primary care physician appointments kept	Name of program/activity/initiative	Investments in Healthcare Access and Delivery
delivery, in part, by partnering with community-based organizations that develop, expand, and promote affordable, culturally, and linguistically appropriate health services for uninsured and underinsured patients. This includes support for initiatives that improve access to primary care, which can offer a usual source of care, preventive care, early detection and treatment of disease, and chronic disease management. § Additionally, enhancing the coordination of primary and behavioral healthcare in a clinical setting is an approach to care delivery that SDMC supports. Primary care has also been identified as an important setting in which to address the social determinants of health, § and SDMC works with organizations that connect patients to additional wraparound resources that promote health and well-being, such as food and housing assistance and employment supports. SDMC invests in organizations, programs, and initiatives that work to address healthcare access and delivery. Examples of clinics within the hospital service area that improve access to primary care and connections to wraparound resources to uninsured and underinsured patients are La Clinica and RotaCare Pittsburg Free Medical Clinic at St. Vincent de Paul, and others. Selected executed grants will be reported at year end. Goals To improve community health by expanding access to healthcare for uninsured and underinsured populations Anticipated Outcomes Improve access to primary healthcare services for low-income patients Increase the percentage of primary care physician appointments that are scheduled and kept Metrics Used to Evaluate the program/activity/initiative Metrics Used to Evaluate the program/activity/initiative Number of patients seen by a primary care physician Appointments that are scheduled and kept Number of persons served Number of patients seen by a primary care physician Number connected to mental health services Number of expanded clinic hours offered Number of primary care physician appointments made		
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supported. For example, Number of expanded clinic hours offered Number of primary care physician appointments made		Number connected to social services
		supported. For example,
Percent of primary care physician appointments kept		Number of primary care physician appointments made
		Percent of primary care physician appointments kept

Healthy People 2020. Access to primary care. Retrieved August 7, 2019, from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/access-to-primary
 World Health Organization. Primary health care. Retrieved August 7, 2019, from https://www.who.int/news-room/fact-sheets/detail/primary-health-care

Name of program/activity/initiative	Advanced Illness Management (AIM) Program
Description	Sutter Health's Advanced Illness Management (AIM) program provides customized support for patients with advanced chronic illnesses in order to improve care transitions and reduce future hospitalization. The program help patients manage their health/illness symptoms, manage their medications, coordinate their care, plan for the future, and live the kind of life they want.
	Sutter Delta Medical Center supports the program, providing funding towards the care of the people who enroll in the East Bay service area.
	Once the AIM team understands the patient's health issues, lifestyle, and personal preferences, they work with the patient to tailor a care plan, ease the transition from hospital to home, and provide continuing overthe-phone support and in-person visits in the home or at the doctor's office as needed. If the patient returns to the hospital, AIM staff continues to support the patient there. The AIM team also provides support for the patient's family and helps them understand anything about the patient's condition that the patient wants them to know.
Goals	Help chronically ill patients better manage their health/illness through skilled, respectful coaching and care tailored to their needs
Anticipated Outcomes	Increase coaching services and support for patients who need help in self-managing advanced chronic illness
Metrics Used to Evaluate the program/activity/initiative	Number of persons enrolled in the program's East Bay service area (including demographics as available)
	Number of persons transitioned to home/self-care from hospital
	Number of persons transitioned to home healthcare service

Name of program/activity/initiative	Community Health Education Programs
Description	Sutter Delta Medical Center offers free classes and workshops focused on health topics such as diabetes self-management education (Living Well with Diabetes) and childbirth education (Ready, Set, Deliver) for the community, described further below. ⁸
	Living Well with Diabetes is a day-long course that is accredited by the American Association of Diabetes Educators and taught by a Registered Dietitian and Certified Diabetes Educator. The class focuses on topics such as supporting participants' understanding of diabetes and its risk factors, blood glucose patterns and diabetes management decisions, exercise and nutrition guidelines, preventing long-term complications, and insulin and oral medications.
	Ready, Set, Deliver helps expecting parents prepare for their childbirth experience. The program addresses anatomy and physiology of pregnancy during the last trimester, signs and symptoms of labor, delivery, postpartum recovery and newborn basics. The course also provides information on relaxation techniques and pain medication options. The course is taught by a Sutter Delta Medical Center Nurse.
Goals	Provide residents with health education that supports healthy behaviors, choices, and ultimately, positive health outcomes
Anticipated Outcomes	Participants experience increased knowledge of relevant health-related topics
	Participants experience an increased sense of confidence to make choices that support their health
Metrics Used to Evaluate	Number of persons served
the program/activity/initiative	Number of classes/workshops provided

⁸ More information about Sutter Delta Medical Center's community health education opportunities can be found at https://www.sutterhealth.org/delta/classes-events

Name of program/activity/initiative	Health Professions Education
Description	Developing the health professions workforce is a critical component of healthcare access and delivery. Sutter Delta Medical Center (SDMC) offers educational experiences to youth and adult students with the goal of facilitating pathways to the health professions. The Professional Services department partners with community colleges, universities, and other training programs to provide internships, residencies, and clinical rotations to health professions students, in alignment with their coursework, degree and/or certification requirements. Educational opportunities are offered in departments including clinical social work, central processing, emergency medical services, healthcare administration, nursing, nutrition, occupational therapy, pharmacy, radiology, and surgery.
	SDMC also offers an Educational Day, providing high school students with opportunities to learn about careers in the health professions, including cardiac catheterization, case management, clinical social work, nursing, pharmacy, physical therapy, and surgery.
Goals	The next generation of health professionals will be prepared to meet the healthcare needs of Eastern Contra Costa County through their training in providing compassionate and excellent care
Anticipated Outcomes	Students successfully complete their training at Sutter Delta Medical Center
	An increased number of health care professionals are trained at Sutter Delta Medical Center
	An increased number of high school students are trained at Sutter Delta Medical Center
Metrics Used to Evaluate	Number of persons served
the program/activity/initiative	Number of high school students served
	Number of health professions students served
	Number of health professions student successfully completing their training hours
	Number of participating health professions programs
	Number of participating high schools
	Number of health professions students trained and hired after graduating by SDMC

Needs Sutter Delta Medical Center Plans Not to Address

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

- Education and Literacy
- Healthy Eating/Active Living
- Community and Family Safety
- Transportation and Traffic
- Climate/Natural Environment

Sutter Delta Medical Center will focus on the top four health needs that were identified and prioritized through the 2019 Community Health Needs Assessment. The decision to not directly address the remaining five health needs, listed above, was based on the magnitude and scale of health needs, resources available, and commitment to developing a focused strategy in response to the needs assessment.

Approval by Governing Board

The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Health Bay Hospitals Board on November 20, 2019.