Sutter Health

Sutter Santa Rosa Regional Hospital (SSRRH)

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

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Introduction

The implementation strategy describes how Sutter Santa Rosa Regional Hospital, 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.

Sutter Santa Rosa Regional Hospital 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 using the hospital's address at 30 Mark West Springs Road, Santa Rosa, CA 95403, attention: Penny Cleary, and
- In-person at the hospital's Information Desk.

About Sutter Health

Sutter Santa Rosa Regional Hospital 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:

We 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 Santa Rosa Regional Hospital, visit www.sutterhealth.org.

2016 Community Health Needs Assessment Summary

The 2016-2019 Sonoma County Community Health Needs Assessment was conducted over a 9 month period from June, 2015 through March of 2016. All seven hospitals in Sonoma County collaborated on this project in partnership with Sonoma County Department of Health Services. Harder and Company, a consulting firm based in San Diego, was contracted to manage the project.

Summary of Needs Assessment Methodology and Process

The CHNA process used a mixed-methods approach to collect and compile data to provide a robust assessment of health in Sonoma County. A broad lens in qualitative and quantitative data allowed for the consideration of many potential health needs as well as in-depth analysis. Data sources included:

- Analysis of over 150 health indicators from publicly available data sources such as the California Health Interview Survey, American Community Survey, and the California Healthy Kids Survey. Secondary data were organized by a framework developed from Kaiser Permanente's list of potential health needs, and expanded to include a broad list of needs relevant to Sonoma County.
- Interviews with 21 key stakeholders from the local public health department, as well as leaders, representatives, and members of medically underserved, low-income, minority populations, and those with a chronic disease. Other individuals from various sectors with expertise in local health needs were also consulted.
- Five focus groups were conducted, reaching 64 residents representing different geographic regions in the county, racial/ethnic subpopulations, and age categories.

The full 2016 Community Health Needs Assessment conducted by Sutter Santa Rosa Regional Hospital is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

The service area for Sutter Santa Rosa Regional Hospital is Sonoma County.

Sonoma County and California Demographic and Socioeconomic Data[1]		
Indicator	**Sonoma County**	**California**
Demographic and Socioeconomic Information		
Total Population	487,469	37,659,181
Median Age	40.2 years	35.4 years
Under 18 Years Old	25.3%	24.5%
65 Years and Older	14.7%	11.5%
White	80.0%	62.3%

[1] Unless noted otherwise, all data presented in this table is from the US Census Bureau, 2009-2013 American Community Survey 5-Year Estimate.

Hispanic/Latino	25.2%	37.9%
Some Other Race	9.2%	12.9%
Asian	4.0%	13.3%
Multiple Races	3.6%	4.32%
Black	1.6%	6.0%
Native American/ Alaskan Native	1.3%	0.8%
Pacific Islander/ Native Hawaiian	0.4%	0.4%
Median Household Income[2]	$67,771	$61,933
Unemployment[3]	5.0%	6.8%
Linguistically Isolated Households	5.6%	10.3%
Renters Spending ≥30% of Household Income on Rent[4]	52.4%	53.8%

The following data provide an overall picture of the Sonoma County population. Demographic and socioeconomic data present a general profile of residents, while overall health indicators present an assessment of the health of the county. Key drivers of health (e.g., healthcare insurance, education, and poverty) illuminate important upstream conditions that affect the health of Sonoma County today and into the future. Finally, climate and physical environment indicators complement these socioeconomic indicators to provide a comprehensive understanding of the determinants of health in Sonoma County. All indicators include California comparison data as a benchmark to determine disparities between Sonoma County and the state. Healthy People 2020 benchmarks are also included when available.

Although Sonoma County is a healthy and affluent county, especially compared to California as a whole, substantial disparities in socioeconomic status and access to opportunity present challenges for the health of Sonoma County residents. The *Portrait of Sonoma County* assessed overall health in the county as well as explored notable geographic disparities. For example, the *Portrait of Sonoma County* identified that life expectancies in the top and bottom census tracks vary by an entire decade. The top five tracts are Central Bennett Valley (85.7 years), Sea Ranch/Timber Cove and Jenner/Cazadero (both 84.8 years), Annadel/South Oakmont and North Oakmont/Hood Mountain (both 84.3 years), and West Sebastopol/Graton (84.1 years). Other areas have far lower life expectancies, including Bicentennial Park (77.0 years), Sheppard (76.6 years), Burbank Gardens (76.0 years), Downtown Santa Rosa (75.5 years), and Kenwood/Glen Ellen (75.2 years). Higher life expectancy was correlated with higher educational attainment and enrollment. This and other indications of health disparity in Sonoma County informed areas of high need to be considered most closely in the CHNA process.

Significant Health Needs Identified in the 2016 CHNA

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

1. **Early Childhood Development:** Child development includes the rapid emotional, social, and mental growth that occurs during gestation and early years of life. Adversities experienced in early life threaten appropriate development, and may include exposure to poverty; abuse or violence in the home; limited access to appropriate learning materials and a safe, responsive environment in which to learn; or parental stress due to depression or inadequate social support.

   Exposure to early adversity is pervasive in Sonoma County. Among adults in Sonoma and Napa County (combined for stability), 22.0% report having experienced four or more unique early childhood experiences (ACEs) before age 18 which may including childhood abuse (emotional, physical, and sexual), neglect (emotional and physical), witnessing domestic violence, parental marital discord, and living with substance abusing, mentally ill, or criminal household members. Key themes among residents and stakeholders included the high cost of living and high cost of child care in Sonoma County, as well as the importance of quality early education and home stability on development among young children.

[2] US Census Bureau, 2014 American Community Survey.
[3] US Department of Labor, Bureau of Labor Statistics, June 2015.
[4] US Census Bureau, 2014 American Community Survey.

2. **Access to Education:** Educational attainment is strongly correlated to health: people with low levels of education are prone to experience poor health outcomes and stress, whereas people with more education are likely to live longer, practice healthy behaviors, experience better health outcomes, and raise healthier children.

   In Sonoma County, Kindergarten readiness is used as an early metric to consider disparities in early learning. Third grade reading level is another predictor of later school success; in Sonoma County 43.0% of third grade children are scoring at or above the "Proficient" level on English Language Arts California Standards Test. Although only 13.0% of county residents age 25+ have less than a high school diploma, extreme racial disparities exist. Among residents identifying as American Indian/Alaska Native, African American/Black, Hispanic/Latino, Native Hawaiian/Pacific Islander, and Some Other Race, a higher percentage of individuals have less than a high school diploma compared to the total population and compared to White residents. English Language Learners are also a population of particularly high concern with respect to educational attainment. Only 39.0% of tenth grade English Language Learners passed the California High School Exit Exam in English Language Arts, compared to 86.0% of all tenth grade students in Sonoma County. Only 55.0% of English Language Learners passed in Mathematics, compared to 87.0% of all Sonoma County tenth graders. For all students in the county, stakeholders identified the need to increase investment in early childhood education as a pathway to reducing educational disparities and increasing overall academic success.

3. **Economic and Housing Insecurity:** Economic resources such as jobs paying a livable wage, stable and affordable housing, as well as access to healthy food, medical care, and safe environments can impact access to opportunities to be healthy.

   The high cost of living in Sonoma exacerbates issues related to economic security and stable housing. Among renters, 52.4% spend 30% or more of household income on rent. A lack of affordable housing and a dearth of jobs paying a living wage were identified as key challenges to achieving economic and housing security in the county.

4. **Oral Health:** Tooth and gum disease can lead to multiple health problems such as oral and facial pain, problems with the heart and other major organs, as well as digestion problems.

   In Sonoma County, oral health is in part affected by lack of access to dental insurance coverage or inadequate utilization of dental care. Among adults, 38.9% do not have dental insurance coverage and may find it difficult to afford dental care. Among adults 65 years and older, 51.8% do not have dental insurance coverage. Among adults, 9.2% have poor dental health. In 2014, 51% of kindergarteners and 3rd graders had tooth decay. Residents and stakeholders highlighted the lack of dental care providers who accept Denti-Cal, as well as the lack of early prevention of oral health problems, in part due to limited access to affordable preventative care.

5. **Access to Health Care:** Ability to utilize and pay for comprehensive, affordable, quality physical and mental health care is essential in order to maximize the prevention, early intervention, and treatment of health conditions.

   With the implementation of the Affordable Care Act (ACA), many adults in Sonoma County are able to obtain insurance coverage and access regular healthcare. However, disparities persist. Specifically, lower income residents have difficulty accessing care, as many remain uninsured due to high premium costs, and those with public insurance face barriers to finding providers who accept MediCal. Foreign-born residents who are not U.S. citizens also face stark barriers in obtaining insurance coverage and accessing care. While only 10.0% of Sonoma County residents are uninsured, 18.7% of residents earning below 138% of the Federal Poverty Level and 34.2% of foreign-born residents who are not U.S. citizens do not have insurance coverage. Among those who do have insurance coverage, primary data identified other barriers to accessing care

including that there are not enough primary healthcare providers in Sonoma County to meet the high demand. Others noted difficulties in navigating the care delivery system in an efficient way.

6. **Mental Health:** Mental health includes emotional, behavioral, and social well-being. Poor mental health, including the presence of chronic toxic stress or psychological conditions such as anxiety, depression or Post-Traumatic Stress Disorder, has profound consequences on health behavior choices and physical health.

   Mental health was raised as a high concern for all residents, especially youth and residents experiencing homelessness. Most notably, Sonoma residents have a high risk of suicide. 12.3 per 100,000 county residents. Depression is also a concern, as 31.3% of youth and 14.1% of Medicare beneficiaries are depressed. Residents and stakeholders noted challenges in obtaining mental health care, including that preventative mental health care and screening is limited and that stigma may prevent individuals from seeking professional treatment.

7. **Obesity and Diabetes:** Weight that is higher than what is considered a healthy weight for a given height is described as overweight or obese. Overweight and obesity are strongly related to stroke, heart disease, some cancers, and Type 2 diabetes.

   In Sonoma County, an estimated 25.4% of adults are obese, and 37.9% are overweight. Among youth, 17.5% are obese and 20.0% are overweight. Busy lifestyles and the high cost of living compete with purchasing and cooking healthy food. Lack of physical activity was also noted as a driver of obesity and diabetes, in part due to a lack of affordable exercise options.

8. **Substance Use**: Use or abuse of tobacco, alcohol, prescription drugs, and illegal drugs can have profound health consequences, including increased risk of liver disease, cancer, and death from overdose.

   In Sonoma County, substance abuse was identified as a concern, particularly with respect to alcohol consumption. Among adults, 21.3% of residents report heavy alcohol consumption. Youth were noted as a high risk population, and data indicates that in the prior 30 days 13.8% of 11th grade students reported using cigarettes, and 28.0% reported using marijuana. Additionally, 24.4% of 11th grade students reported ever having driven after drinking.

9. **Violence and Unintentional Injury:** Violence and injury is a broad topic that covers many issues including motor vehicle accidents, drowning, overdose, and assault or abuse, among others. In Sonoma County, the data show that the core issues within this health need are related to domestic violence and violent crime. Among adults, 17.1% self-report having experienced sexual or physical violence by an intimate partner during adulthood. The county also has high rates of reported violent crime, including 28.4 incidents of rape per 100,000 population, compared to 21.0 per 100,000 residents on average in California, and 285.7 incidents of assault per 100,000 population, compared to 249.4 per 100,000 in California overall.

Data were used to score each health need. Potential health needs were included in the prioritization process if:

- At least two distinct indicators reviewed in secondary data demonstrated that the county estimate was greater than 1% “worse” than the benchmark comparison estimate (in most cases, California state average);
- Health issue was identified as a key theme in at least eight interviews; and
- Health issue was identified as a key theme in at least two focus groups.

The CHNA Core Planning Team with additional hospital representatives was convened on November 20, 2015, to review the health needs identified, discuss the key findings from CHNA, and prioritize top health

issues that need to be addressed in the County. The group utilized the Criteria Weighting Method, which enabled consideration of each health area using four criteria: severity; disparities; impact; and prevention.

The CHNA is an important first step towards taking action to effect positive changes in the health and well-being of county residents. Each hospital will develop an implementation strategy for the priority health needs the hospital will address. These strategies will build on their assets and resources, as well as evidence-based strategies, wherever possible. In alignment with the hospital implementation plans, Health Action will use this report for strategic planning and developing cross-sector approaches to address key health needs.

2016 – 2018 Implementation Strategy

The implementation strategy describes how Sutter Santa Rosa Regional Hospital 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 Sutter Santa Rosa Regional Hospital initiatives that may not be described herein, but which together advance Sutter Santa Rosa Regional Hospital commitment to improving the health of the communities it serves. Each year, Sutter Santa Rosa Regional Hospital programs are evaluated for effectiveness, the need for continuation, discontinuation, or the need for enhancement. Depending on these variables, programs may change to continue Sutter Santa Rosa Regional Hospital focus on the health needs listed below.

The prioritized significant health needs the hospital will address are:

1. Economic and Housing Insecurity
2. Access to Health Care
3. Obesity and Diabetes
4. Access to Education
5. Oral Health

Economic and Housing Insecurity

Name of program/activity/initiative	Catholic Charities Nightingale Project
Description	The Project Nightingale – Respite Care Expansion Pilot Program provides post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets, but are not ill enough to be in a hospital or skilled-nursing facility (SNF). Medical respite is short-term residential care that allows homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. This project is a significant collaboration between Catholic Charities, Sutter Health, Kaiser Permanente, Providence St Joseph Health

	and the Sonoma County Department of Health Services. Each partner commits annual grant funding to operate the program and provides consultation around the referral process, home-health services and services needed to reduce the occurrence of re-admission and/or unnecessary emergency department visits.
Goals	The goals of the Nightingale Project are: 1) Provide a safe discharge plan for hospitalized homeless patients with appropriate after care 2) Reduce unnecessary/inappropriate use of valuable hospital resources to ensure that hospital beds are available for people who require that level of care
Anticipated Outcomes	• Improved (and measured) short- and long-term health outcomes for clients. • More appropriate use of health care services which will, in turn, lower hospital inpatient cost and decrease the number of unnecessary hospital stays and re-admission. • Clients will be linked to a primary care home and enrolled in available enabling services to ensure that basic needs are met (especially around housing).
Plan to Evaluate	a. Evaluation plan will measure: i. Patient Engagement in Care ii. Hospital Readmission Rates iii. Emergency Department Readmission Rates iv. Direct Service Performance Indicators (number of clients linked to primary care home, health insurance, housing, etc.) b. In addition, return on investment will be analyzed in order to capture saving that could be reinvested in the project in the future.
Metrics Used to Evaluate the program/activity/initiative	1. # of visits to PCP after admission 2. Tracking of hospital re-admission data 3. Tracking of hospital ER visits 4. Logs of services that clients are connected to 5. Creation of standard daily bed rate by hospitals that will be used to determine cost savings per # of days patient is in shelter

Name of program/activity/initiative	Social Advocates For Youth-Dream Center
Description	Social Advocates For Youth (SAY) is a community based organization that serves teens and transition-age young adults by providing housing, counseling and career services. SAY's Housing Continuum program empowers youth on the pathway to being stable and able to rise to life's challenges and opportunities. This wrap-around approach is built on evidence-based programs and practices designed to support youth and young adults who have been disconnected from caring adults and community-based support structures. SAY's Housing Continuum provides

	safe, stable, and appropriate housing; education and employment services; counseling; and permanent connections within a welcoming and supportive environment. Our Street Outreach Program, Teen Shelters, Transitional Housing Programs, Counseling Department, and Career Services work in concert to provide a continuum of care. The Dream Center provides permanent housing for at-risk youth along with a myriad of support services designed to send them on the path of successful independent living. The building for the Center was donated by Sutter Health and we continue to partner with SAY to support this vulnerable population in order to reduce the risk of chronic homelessness with annual grants.
Goals	To provide safe, stable housing for at-risk and homeless youth along with counseling and school/career readiness services
Anticipated Outcomes	• 75% of participants experience increased life skills (improvement on at least two domains on Casey Life Skills Assessment) • 80% of participants are employed for 3+ months in an unsubsidized job • 90% employed at least half-time at a living wage for a minimum of six months post-program • 92% stably housed (in a non-temporary, rent-paying housing situation) for a minimum of six months post-program
Plan to Evaluate	Impact data will be collected by client surveys, and observation checklists
Metrics Used to Evaluate the program/activity/initiative	# of participants experience increased life skills (improvement on at least two domains on Casey Life Skills assessment) # of participants are employed for 3+ months in an unsubsidized job # employed at least half-time at a living wage for a minimum of six months post-program # stably housed (in a non-temporary, rent-paying housing situation) for a minimum of six months post-program

Access to Health Care

Name of program/activity/initiative	Santa Rosa Family Medicine Residency Program
Description	The Santa Rosa Family Medicine Residency Program has been the sole local contributor to the primary care provider pipeline in Sonoma County for more than 45 years. In affiliation with the UCSF School of Medicine, this training program for family physicians is one of the most renowned training program for family doctors in the United States. In fact, more than half of all medical school graduates who apply to family medicine residencies apply to our program. Graduates of the program represent about 50% of the current practicing family doctors in Sonoma County and about 2/3 of the medical staff at our local FQHC's are graduates. FQHC's care for about 25% our county's population. During their three years of training, the residents (under the supervision of Sutter attending physicians) provide all of the primary care to the patients at the largest FQHC in our community. This represents about 25,000 patient visits, provided at no charge to the clinic. Sutter covers all the costs related to this program that are not covered through Medicare IME reimbursement.
Goals	In addition to providing high quality training to family medicine residents, the

	program provides greater access to care by addressing the shortage of primary care providers. In an area with a high-cost of living, recruitment from outside the area would be extremely challenging, thereby creating an even greater shortage. Having a highly-skilled primary care workforce also can reduce health care costs.
Anticipated Outcomes	1) Adequate supply of primary care physicians to meet community demand 2) Reduced cost to provide primary care thereby increasing access for all
Plan to Evaluate	1) Assess and compare penetration of primary care providers as a percentage of the population. 2) Compare cost of health care and mortality rate to similar communities with lower penetration of primary care providers
Metrics Used to Evaluate the program/activity/initiative	Dartmouth Atlas of Health Care reports: 1) Total Medicare Reimbursements per hospital region 2) Number of primary care providers per 100,000 people

Name of program/activity/initiative	Operation Access
Description	Since 2001, Operation Access has enabled physicians and medical centers in the Sonoma County to donate vital surgical and specialty care to people in need. Sutter Health has partnered with OA to provide free time in the operating room, staffing and surgical supplies to facilitate surgeries for people without insurance or for whom public health coverage will not authorize an elective but important restorative or corrective surgical procedure. Surgeries provided through OA often restore functionality so as to allow a previously disabled patient to return to work. OA is also able to facilitate surgical intervention of conditions before they become emergent which increases morbidity, mortality and cost to the healthcare system. SSRRH will provide $150,000 value in free OR time (which includes staffing and supplies) each year.
Goals	Provide every eligible person access to needed surgical services, regardless of their ability to pay
Anticipated Outcomes	1. Increase in the number of high volume specialty volunteers 2. Improved patient outcomes through timely surgical procedures 3. Provision of free surgical and specialty services to all eligible uninsured people
Plan to Evaluate	Quarterly tracking against stated targets for each metric below
Metrics Used to Evaluate the program/activity/initiative	1) # surgical procedures and diagnostic services provided 2) # unduplicated individuals receiving care through Operation Access 3) # of individuals indirectly (household members) served through Operation Access 4) # of patient visits/treatment sessions through Operation Access 5) # of days median wait time between referral and first appointment with a specialist; # of days median wait time between referral and procedure with a specialist 6) % of Operation Access clients will report satisfaction with the quality of care received 7) % of Operation Access clients reporting an improved ability to work 8) Beginning in 2017 we will be measuring the % of clients who report their health status as fair or poor (the bottom 2 of 5 categories) both during intake and after the procedure; changes in this might correlate to important health outcome indicators. This measure

	mirrors an indicator that was highlighted in Sarah Katz's report to the Covered Sonoma committee several months ago from her recent study on the local residually uninsured population.

Obesity and Diabetes

Name of program/activity/initiative	Northern California Center for Well-Being
Description	The Northern California Center for Well-Being (NCCWB) is a not-for-profit community –based organization with a mission to improve the health of the community through prevention-oriented education and intervention to address obesity, diabetes and heart disease. They offer a myriad of classes and health education materials that are free or sliding-scale fee-based for low-income families. Sutter Santa Rosa Regional Hospital has partnered with the NCCWB for many years to provide cardiac rehab services aimed at reducing the incidence of future cardiac events. We will augment this support to help fund their programs specifically targeted at educating the Latino Community on healthy eating, active living and the management of diabetes. Examples of programs include "Ido26.2" a school-based program that promotes physical activity and includes a curriculum for healthy eating. Students work toward completing a 26.2 mile marathon in walking during the time they are enrolled in the program.
Goals	To empower people to take charge of their health and wellness by making knowledgeable and healthy choices about eating, fitness and disease prevention/management.
Anticipated Outcomes	Through the integration of knowledge, participants in these education classes will report: 1) Healthier food choices for themselves and their families 2) Sustained positive behaviors around physical activity 3) Better self-management of diabetes
Plan to Evaluate	Quarterly reports that include various metrics measuring knowledge, behavior change and health improvement by a variety of methods, including observation, self-report, and clinical data.
Metrics Used to Evaluate the program/activity/initiative	1. Pre and post intervention knowledge 2. Behavior change 3. Improvement on specific clinical markers 4. Client Satisfaction with experience

Name of program/activity/initiative	Community Soils Foundation
Description	Community Soils Foundation exists to cultivate the wellness of Sonoma County communities by offering land-based education, creating access to organic produce and regenerating habitat and natural resources. The demonstration project of the foundation is the Larkfield Community Garden, co-located near the campus of an elementary school in Santa Rosa, nearby the hospital. The garden provides an outdoor learning lab for the students on healthy eating, the food cycle, sustainable farming and the economics of food/food scarcity. SSRRH is the lead sponsor of this project. Collaborative partners include the Mark West Union School District, County of Sonoma Departments of Public Health and Regional Parks.
Goals	1. Place-based learning for children

	2. Youth Development and Leadership 3. Healthy Food Production and Distribution to Low-Income residents 4. Sustainable Agriculture/Ecology Education and Community Building
Anticipated Outcomes	More than 25 classrooms from K-8th grade at Mark West Elementary School will receive instruction in the garden and learn about the benefits of increasing physical activity and eating more fruits and vegetables. In addition, the 3rd, 4th and 5th grades receive extensive nutrition education through a SNAP-Ed approved curriculum, Growing Healthy Habits that focuses on the importance of eating a balanced, organic whole foods diet rich in plant-based ingredients. We expect to see youth and their families in the community eating more fruits and vegetables and increasing their physical activity leading to overall positive health outcomes.
Plan to Evaluate	Pre-test of students Post-test of students
Metrics Used to Evaluate the program/activity/initiative	-# of students served -increased knowledge about healthy eating and fitness

Oral Health

Name of program/activity/initiative	Sonoma County Dental Health Network
Description	The Sonoma County Dental Health Network (DHN) is a cross-sector team of professionals committed to improving the dental health of our community, with an upstream focus targeting children and families. The DHN has 4 specific action areas with teams working on strategies to achieve objectives within the scope of the work of the respective team but all working toward the overall goal of 75% of kindergartners being cavity-free in 2020. The teams are as follows: • Leadership and Sustainability • Community Education and Engagement • Integrated Service System • Evaluation
Goals	That 75% of kindergarten children in Sonoma County will be cavity-free in 2020.
Anticipated Outcomes	**Leadership and Sustainability** **Goal:** Engage local political support and leadership championing the DHN vision and the financial resources needed to support it. **Strategies:** 1. Educate and Mobilize Consumers and Voters to advocate for community dental health 2. Engage and Influence Local and State Policy Makers to champion positive oral health policies 3. Identify and cultivate additional funding for the Dental Health Network **Community Education and Engagement**

Goal: Improve the dental health of pregnant women and children age 0-5 through community engagement and education.

Strategies:

1. Engage and include community-based advocates, educators, community leaders, and community members around promotion of dental health
2. Develop community-wide, consistent messaging and a marketing plan
3. Embed dental health in existing community health initiatives

Integrated Service System

Desired Outcome: All participating health clinics increase the following measures by 10%:

- % of children who a dental assessment by age 1
- % of children who receive at least 2 fluoride varnish applications per year
- % of OB woman who have dental exam

Goal: Design a comprehensive oral health service delivery program that includes: a) standards and referral and follow-up procedures; b) the engagement of community-based sites (e.g., WIC, schools, child-care, health and dental clinics, etc.); and c) a training and capacity-building infrastructure.

Strategies:

1. Engage medical and dental providers as 'thought partners' in the design of an integrated oral health service system
2. Design the specific standards, procedures, and programmatic infrastructure needed at each site
3. Establish the organizational and personnel capacity to address the gaps in, and provide care within, the service delivery system

Evaluation (see below)

Plan to Evaluate	One of the four action teams is focusing exclusively on evaluation and surveillance. At the time of this writing, specific evaluation methodology is in development but will include: **Strategies:** 1. Establish a surveillance system to monitor dental health in Sonoma County 2. Build a culture of quality improvement in dental health **3.** Evaluate the Strategic Plan
Metrics Used to Evaluate	Tbd (see above)

the program/activity/initiative	

Name of program/activity/initiative	Pediatric Dental Initiative
Description	Since 2008, the Pediatric Dental Initiative (PDI) has existed to provide safe, child-friendly surgical intervention to treat severe dental caries in children and to provide effective and culturally appropriate health education to families of patients to reduce the risk of recurrence with the patient or younger siblings. The goal of the program is to educate itself out of business by increasing dental health and reducing the need for surgical intervention. Sutter Health has been a supporter of PDI since its inception but will focus our support to assist them in measuring the impact of their interventions on reducing the incidence of repeat visits within the same family. To date, PDI does not have the resources to conduct robust evaluation. Sutter will invest in staffing to focus on evaluation.
Goals	To provide useful outcome and impact data to demonstrate the effectiveness of the education efforts in reducing recurrence of serious decay in pediatric patients of the surgery center.
Anticipated Outcomes	Seeing your child undergo general anesthesia to treat a completely preventable disease is often the “wake-up” call parents need to take seriously the dental health of their children. These are very teachable moments when families are open to intervention and accept education and support in making the behavioral changes necessary to prevent future decay.
Plan to Evaluate	The evaluation plan will be more formally developed upon the hire of the staff person who will be responsible for it but it will likely be focused on self-report (via face-to-face survey) of parents of patients pre and post-surgery and the oral health education program
Metrics Used to Evaluate the program/activity/initiative	TDB but possible metrics to include: -Do you supervise your child when they brush their teeth? -How many times a day does your child brush? -Do you give your child a bottle or sippy cup at bedtime? What does it contain? -Does your child eat any of the following: gummy vitamins, goldfish crackers, etc? -How many times a day do you drink a glass of water? -Is there water served at mealtime? -How many times a day do you drink soda? 1x, 2x, 3x, none -Do you check the labels of foods and beverages for sugar content? -Have you seen PDI’s billboard or movie theater ads? -Do you see a dentist twice a year? -When was the last time you and/or your child saw a dentist?

Access To Education

Name of program/activity/initiative	Health and Wellness Workforce Development Program
Description	The Health and Wellness Workforce Development Program is an expanded collaborative that is building upon the work done by its predecessor, The

	Healthcare Workforce Development Roundtable. Both have been/are focused on two over-arching goals: 1) to build a skilled and culturally diverse local pipeline for the health and wellness industries 2) support dis-advantaged students of color in achieving educational and training goals to enter the healthcare workforce. This effort is a collaboration among health care, workforce development and education (HS and college/vocational training) partners. Sutter Santa Rosa Regional Hospital is a founding partner and will continue to provide leadership on the steering committee, staff resources to coordinate job shadowing experiences and financial support.
Goals	The current priorities are of the program are: 1) Create a "user-friendly" web-based platform for hosting information about health careers, job and training opportunities, professional profiles, etc designed to interest and engage the "technology-age" students in pursuing health careers 2) Create innovative and engaging educational and career prep programs and opportunities for students.
Anticipated Outcomes	1. Increased awareness of health careers and pathways for high school and college students 2. Better coordinated and higher functioning job/career shadowing program that creates a "one-stop" point of contact for all school-based health career pathway programs.
Plan to Evaluate	These are brand new initiatives for which specific evaluation plans and methodology have not yet been developed. As much of this work will be grant funded, the staff understand the imperative to measure and report impact. The first annual update of this plan will include specifics.
Metrics Used to Evaluate the program/activity/initiative	tbd

Name of program/activity/initiative	Social Advocates for Youth (SAY)-College and Career Readiness Program
Description	SAY's College and Career Readiness program offers work-based learning programs at high schools in the Santa Rosa City Schools District. Work-based learning is an educational approach that, by design, links learning in the workplace to learning in the classroom to engage students more fully and to intentionally promote their exposure and access to future educational and career opportunities. SAY Work-based learning opportunities and activities include guest speakers, employer tours, informational interviews, job shadows, volunteering, paid/unpaid internships, and community employment. Evidence suggests that students who engage in experiences that connect school learning to the real world are more likely to stay in school and increases the chances that students will be both college and career ready.
Goals	Prepare at-risk youth for the workforce by addressing barriers to completing high school, facilitating entrance into higher education and/or job training programs and providing mentoring and job shadowing experiences.
Anticipated Outcomes	The program has not yet developed specific evaluation measures to track outcomes but is planning to do that this year so that they can measure the impact of the many activities students participate in that help prepare them to complete their education and prepare for the workforce, including:

	• Industry connections • Job readiness workshops • Worksite tours • Job shadows • Mock interviews • Guest speakers • Informational interviews • Support of the district-wide college and career fair
Plan to Evaluate	Data is collected upon program intake and during the academic year while the students are involved in College and Career Readiness. The CCR Program Manager is currently working with the schools to develop an information sharing system that does not conflict with HIPAA standards and will enable CCR program staff to track the progress of students related to employment and post-secondary education and training. Meantime, the CCR team collects data on the number of students participating in the program and the number of students involved in specific activities. Data collection is ongoing throughout the academic year and a final report prepared at year-end.
Metrics Used to Evaluate the program/activity/initiative	Sutter will work with program team to incorporate evaluation template developed by Sutter Health to track metrics and measure outcomes but for now, only # of students participating in the various activities is tracked.

Needs Sutter Santa Rosa Regional Hospital **Plans Not to Address**

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

1. **Early Childhood Development-**the primary issue within this identified priority is Adverse Childhood Experience, or ACES. SSRRH does not have any expertise or strategic activity in this area. There are many robust programs and agencies county-wide that are addressing these issues and we will consider small requests for support.

2. **Mental Health**-though a significant issue in our community, it is not within the scope of the hospital's services to provide mental health programs nor do we have this expertise. Though not a major priority for SSRRH, we have and will continue to respond to modest requests for funding to support programs that address these issues.

3. **Substance Abuse-** though a significant issue in our community, it is not within the scope of the hospital's services to provide substance abuse treatment or prevention programs nor do we have this expertise. Though not a major priority for SSRRH, we have and will continue to respond to modest requests for funding to support programs that address these issues.

4. **Violence and Unintentional Injury**-there are several programs in the community that are working, separately and collaboratively to address this issue, particularly in the areas of domestic and gang violence. Though not a major priority for SSRRH, we have and will continue to respond to modest requests for funding to support programs that address these issues.

Approval by Governing Board

The implementation strategy was approved by the Sutter Health Bay Area Board on November 16, 2016.