Sutter Health

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Sutter Tracy Community Hospital

2019 – 2021 Community Benefit Plan
Responding to the 2019 Community Health Needs Assessment
Submitted to the Office of Statewide Health Planning and Development May 2020

1420 N. Tracy Boulevard, Tracy, CA 95376
License #30000105
www.sutterhealth.org

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

Introduction

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

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

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

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

- By emailing the Sutter Health System Office Community Benefit department at SHCB@sutterhealth.org;
- Through the mail using the hospital's address at Sutter Tracy Community Hospital, ATTN: Brooke Galas, 1420 N. Tracy Boulevard, Tracy, CA 95376; and
- In-person at the hospital's Information Desk.

About Sutter Health

Sutter Health is nearly 60,000 people strong thanks to its integrated network of clinicians, employees and volunteers. Headquartered in Sacramento, California, Sutter Health provides access to high quality, affordable care for more than 3 million Northern Californians through its network of hospitals, medical foundations, urgent and walk-in care centers, home health and hospice services. Nearly 14,000 doctors and advanced practice clinicians care for Sutter patients.

Recognized as a national leader in quality and access, Sutter's integrated healthcare system provides access to some of the best medical care in the country that outperforms state and national averages in nearly every quality measure. Through integration, Sutter Health fosters medical innovation and enables care teams to share best practices across the system. This gives patients access to a full range of treatments and services—helping lead to healthier outcomes.

Grounded in its not-for-profit mission, Sutter Health heavily reinvests in its communities, committing hundreds of millions of dollars annually to support programs and organizations that provide healthcare access and services for those in need. From deploying technology that improves the patient experience to supporting strong community partnerships, the strength of Sutter's integrated system provides a model that can shape the future of healthcare.

Sutter Health's total investment in community benefit in 2019 was $830 million. This amount includes traditional charity care and unreimbursed costs of providing care to Medi-Cal patients, as well as investments in community health programs to address prioritized health needs as identified by regional community health needs assessments.

- As part of Sutter Health's commitment to fulfill its not-for-profit status and serve the most vulnerable in its communities, Sutter hospitals, affiliated medical foundations and other healthcare providers offer charity care policies to ensure that patients can access needed medical care regardless of their ability to pay. Sutter's charity care policies, which have been in place for many years, offer financial assistance to uninsured and underinsured patients earning less than 400 percent of the annually adjusted Federal Poverty Level. In 2019, Sutter Health invested $125 million in charity care, compared to $89 million in 2018.

- Overall, since the implementation of the Affordable Care Act, greater numbers of previously uninsured people now have more access to healthcare coverage through the Medi-Cal and Medicare programs. The payments for patients who are covered by Medi-Cal and Medicare do not cover the full costs of providing care. In 2019, Sutter Health invested $499 million more than the state paid to care for Medi-Cal patients.

- Examples of regional prioritized health needs include access to mental health and addiction care, disease prevention and management, access to basic needs such as housing, jobs and food, as well as increased access to primary care services.

See more about how Sutter Health reinvests into the community by visiting sutterpartners.org.

In addition, 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 visit www.sutterhealth.org.

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

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

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

2019 Community Health Needs Assessment Summary

The Sutter Tracy Community Hospital 2019 Community Health Needs Assessment (CHNA) presents a comprehensive picture of community health that encompasses the conditions that impact health in San Joaquin County. The overall goal of the CHNA is to inform and engage local decision-makers, key stakeholders, and the community-at-large in efforts to improve the health and well-being of all San Joaquin County residents. From data collection and analysis to the identification of prioritized needs, the

development of the 2019 CHNA report has been an inclusive and comprehensive process guided by a Core Team planning group and broadly representative Steering Committee, with input from hundreds of community residents. This collaborative effort stems from a desire to address local needs and a dedication to improving the health of everyone in the community.

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

The 2019 CHNA process applied a social determinants of health framework and examined San Joaquin County's social, environmental, and economic conditions that impact health in addition to exploring factors related to diseases, clinical care, and physical health. Analysis of this broad range of contributing factors resulted in identification of the top health needs for the county. The CHNA report places particular emphasis on the health issues and contributing factors that impact vulnerable populations that disproportionately have poorer health outcomes across multiple health needs. It explored disparities for populations residing in specific geographic areas referred to as "Priority Neighborhoods", as well as disparities among the county's diverse ethnic populations. These analyses will inform intervention strategies to promote health equity. Through a comprehensive process combining findings from demographic and health data as well as community leader and resident input, nine health needs were identified.

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

Definition of the Community Served by the Hospital

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

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

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

Source: US Census, 2017

Significant Health Needs Identified in the 2019 CHNA

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

1. **Mental Health** – Maintaining mental health is as important as physical health and is essential to one's well-being. Access to mental health care services can equip people with the necessary skills to cope with and move on from daily stressors and life's difficulties, allowing for improved personal wellness, meaningful social relationships, and contributions to communities or society. Deaths by suicide, drug overdose and alcohol poisoning combined are higher in San Joaquin County when compared to the state average. Primary data indicates there is a perception of limited access to providers and culturally competent services. Poor mental health was also linked to stigma, low incomes, substance abuse, and homelessness.

2. **Economic Security** – Economic security contributes to good health. It facilitates access to healthcare services, healthy eating, and other factors that play a role in overall wellbeing. San Joaquin County benchmarks poorly compared to the state on many economic security indicators and there are a significant number of ethnic/racial disparities within the county. Black and Latino populations are among those most impacted by poverty. Unemployment is also higher in the County relative to the state. Homelessness and housing instability, lack of employment, poor recovery post-recession, transportation access and substance abuse are connected with economic security and were mentioned as important issues by key informants and in the focus groups.

3. **Obesity/Healthy Eating, Active Living/Diabetes** – A lifestyle that includes eating healthy and physical activity improves overall health, mental health, and cardiovascular health, thus reducing costly and life-threatening health outcomes such as obesity and diabetes. Obesity rates and diabetes prevalence were higher in San Joaquin County as compared to the state. Physical inactivity is higher among youth and adults in San Joaquin County compared to the state, and disparities are higher for Latino and Black youth in particular. Poverty, lack of access to healthy food and safe places for physical activity, and easy access to unhealthy foods were frequently mentioned as barriers in primary data and confirmed by secondary data.

4. **Violence/Injury Prevention** – Safe communities contribute to overall health and well-being. Safe communities promote community cohesion and economic development, and provide more opportunities to be active and improve mental health while reducing untimely deaths and serious injuries. Non-Hispanic Whites and Blacks are disproportionately impacted by motor vehicle crash deaths. Injury deaths and violent crime rates are both higher in San Joaquin County compared to the state. Key informants and focus group participants linked violence and injury prevention to poor lighting, loose dogs, traffic and drug use. Poverty and the economy's impact on jobs were mentioned in primary data as well.

5. **Access to Care** – Access to high quality, culturally competent, affordable healthcare and health services is essential to the prevention and treatment of morbidity and increases the quality of life, especially for the most vulnerable. In San Joaquin County, residents are more likely to be enrolled in Medicaid or other public insurance, which is a factor related to overall poverty. Latinos are most likely to be uninsured. Secondary data revealed that poor access to affordable health insurance and the lack of high-quality providers, including urgent care and mental health, impact access to care. Language and cultural barriers, including poor language access, were also discussed by key informants and in the focus groups.

6. **Substance Abuse/Tobacco** – Reducing and treating substance abuse (including alcohol, opioids, marijuana, methamphetamines and tobacco) improves the quality of life for individuals and their communities. Tobacco use is the most preventable cause of death, with second hand smoke exposure putting people around smokers at risk for the same respiratory diseases as smokers. Substance abuse is linked with community violence, sexually transmitted infections, and teen pregnancies. Impaired driving deaths are higher in San Joaquin County than the state. Marijuana, methamphetamine, tobacco and alcohol use were frequently mentioned in primary data, as was the intersection of substance abuse, homelessness and poverty, and mental illness. Although opioids were not mentioned specifically in primary data, key informants discussed challenges associated with drug use in general.

7. **Asthma** – Prevention and management of asthma by reducing exposures to triggers such as tobacco smoke and poor air quality, improves quality of life and productivity as well as reduces the cost of care. Asthma prevalence and the asthma hospitalization rate are greater in San Joaquin County than in the state. Focus group participants discussed allergies, unsafe air from farming, and bad smelling air as factors impacting this health need.

8. **Oral Health** – Tooth and gum diseases are associated with poverty, an unhealthy diet that includes excessive sugar consumption, and oral tobacco use, and can lead to multiple health problems. Access to oral health services is a challenge for many vulnerable populations as it can be difficult to find affordable, convenient, and culturally/linguistically appropriate dental care. San Joaquin County performs similarly to the rest of California when it comes to oral health outcomes. Insufficient insurance coverage and high out of pocket costs, as well as a lack of high quality dental care providers, were mentioned as key concerns by key informants and focus groups.

9. **Climate and Health** – Climate change poses a threat for the health and well-being of current and future generations. Climate change has been linked to vector-borne disease, health related issues, and respiratory diseases. Clean air and water are necessary for health, but rapid climate change contributes to increased drought and poor air quality. Unsafe drinking water and poor air quality were mentioned in focus groups. Traffic pollution and farming are factors that contribute to this health need.

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

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

The following methods were used:

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

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

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

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

2019 – 2021 Implementation Strategy Plan
The implementation strategy plan describes how Sutter Tracy Community Hospital plans to address significant health needs identified in the 2019 Community Health Needs Assessment and is aligned with the hospital's charitable mission. The strategy describes:

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

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

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

Mental Health

Name of program/activity/initiative	Area Wide Mental Health Strategy
Description	The need for mental health services and resources, especially for the underserved, has reached a breaking point across the Sutter Health Valley Operating Unit. This is why we are focused on building a comprehensive mental health strategy that integrates key elements such as policy and advocacy, county specific investments, stigma reduction, increased awareness and education, with tangible outreach such as expanded mental health resources to professionals in the workplace and telepsych options to the underserved. In addition, we will identify opportunities to build and foster mental health programs and resources locally in the STCH service area.
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.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, anecdotal stories, types of services/resources provided and other successful linkages.

Name of program/activity/initiative	Mental Wellness for Families
Description	Sutter Tracy Community Hospital makes significant investments in programs that connect at-risk and underserved families to the mental health resources they need. Through partnerships with local shelters and resource centers, we increase access to culturally appropriate mental health care services. This includes families experiencing homelessness, under or uninsured, low-income and those with disabilities.
Goals	Goals include greater mental health awareness, prevention and early intervention, stigma reduction, increased access to resources, and suicide prevention.
Anticipated Outcomes	We anticipate these investments will serve at least 100 individuals per year and connect them to mental health support services, as well as other wraparound support as needed.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of resources provided, anecdotal stories, types of services/resources provided, and number of individuals referred to a mental health provider.

Economic Security

Name of program/activity/initiative	Homeless Shelters and Case Management Services
Description	Provide temporary, emergency shelter to persons experiencing homelessness or who are at risk of homelessness to connect them with permanent housing as well as services such as primary and mental health care, insurance enrollment and income assistance.

Goals	Our goal is to provide a safe emergency shelter for persons experiencing homelessness or at risk of homelessness to better connect them with mainstream shelter services, housing services and supportive services.
Anticipated Outcomes	We anticipate this program will help participants establish a medical home, obtain a source of income and obtain housing.
Metrics Used to Evaluate the program/activity/initiative	Number of people served, number of referrals to support services provided, anecdotal stories, successful linkages to housing or emergency shelter, and number of individuals connected with a PCP or mental health provider.

Name of program/activity/initiative	Family Resource Centers
Description	Family Resource Centers help families build protective factors such as child development knowledge, parent/youth resilience, and access to concrete supports—primarily through parent skill building, resource referral, and working with other organizations to improve service access.
Goals	Provide tools, resources and connections to help families improve their quality of life. The program will seek to 1) engage parents, youth and appropriate service provider in a multi-disciplinary step-by-step approach to untangling interrelated crises and risks, while also building protective factors that help prevent future crises, 2) involve families and youth in building nurturing and thriving neighborhoods and communities, 3) connect low-income and under-served families with community resources that help prevent crisis.
Anticipated Outcomes	Low-income and/or under-served families in Tracy will access social, employment, parenting and health services which tend to decrease the risk of adverse outcomes such as chronic disease, mental health crisis, family dissolution, justice system involvement and violence.
Metrics Used to Evaluate the program/activity/initiative	Number of individuals and families served, number of referrals to support services such as income, assistance and basic needs, anecdotal stories, successful linkages to housing or emergency shelter, and number of individuals connected with a PCP or mental health provider.

Obesity/Healthy Eating, Active Living/Diabetes

Name of program/activity/initiative	Health and Wellness Programs for Youth
Description	Afterschool and summer programs that address the health, wellness and fitness needs of the youth in the community, including those with disabilities.
Goals	Youth receive regular physical activity, access to fresh fruits/vegetables and regular healthy meals.
Anticipated Outcomes	Youth will reach the CDC recommended standards of physical activity, and have access to year-round affordable fitness programming, as well as free access to healthy meals, fruits, vegetables and clean water. They will better understand how to incorporate healthy foods and exercise into their lifestyles.
Metrics Used to Evaluate the program/activity/initiative	Number of youth served, bags of healthy food distributed per week, number of minutes of physical activity per week and number of free healthy meals.

Name of program/activity/initiative	Movement Videos & Games for Classroom Physical Activity

Description	We will invest in a suite of online movement videos and games designed to bring movement and mindfulness into elementary school classrooms and homes. The program improves classroom engagement by helping teachers channel students' natural energy to improve behavior, focus, and achievement.
Goals	Our goals are: to facilitate physical activity, promote classroom engagement, reinforce core subjects and social/emotional learning, and improve academic achievement.
Anticipated Outcomes	Increased physical activity in schools resulting in decreased obesity for youth and better health outcomes.
Metrics Used to Evaluate the program/activity/initiative	Number of students served, number of minutes of physical activity and anecdotal stories.

Name of program/activity/initiative	Parks Improvement
Description	Increase access to and usage of public parks in the Tracy community through improvements such as renovation, lighting, landscaping, ADA compliance, access, and upgrades to facilities.
Goals	Encourage the public to adopt healthier habits by providing a safe public space for them to be outdoors and exercise.
Anticipated Outcomes	Individuals and families in the Tracy area will increase their physical activity and make healthier choices, with more daily exercise and a better understanding of how it will improve their overall mental and physical health.
Metrics Used to Evaluate the program/activity/initiative	Number of individuals and families served by the parks, number of people reached through programming, and overall satisfaction level of park visitors.

Access to Care

Name of program/activity/initiative	Recuperative Care Program
Description	Provides transitional care services to patients recently discharged from the hospital. The program assists at-risk clients to return home with increased stability through support services.
Goals	The goal is to provide care management and support services to patients as they return home to help stabilize and achieve optimal recovery.
Anticipated Outcomes	Patients will have a decreased likelihood of readmission to the hospital or unnecessary emergency department visits because they will have support to properly manage their condition and recovery.
Metrics Used to Evaluate the program/activity/initiative	Number of individuals served, number of referrals to support services, number of individuals connected with a PCP or mental health provider, number of follow-up appointments scheduled, and number of times transportation was provided.

Name of program/activity/initiative	Medical Care for Individuals Experiencing Homelessness
Description	This investment will deliver medical care for acute and chronic health conditions, behavioral health, dental, lab services, and pharmacy services, all at no cost to homeless patients. In addition to clinic-based services, the program will provide medical outreach services 16–20 hours

	a week at area shelters, drug treatment programs, halfway houses, and in other areas where homeless people congregate.
Goals	Connect individuals experiencing homelessness with primary health care as well as wraparound support such as mental health care, housing, and transportation.
Anticipated Outcomes	Individuals experiencing homelessness will establish a primary health care home to receive care in an appropriate setting, resulting in a decrease in unnecessary emergency department visits.
Metrics Used to Evaluate the program/activity/initiative	Number of individuals reached, number of referrals to support services, and number of follow-up appointments scheduled.

Violence/Injury Prevention

Name of program/activity/initiative	Shelter and Support Services for Victims of Domestic Violence
Description	Provide free, confidential, supportive services to homeless and runaway youth and victims of domestic violence, sexual assault and human trafficking. Supportive services include, but are not limited to: food and clothing, two domestic violence shelters, two homeless youth shelters, individual peer counseling, support groups, case management, parenting classes, 24-hour helplines, Youth Drop-In Center, mentoring program for youth, referrals, etc. to help them begin healing from trauma.
Goals	The goal is to reduce and end the cycle of violence and homelessness to build healthier families and a safer community.
Anticipated Outcomes	We anticipate that families and youth will have increased access to emergency shelter to escape violence, as well as immediate and basic needs such as food and medical care. In addition, they will be connected to support services to recover such as counseling and support groups.
Metrics Used to Evaluate the program/activity/initiative	Number of youth, women and families connected to emergency shelter, number connected to support services such as counseling and crisis intervention, number of people provided transportation, and anecdotal success stories.

Needs Sutter Tracy Community Hospital Plans Not to Address

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

1. **Substance Abuse and Tobacco** – While our strategy does not directly focus on substance abuse and tobacco, this is an area that will be addressed through our investments in access to care and economic security. Many individuals experiencing homelessness or at-risk of becoming homeless are also grappling with mental health and substance abuse issues, so through programs such as street outreach, homeless shelters, and recuperative care, we will likely be connecting individuals to the appropriate substance abuse referrals as needed.

2. **Asthma** – Asthma is not specifically addressed in our implementation plan as an area of focus, but we recognize its prevalence in San Joaquin County and many of our other strategies will seek to address this chronic condition. Through our investments in access to care, we will seek to identify individuals with asthma and connect them with a primary care provider so that they can appropriately manage their condition.

3. **Oral Health** – Although the hospital does not have a specific strategy to address this component of overall health, it does intend to indirectly address the priority finding through the various other interventions as mentioned in this report. Many of the strategies in this plan look to provide whole-person care, and will offer referrals to oral health care resources to individuals as necessary.

4. **Climate and Health** – Due to limited resources and ability to impact environmental policies, the hospital does not intend to directly address this health issue at this time.

Approval by Governing Board

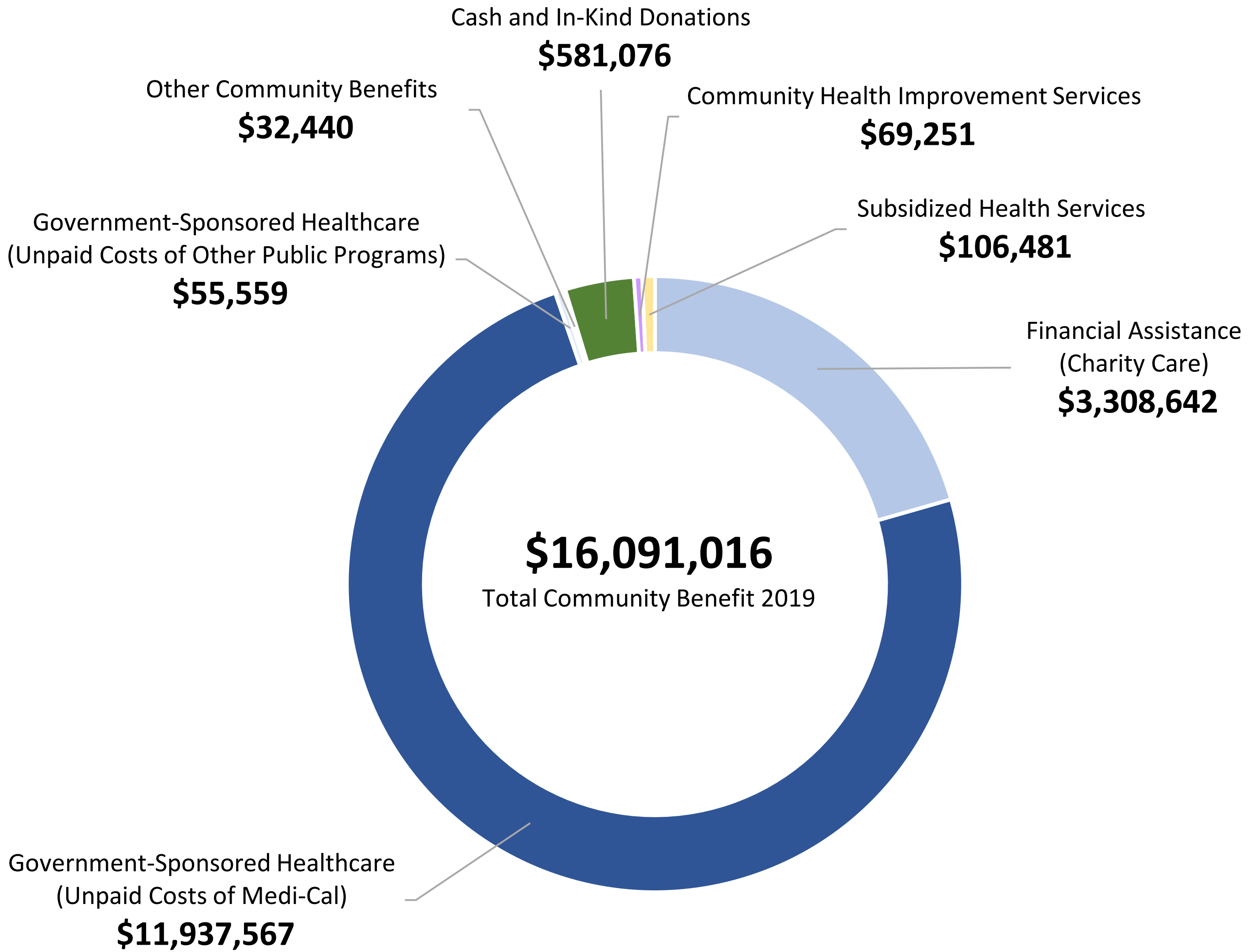
The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Health Valley Hospitals Board on November 21, 2019.

Appendix: 2019 Community Benefit Financials

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

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

Sutter Tracy Community Hospital
2019 Total Community Benefit
& Unpaid Costs of Medicare



2019 unpaid costs of Medicare were $15,209,938