Sutter Health
Sutter Medical Center, Sacramento and Sutter Center for Psychiatry

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

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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 Medical Center, Sacramento (SMCS) and Sutter Center for Psychiatry (SCP), 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 Medical Center, Sacramento (SMCS) and Sutter Center for Psychiatry (SCP) 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 2700 Gateway Oaks, Suite 2200, Sacramento, CA 95833 ATTN: Community Benefit; and
- In-person at the hospital’s Information Desk.

About Sutter Health

Sutter Health is a not-for-profit, integrated healthcare system located in Northern California and committed to health equity, community partnerships and innovative, high-quality patient care. Our over 60,000 employees and affiliated clinicians serve more than 3 million patients through our hospitals, clinics and home health services.

Learn more about how we’re transforming healthcare at sutterhealth.org and vitals.sutterhealth.org

Sutter Health’s total investment in community benefit in 2020 was $1.03 billion, an increase of about $200 million over 2019. 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 Health’s hospitals and medical foundations along with other aligned healthcare providers, offer charity care 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 individuals earning less than $51,520 a year or $106,000 for a family of four. In 2020, Sutter Health invested $109 million in charity care.
- 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 2020, Sutter Health invested $698 million more than the state paid to care for Medi-Cal patients, an increase of almost $200 million over 2019.

- Through community benefit investments, Sutter helped local communities access primary, mental health and addiction care, and basic needs such as housing, jobs and food.

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

1. Access to quality primary healthcare services
2. Access to mental/behavioral/substance-abuse services
3. Access to basic needs such as housing, jobs, and food
4. System navigation
5. Injury and disease prevention and management
6. Safe and violence-free environment
7. Access to active living and healthy eating
8. Access to meeting functional needs (transportation and physical mobility)
9. Cultural competency
10. Access to specialty and extended care

The 2019 Community Healthy Needs Assessment conducted by Sutter Medical Center, Sacramento (SMCS) and Sutter Center for Psychiatry (SCP) is publicly available at www.sutterhealth.org.

2019 Community Health Needs Assessment Summary

The purpose of this community health needs assessment (CHNA) was to identify and prioritize significant health needs of the greater Sacramento area community. The priorities identified in this report help guide nonprofit hospitals’ community health improvement programs and community benefit activities as well as their collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets requirements of the Patient Protection and Affordable Care Act (and in California, Senate Bill 697) that nonprofit hospitals conduct a community health needs assessment at least once every three years. The CHNA was conducted by Community Health Insights (www.communityhealthinsights.com) and was a collaboration between Dignity Health, Sutter Health, and UC Davis Health System. Multiple other community partners collaborated to conduct the CHNA.

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation’s County Health Rankings model. This model of population health includes many factors that impact and account for individual health and well-being. Further, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included interviews with 121 community health experts, social-service
providers, and medical personnel in one-on-one and group interviews as well as one town hall meeting. Further, 154 community residents participated in 15 focus groups across the county.

Focusing on social determinants of health to identify and organize secondary data, datasets included measures to describe mortality and morbidity and social and economic factors such as income, educational attainment, and employment. Measures also included indicators to describe health behaviors, clinical care (both quality and access), and the physical environment. In all, 665 resources were identified in the Sacramento County area that were potentially available to meet the identified significant health needs. The identification method included starting with the list of resources from the 2016 CHNAs, verifying that each resource still existed, and then adding newly identified resources into the 2019 CHNA report.

The full 2019 Community Health Needs Assessment conducted by Sutter Medical Center, Sacramento (SMCS) and Sutter Center for Psychiatry (SCP) is available at www.sutterhealth.org.

**Definition of the Community Served by the Hospital**
Sacramento County has over 30 cities, census-designated places, and unincorporated communities that include neighborhoods with rich heritages such as Oak Park, known as Sacramento's first suburb, to newer communities such as the City of Rancho Cordova, incorporated in 2003. Sacramento County ranks as California’s 31st-most overall healthy county among the 58 in the state. The area is served by a number of healthcare organizations, including those that collaborated in this assessment.

In this CHNA, two additional ZIP Codes from El Dorado County, a neighboring county east of Sacramento, were included to capture the portion of the community served by Mercy Hospital of Folsom, located near the border of these two counties. With some exceptions, findings described in this report are organized both at the county level and, as detailed later in this report, by designated regions within the county.

The definition of the community served included most portions of Sacramento County, and a small portion of western El Dorado County, California. Regarded as a highly diverse community, Sacramento County covers 994 square miles and is home to approximately 1.5 million residents. The CHNA uses this definition of the community served, as this is the primary geographic area served by the seven nonprofit hospitals that collaborated on this CHNA.

**Significant Health Needs Identified in the 2019 CHNA**
The following significant health needs were identified in the 2019 CHNA:

1. Access to quality primary healthcare services
2. Access to mental/behavioral/substance-abuse services
3. Access to basic needs such as housing, jobs, and food
4. System navigation
5. Injury and disease prevention and management
6. Safe and violence-free environment
7. Access to active living and healthy eating
8. Access to meeting functional needs (transportation and physical mobility)
9. Cultural competency
10. Access to specialty and extended care
Data collected and analyzed included both primary and secondary data. Primary data included interviews with 121 community health experts, social-service organizations, and medical personnel in one-on-one and group interviews as well as one town hall meeting. Further, 154 community residents participated in 15 focus groups across the county.

Secondary data included four datasets selected for use in the various stages of the analysis. A combination of mortality and socioeconomic datasets collected at subcounty levels were used to identify the portions of Sacramento County with greater concentrations of disadvantaged populations and poor health outcomes. A set of county-level indicators was collected from various sources to help identify and prioritize significant health needs. A set of socioeconomic indicators was also collected to help describe the overall social conditions within the service area. Health outcome indicators included measures of both mortality (length of life) and morbidity (quality of life). Health factor indicators included measures of 1) health behaviors, such as diet and exercise, tobacco, alcohol, and drug use; 2) clinical care, including access and quality of care; 3) social and economic factors such as race/ethnicity, income, educational attainment, employment, and neighborhood safety; and 4) physical environment measures, such as air and water quality, transit and mobility resources, and housing affordability. In all, 84 different health outcome and health factor indicators were collected for the CHNA.

Primary and secondary data were analyzed to identify and prioritize significant health needs. This began by identifying 10 potential health needs (PHNs). These PHNs were those identified in the previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the area. After these were identified for the county, PHNs were prioritized based on an analysis of primary data sources that described the PHN as a significant health need. Data were also analyzed to detect emerging health needs beyond those 10 PHNs identified in previous CHNAs.

2019 – 2021 Implementation Strategy Plan
The implementation strategy plan describes how Sutter Medical Center, Sacramento (SMCS) and Sutter Center for Psychiatry (SCP) 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.

Prioritised Significant Health Needs the Hospital will Address: The Implementation Strategy Plan serves as a foundation for further alignment and connection of other Sutter Medical Center, Sacramento (SMCS) and Sutter Center for Psychiatry (SCP) 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. Access to mental/behavioral/substance-abuse services
2. Access to quality primary healthcare services
3. Access to basic needs such as housing, jobs, and food
4. Access to specialty and extended care
5. Access to active living and healthy eating
6. Access to meeting functional needs (transportation and physical mobility)
7. System navigation

8. Cultural Competency

**ACCESS TO MENTAL/BEHAVIORAL/SUBSTANCE-ABUSE SERVICES**

<table>
<thead>
<tr>
<th>Name of program/activity/initiative</th>
<th>Description</th>
<th>Goals</th>
<th>Anticipated Outcomes</th>
<th>2020 Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area Wide Mental Health Strategy</td>
<td>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.</td>
<td>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.</td>
<td>The anticipated outcome is a stronger mental/behavioral safety net and increased access to behavioral/mental health resources for our community.</td>
<td>CitiesRISE is a multi-stakeholder initiative that includes many of the world’s leading experts and practitioners working to increase hope, inclusion, and access to care for young people through a network of cities. It is a global platform using a local collective action model that is dedicated to scaling up mental health enhancing interventions and models that have been developed in recent years, through proven methodologies of collective action and a network approach. CitiesRISE work does not fall squarely into direct services, therefore data collection at this stage in the program’s development is conducted through individual semi-structured interviews and small group conversations. These are the most effective approaches for measuring change, when conducted in a consistent, outcomes-focused manner. Suicide Prevention Awareness Reflection Knowledge (SPARK) is based upon the belief that teens often recognize anxiety, depression and suicidal behavior in their peers before family and school staff. With education, teens can reflect and then become aware, knowledgeable, and self confident to help others (as well as themselves) to prevent suicides. SPARK worked with school districts in Sacramento and Davis, the State Department of Education Mental Health Services Program and other community groups in hosting various events during the pandemic and post-pandemic periods. In 2020, CitiesRISE hosted a viewing of the film ANGST which saw 1,050 registrations, of which 750 were actual viewers and 150 participated in the online panel. While we focused on three school districts: Elk Grove, Sacramento City and Davis Unified, a late push to go statewide increased the viewership from 500 to 750. Event organizers, ZCares (ZCares.org) and SASF were very pleased with the response rate such that we are planning to have another viewing in May 2021.</td>
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</tbody>
</table>
to address: 1) Awareness & Education; 2) Access; and 3) Engagement and improvement of mental health and behavioral outcomes for students (K-12). The program serves to eliminate barriers to mental health care by delivering services where children and youth spend a majority of their day on school campuses. Services include: mental health awareness initiatives, assessments, referral and linking to appropriate mental health services, family support services, and collateral support. Throughout 2020 457 children received services which included over 9,000 mental health appointments being made, over 5,000 bed nights provided, medication management services, crisis services and meeting basic needs such as meals and clothing.

<table>
<thead>
<tr>
<th>Metrics Used to Evaluate the program/activity/initiative</th>
<th>Number of people served, number of resources provided, anecdotal stories, types of services/resources provided and other successful linkages.</th>
</tr>
</thead>
</table>

### 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

Suicide Prevention ED Follow-Up Program

#### Description

The Emergency Department Suicide Prevention Follow Up Program is designed to prevent suicide during a high-risk period, and post discharge, provide emotional support, and continue evidence based risk assessment and monitoring for ongoing suicidality. That includes personalized safe plans, educational and sensitive outreach materials about surviving a suicide attempt and recovery, 24-hour access to crisis lines, and referrals to community-based resources for ongoing treatment and support.

#### Goals

The goal of the Suicide Prevention program is to wrap patients with services and support following a suicide attempt or suicidal ideation.

#### Anticipated Outcomes

The anticipated outcome of the suicide prevention follow up program is to decrease instances of suicide reattempts or ideations.

#### 2020 Impact

The program did not begin in 2020.

#### Metrics Used to Evaluate the program/activity/initiative

SMCS/SCP will continue to evaluate the impact of the suicide prevention program on a quarterly basis, by tracking the number of people served, number of linkages to other referrals/services and other indicators. We will look at metrics including (but not limited to) number of people served, number of resources provided, suicide attempts post program intervention, type of resources provided and other successful linkages.

### 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

Triage Navigator Program

#### Description

The Triage Navigator has become an important part of the ED and Psych Response Team and a vital resource for patients suffering from a mental health crisis. The Triage Navigator connects with complex patients who are not only battling mental health issues, but also have countless other challenges around substance abuse, homelessness, poverty and other health problems. The Triage Navigator, through the offering of specialized, wrap-around services, is making a positive impact on the lives of patients.

#### Goals

The goal of the Triage Navigator is to provide a linkage between our underserved population and behavioral/mental health resources.

#### Anticipated Outcomes

The anticipated outcome of this program is more underserved patients connected with the mental health resources they so desperately need.

#### 2020 Impact

COVID-19 impacted the hospital, our whole community and our normal work flows. The ED Navigator continued to present to the hospital and provide services throughout this reporting timeframe. By keeping a consistent presence in the hospital there was no break in services to this vulnerable population. In 2020 161 individuals received services such as
primary health and mental health appointments as well as referrals to behavioral health, housing basic needs, transportation and income assistance.

**Metrics Used to Evaluate the program/activity/initiative**
The Triage Navigator program has proven to be effective in improving access to care for the underserved community. SMCS/SCP will continue to evaluate the impact of the Triage Navigator on a quarterly basis, by tracking the number of people served, anecdotal stories from patients and staff, number of linkages to other referrals/services and other indicators. We will look at metrics including (but not limited to) number of people served, number of resources provided, type of resources provided and other successful linkages.

### ACCESS TO QUALITY PRIMARY HEALTHCARE SERVICES

<table>
<thead>
<tr>
<th>Name of program/activity/initiative</th>
<th>Emergency Department Navigator (ED Navigator)</th>
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<tbody>
<tr>
<td><strong>Description</strong></td>
<td>The ED Navigator serves as a visible ED-based staff member. Upon referral from a Sutter employee (and after patient agreement), ED Navigators attend to patients in the ED and complete an assessment for T3 case-management services. Upon assessment, the ED Navigator determines and identifies patient needs for community-based resources and/or case-management services, such as providing a patient linkage to a primary care provider and establishing a medical home.</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>The goal of the ED Navigator is to connect patients with health and social services, and ultimately a medical home, as well as other programs (like T3) when appropriate.</td>
</tr>
<tr>
<td><strong>Anticipated Outcomes</strong></td>
<td>The anticipated outcome of the ED Navigator is reduced ED visits, as patients will have a medical home and access to social services, in turn, reducing their need to come to the ED for non-urgent reasons and making the patient healthier overall.</td>
</tr>
<tr>
<td><strong>2020 Impact</strong></td>
<td>COVID-19 impacted the hospital, our whole community and our normal work flows. The ED Navigator continued to present to the hospital and provide services throughout this reporting timeframe. By keeping a consistent presence in the hospital there was no break in services to this vulnerable population. In 2020 161 individuals received services such as primary health and mental health appointments as well as referrals to behavioral health, housing basic needs, transportation and income assistance.</td>
</tr>
<tr>
<td><strong>Metrics Used to Evaluate the program/activity/initiative</strong></td>
<td>The ED Navigator program has proven to be effective in improving access to care for the underserved community. SMCS/SCP will continue to evaluate the impact of the ED Navigator on a quarterly basis, by tracking the number of people served, recidivism rates, number of linkages to other referrals/services and other indicators. We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories, type of resources provided, number of patients referred to T3 and other successful linkages.</td>
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<table>
<thead>
<tr>
<th>Name of program/activity/initiative</th>
<th>Health Navigation: Reducing Barriers to Care</th>
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<tbody>
<tr>
<td><strong>Description</strong></td>
<td>The Sacramento Health Navigator Program expands health navigation services in Sacramento 11 County and connects thousands of low-income residents to affordable health care coverage.</td>
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<tr>
<td><strong>Goals</strong></td>
<td>The overall goal of the project is to establish medical homes, thereby reducing dependence on emergency room systems of care.</td>
</tr>
<tr>
<td><strong>Anticipated Outcomes</strong></td>
<td>The community needs addressed by this project, all of which support the under-insured and uninsured, include: 1) access to primary care, 2) access to preventive care, and 3) access to dental care.</td>
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<tr>
<td><strong>2020 Impact</strong></td>
<td>In October, Sacramento Covered (SC) hosted its 20th annual free community health event, Healthy Community Day in partnership with the Yolo County Children’s Alliance at Sutter Health Park. Due to the pandemic, the services were provided following the public health’s guidelines in a drive-thru style. During this event, SC provided critically needed services as we live through the pandemic. Services included 561 flu shots and 56 childhood immunizations; distribution of 2,000 individual bags of fresh fruits and vegetables. In total, we served 983 individuals that came from various parts of Sacramento and Yolo county.</td>
</tr>
<tr>
<td><strong>Metrics Used to Evaluate the program/activity/initiative</strong></td>
<td>The plan to evaluate will follow the same process as many of our other community benefit program with bi-annual reporting and partner meetings to discuss/track effectiveness of each program within this strategy. We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories, types of services/resources provided and other successful linkages.</td>
</tr>
<tr>
<td><strong>Name of program/activity/initiative</strong></td>
<td>Interim Care Program (ICP)</td>
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<tr>
<td><strong>Description</strong></td>
<td>A collaborative of the four health care systems and WellSpace Health, Volunteers of America and Sacramento County, the Sacramento Interim Care Program (ICP) is a respite-care shelter for homeless patients discharged from hospitals. The ICP wraps people with health and social services, while giving them a place to heal. Started in 2005, the ICP links people in need to vital community services while giving them a place to heal. The clients who are enrolled in the ICP are homeless adult individuals who otherwise would be discharged to the street or cared for in an inpatient setting only. The program is designed to offer clients up to six weeks during which they can focus on recovery and developing a plan for their housing and care upon discharge. This innovative community partnership provides temporary respite housing that offer homeless men and women a place to recuperate from their medical conditions, link them to vital community services, and provide them a place to heal.</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>The ICP seeks to connect patients with a medical home, social support and housing.</td>
</tr>
<tr>
<td><strong>Anticipated Outcomes</strong></td>
<td>The anticipated outcome of the ICP is to help people improve their overall health by wrapping them with services and treating the whole person through linkage to appropriate health care, shelter and other social support services.</td>
</tr>
<tr>
<td><strong>2020 Impact</strong></td>
<td>ICP as received nearly 300 referrals from SMCS and provided over 8,000 services such as primary health, mental health, AOD and dental &amp; vision appointments, transportation services, specialty care, and nurse assessments. ICP continues to track clients with COPD, CHF, diabetes and asthma to focus on identification, education and referrals in turn impacting client outcomes who are living with these chronic conditions. Although ICP is not a housing program the ICP case management team has secured over 3,000 bed nights to clients and helped refer over 100 people to shelters, transitional or permanent housing. ICP continued to provide services during the COVID-19 pandemic. ICP staff coordinated COVID-19 testing for clients and staff, provided PPE to clients and collaborated with city and county representatives to minimize interruptions in service.</td>
</tr>
</tbody>
</table>
### Metrics Used to Evaluate the Program/Activity/Initiative

The ICP program has proven to be effective in improving access to care for the underserved community. SMCS/SCP will continue to evaluate the impact of ICP on a quarterly basis, by tracking the number of people served, recidivism rates, number of linkages to other referrals/services and other indicators. We will look at metrics including (but not limited to) number of people served, number of resources provided, hospital usage post program intervention, type of resources provided and other successful linkages.

**Name of Program/Activity/Initiative**

Interim Care Program Plus (ICP+)

**Description**

SMCS/SCP offers an “expanded ICP” ICP+ aimed to meet the needs of patients with more complex needs and acute health issues. The program offers short-term (60-90 days) respite center serving homeless individuals post-hospitalization. Caters to individuals with higher medical acuity. Offers intensive case mgmt., access to LVNs & CNAs, medication educ., transportation, & referrals.

**Goals**

ICP+ seeks to connect patients with a medical home, social support and housing.

**Anticipated Outcomes**

The anticipated outcome of the ICP+ is to help people improve their overall health by wrapping them with services and treating the whole person through linkage to appropriate health care, shelter and other social support services.

**2020 Impact**

ICP+ provided services to nearly 500 clients this reporting period. This included 205,559 services provided such as primary health appointments, mental health appointments, dental & vision appointments, transportation services, specialty care, medication management, crisis services, CNA and nurse assessments as well as other basic needs such as meals and clothing. Staff continued to track clients with COPD, CHF, diabetes and asthma to better provide resources, education and referral for clients living with these chronic conditions. Although ICP+ is not a housing program the case managers helped obtain over 3,000 bed nights, referred over 1,000 clients to housing services and saw 121 clients obtain shelter, transitional or permanent housing.

**Metrics Used to Evaluate the Program/Activity/Initiative**

We will look at metrics including (but not limited to) number of people served, number of resources provided, hospital usage post program intervention, type of resources provided and other successful linkages.

**Name of Program/Activity/Initiative**

Triage, Transport, Treatment (T3)

**Description**

T3 provides case management services for people who frequently access the SMCS/SCP EDs for inappropriate and non-urgent needs, by connecting vulnerable patients to vital resources such as housing, primary care, mental and behavioral health services, transportation, substance abuse treatment and other key community resources. By linking these patients to the right care, in the right place, at the right time and wrapping them with services, we see a drastic improvement to the health and overall quality of life for this often underserved, patient population.

**Goals**

The goal of T3 is to wrap patients with health and social services, and ultimately a medical home.

**Anticipated Outcomes**

The anticipated outcome of T3 is reduced ED visits, as patients will have a medical home and access to social services, in turn, reducing their
need to come to the ED for non-urgent reasons and making the patient healthier overall.

### 2020 Impact

In 2020 672 individuals received services such as primary health appointments, mental health appointments, and transportation services or vouchers as well as an additional 6,529 referrals to primary health care, health insurance, behavioral health, housing, transportation, crisis services and other basic needs. T3/HART Case Management partnered with Mercy Housing on a new Permanent Supportive Housing (PSH) project. The collaboration with Mercy Housing has successfully housed 72 of the T3 clients into permanent supportive housing. This new PSH project has had a huge impact reducing the amount of homeless individuals in the community.

### Metrics Used to Evaluate the program/activity/initiative

The T3 program has proven to be effective in improving access to care for the underserved community. SMCS/SCP will continue to evaluate the impact of T3 on a quarterly basis, by tracking the number of people served, recidivism rates, number of linkages to other referrals/services and other indicators. We will look at metrics including (but not limited to) number of people served, number of resources provided, hospital usage post program intervention, type of resources provided and other successful linkages.

### Name of program/activity/initiative

Triage, Transport, and Treatment Plus (T3+)

### Description

T3+ is similar to T3, except patients are identified in an inpatient setting and are often more complex. The T3+ navigator follows patients after discharge and works with Sutter Health staff to provide a follow-up health plan, tele-health, pain management, etc. All of this occurs while the T3+ navigators address the patient’s other needs (including housing, insurance enrollment, etc) and ensure a connection is made to primary and preventive care to reduce further hospitalization.

### Goals

The goal of T3+ is to wrap patients with health and social services, and ultimately a medical home.

### Anticipated Outcomes

The anticipated outcome of T3+ is to successfully connect patients with a medical home and social services, in turn, managing any long term health ailments and making the patient healthier overall.

### 2020 Impact

In 2020 223 individuals received 265 services including primary health appointments, mental health appointments and transportation services/vouchers. In addition, 1,986 referrals were given to primary health care, behavioral health, health care coverage, housing, crisis services, legal and employment services.

### Metrics Used to Evaluate the program/activity/initiative

The T3+ program has proven to be effective in improving access to care for the underserved community. SMCS/SCP will continue to evaluate the impact of T3+ on a quarterly basis, by tracking the number of people served, recidivism rates, number of linkages to other referrals/services and other indicators. We will look at metrics including (but not limited to) number of people served, number of resources provided, hospital usage post program intervention, type of resources provided and other successful linkages.

### Name of program/activity/initiative

Street Nurse

### Description

Street Nurse works alongside our local community navigators. This increases opportunities to connect more homeless individuals to immediate medical care, necessary follow-up treatment and eventually a primary and behavioral health home to address the long-term healthcare
needs for this underserved population. The Street Nurse has become a
direct conduit from the community navigators to programs like ICP and
ED Navigators.

**Goals**
The goal of the street nurse is to connect with patients in their
environment (often homeless patients, on the street) provide them with
health advice and certain services, then work with community partners to
wrap patients with health and social services, and ultimately a medical
home.

**Anticipated Outcomes**
The anticipated outcome of the street nurse is to successfully connect
patients with a medical home and social services, in turn, getting patients
off the street and making the patient healthier overall.

**2020 Impact**
WellSpace Health Street Nurses have become an even more critical and
trusted resource for clients to utilize during the COVID-19 pandemic.
Many clients have reported feelings of uncertainty about going to area
clinics and local hospital emergency rooms to receive much needed
services due to possible exposure to COVID-19. Many clients have
turned to the Street Nurses as their first option to have their medical and
or nursing needs met. The nurses were available to provide wound
assessment and care to client that were deemed at risk on the street and
COVID-19 Room Key Hotels along with encampments, hospital referral
and via collaboration with other organizations serving individuals
experiencing homelessness. The presence and availability of the Street
Nurses provided clients with a sense of continuity of care from nurses
they were already familiar with and in turn decreasing anxieties while
receiving the highest quality care. Outreach to encampments with not
only assessment, care, referrals and education continued this reporting
period but the street nurses also provided much needed weather
protection, tents, clothing, nutrition, hydration and hygiene supplies. In
total, 479 individuals were served and an additional 751 were reached
through events/outreach efforts. 6,503 services were provided such as
primary health, mental health, nurse assessments, specialty care,
medication management and other basic needs.

**Metrics Used to Evaluate**
the
**program/activity/initiative**
The street nurse has proven to be effective in improving access to care
for the underserved community. SMCS/SCP will continue to evaluate the
impact of T3+ on a quarterly basis, by tracking the number of people
served, recidivism rates, number of linkages to other referrals/ services
and other indicators. We will look at metrics including (but not limited to)
number of people served, number of resources provided, anecdotal
stories from staff and patients, type of resources provided and other
successful linkages.

<table>
<thead>
<tr>
<th>Name of program/activity/initiative</th>
<th>Ongoing Clinic Investments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>With access to care, including primary, mental health and specialty care continuing to be a major priority area in the SMCS/SCP health service area, we will continue to make strategic investments in our local FQHC partners to increase clinic capacity and services offered. Creative collaborations and innovative opportunities with our clinic partners will continue to evolve with the needs of the community.</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>The goal is to expand access to care, especially for underserved populations who have barriers to receiving proper medical care.</td>
</tr>
<tr>
<td><strong>Anticipated Outcomes</strong></td>
<td>The anticipated outcome is expanded capacity to serve the underserved population with primary care, behavioral/mental health care, and dental and other specialty services.</td>
</tr>
</tbody>
</table>
YoloCares is a comprehensive, 24/7, 360-degree palliative care program (including behavioral health services, disease management, and improved access to care), serving patients throughout Yolo, Sacramento, Solano and Sutter counties. YoloCares provides coordination and oversight of care with primary care physicians, working with other providers to coordinate patient care. Peer-to-peer education and workshops are available to physicians throughout the YoloCares service area to promote a streamlined continuum of care and referral process between referral partners. The program works to expand knowledge of palliative care, YoloCares services, and advance care planning issues through educational workshops with community faith leaders, community partners, and the general public. In 2020, 14 individuals received 177 services such as nurse assessments, counseling sessions, medication management and other support services.

SMCS invests in the Keaton’s Child Cancer Alliance Family Navigator Program in Sacramento which has a team of bilingual bachelors level social workers that serve as Family Navigators (FNs) who equip parents with the tools necessary to take an active role in supporting their child during their cancer treatments. FNs will provide informal counseling and emotional support to help families problem-solve and cope. FNs will assist in navigating the complex health and social services systems to assure access to quality care and work to overcome barriers that might interfere with treatment adherence. In 2020, 1,640 individuals were served.

Metrics Used to Evaluate the program/activity/initiative
Number of people served, number of appointments provided, and types of services provided, anecdotal stories and other successful linkages.

ACCESS TO BASIC NEEDS SUCH AS HOUSING, JOBS, AND FOOD

Name of program/activity/initiative: Short-Term Medical Housing

Description: Provide free short-term housing for patients and families who must leave their own community to seek medical care at Sutter Healthcare Centers and other medical facilities. This unique home-away-from-home experience has brought a compassionate response as well as emotional and financial relief to guests in need. These programs help families to access specialized medical treatment by providing a place to stay at little or sometimes no cost.

Goals: Keeping families with a sick family member together and near the care and resources they need.

Anticipated Outcomes: Families are stronger when they are together. By staying at a short-term medical housing establishment, families can better communicate with their loved ones medical team and keep up with complicated treatment plans when needed. They can also focus on the health of their family member, rather than grocery shopping, cleaning or cooking meals.

2020 Impact: In 2020 the second apartment location opened April 2020, and third opened July 2020. Hattie’s House now has a three 1 bedroom apartments fully furnished being used by families, friends, and patients seeking care at Sutter Healthcare Centers Sacramento. During COVID, it was found that the apartment model was crucial as so many health compromised patients could not stay in alternative housing. In total, 59 individuals were served and 808 bed nights were provided throughout the year.
<table>
<thead>
<tr>
<th>Metrics Used to Evaluate the program/activity/initiative</th>
<th>Internal reports. Number of nights stayed. Number of families/people served.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of program/activity/initiative</td>
<td>Serial Inebriate Program</td>
</tr>
<tr>
<td>Description</td>
<td>The Serial Inebriate Program (SIP) addresses the health, safety, and housing needs of intoxicated, chronically homeless adults living on the streets of Sacramento. To qualify for SIP, individuals must have been admitted to local EDs, the Comprehensive Alcohol Treatment Center 16 (also known as the “detox” program) or arrested at least 25 times within the previous 12 months, and who pose a danger to themselves or others due to excessive alcohol consumption. During the 90-day stay, clients receive alcohol addiction counseling, and are offered permanent housing through Sacramento Self Help Housing. SIP clients are not only placed in a safe housing environment, but they are also wrapped with services to get on the road to sobriety and connect to health resources they were not aware of during their time on the streets. Additionally, SIP clients are connected with primary and mental health services, to help address their long-term medical needs and place these at-risk patients in permanent medical homes.</td>
</tr>
<tr>
<td>Goals</td>
<td>The goal is to get serial inebriates off the streets and into housing and alcohol and drug treatment.</td>
</tr>
<tr>
<td>Anticipated Outcomes</td>
<td>The anticipated outcomes are reduced ED visits, reduced arrests, better health and improved sobriety.</td>
</tr>
<tr>
<td>2020 Impact</td>
<td>In 2020, 3,861 bed nights were provided with 133 referrals made to services such as primary health care, behavioral health, health care coverage, health education, crisis services and housing services. The group continues to focus on the serial inebriates who reside in the parks and sidewalks in the downtown core and those that need assistance around the central city.</td>
</tr>
<tr>
<td>Metrics Used to Evaluate the program/activity/initiative</td>
<td>We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories from staff and patients, number of people successfully housed, type of resources provided, reduced arrests and other successful linkages.</td>
</tr>
<tr>
<td>Name of program/activity/initiative</td>
<td>Community College Promise Scholarship Program</td>
</tr>
<tr>
<td>Description</td>
<td>The Promise Scholarship is targeted to the neediest of these students attending full-time and gives flexible support that can help meet their most important needs. In addition to tuition fees, community college students have other attendance costs that stand in the way of postsecondary success (books, transportation, housing, student fees, lab equipment, supplies, childcare expenses, etc.), but they have less access to financial aid. 56% of Los Rios students are low income (approx. 40,000) nearly 32% live below the poverty line, and 13% are homeless.</td>
</tr>
<tr>
<td>Goals</td>
<td>The Promise Scholarship aims to remove the barriers that prevent students from achieving college success. By removing barriers, students have a greater chance of completing their degrees and entering the workforce ready to succeed.</td>
</tr>
<tr>
<td>Anticipated Outcomes</td>
<td>These scholarships will really help bridge the gap for students. They will meet the needs that fall outside the traditional lines of what existing aid programs will cover and help students complete their degrees and enter the workforce ready to succeed.</td>
</tr>
<tr>
<td>2020 Impact</td>
<td>The Promise Scholarship provides $500 scholarships to help students overcome the barriers that prevent them from achieving college success. It is targeted to the neediest of students attending the Los Rios colleges full-time and provides flexible support to meet their needs. In 2020, 180 scholarships were provided to students in need.</td>
</tr>
<tr>
<td>Metrics Used to Evaluate the program/activity/initiative</td>
<td>We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories from students.</td>
</tr>
</tbody>
</table>

| Name of program/activity/initiative | Food Factory Program |
| Description | The Food Factory is a neighborhood incubator project and manufacturing facility that will provide a multitude of critical services for food entrepreneurs, including kitchen space, storage, distribution, marketing and business services. |
| Goals | The long-term goal of the project is to foster community investment and reduce health and economic inequities. |
| Anticipated Outcomes | The Food Factory will provide space which can used for healthy food retail and farmer’s market space. In addition, will provide residents an opportunity to improve their employment, educational, and health outcomes through supportive services including job training, connection to jobs, entrepreneurship, and increased access to food. |
| 2020 Impact | Enthusiasm and the need for The Food Factory has proven to increase, even through Covid. They have doubled the interest list of potential tenants, from 25 to 50. They planned an event in March for the potential tenants, stakeholders, and corporate partners to gather and discuss The Food Factory, however because of Covid, the event has been postponed as it's critical to the project for the makers, the funders, and any other stakeholders to meet in person, taste the products, and have one-on-one conversations. They continued digital outreach via social media, new website, and email database along The Kitchen Door, a national listing for food incubators. Phone communication and in person meetings with potential tenants, stakeholders, and numerous corporate partners also continued. |
| Metrics Used to Evaluate the program/activity/initiative | We will look at metrics including (but not limited to) number of people served, observation checklist, surveys, and qualitative Interviews |

<p>| Name of program/activity/initiative | Jr. Robotic Program |
| Description | Jr. Robotic Program is designed to meet the 21st Century Science Standards and provide students with the opportunity to learn, technology and engineering and math concepts (STEM) in after school programs. |
| Goals | Encourage at-risk, underserved, and socio-economically disadvantaged children to further develop their education in the sciences and mathematics, as well as to encourage the development of partnerships between education and the industrial partners. |
| Anticipated Outcomes | Students will develop critical thinking and team-building skills, core values, practices, basic STEM application and presentation skills. |
| 2020 Impact | During this reporting period Sierra Nevada Journeys served 876 students. These students represented youth with some of the highest needs in our community, with an average FRL (Free and Reduced Lunch Program) participation rate of 85%. |</p>
<table>
<thead>
<tr>
<th>Metrics Used to Evaluate the program/activity/initiative</th>
<th>We will look at metrics including (but not limited to) number of people served, observation checklist, surveys, and qualitative interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of program/activity/initiative</td>
<td>Clean Air Partnership (CAP)</td>
</tr>
<tr>
<td>Description</td>
<td>CAP is a joint project of Breathe California Sacramento Region, the Sacramento Metro Chamber of Commerce, Valley Vision, and others to help the Sacramento region meet clean air standards that protect health, promote economic growth, and support equity.</td>
</tr>
<tr>
<td>Goals</td>
<td>CAP provides regional leadership to influence public policy centered on air quality and greenhouse gases. CAP’s work centers on programs that help minimize smog-forming emissions from vehicles, which are the dominant source of the capital region’s air pollution.</td>
</tr>
<tr>
<td>Anticipated Outcomes</td>
<td>Expand and maintain a regional air quality coalition of business, public health, government, transportation and community leaders focused on reducing air emissions and advancing air quality and health benefits</td>
</tr>
<tr>
<td>2020 Impact</td>
<td>Program data in this time period related to number of participants who attended the clean air policy-related Zoom webinars on May 1st (80 individuals), September 25th (74 individuals), and December 11th (80 individuals). They also sent monthly email newsletters (12 over the course of this program period) to the distribution of ~3,600 stakeholders from across the Sacramento region.</td>
</tr>
<tr>
<td>Metrics Used to Evaluate the program/activity/initiative</td>
<td>We will look at metrics including (but not limited to) number of communities served, policies enacted, and reported air quality indicators like AQI, PM 2.5, NO2, and Ozone levels.</td>
</tr>
</tbody>
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**ACCESS TO SPECIALTY AND EXTENDED CARE**

<table>
<thead>
<tr>
<th>Name of program/activity/initiative</th>
<th>SPIRIT</th>
</tr>
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<tbody>
<tr>
<td>Description</td>
<td>The Sacramento Physicians’ Initiative to Reach out, Innovate and Teach (SPIRIT) program recruits and places physician volunteers in community clinics to provide free medical services to our region’s uninsured. The SPIRIT program also provides physician volunteers and case management for surgical procedures, including hernia and cataract repair, at local hospitals and ambulatory surgery centers that wish to donate services.</td>
</tr>
<tr>
<td>Goals</td>
<td>The overall goal of the project is to provide uninsured patients with outpatient surgeries they otherwise couldn’t afford.</td>
</tr>
<tr>
<td>Anticipated Outcomes</td>
<td>Patients will live happier, healthier and more productive lives.</td>
</tr>
<tr>
<td>2020 Impact</td>
<td>SPIRIT continues to make an impact on the health and well-being of undocumented uninsured adults who have been unable to access specialty care. In 2020, the SPIRIT Program completed the following: 300 patients treated, 156 volunteer hours, 93 surgeries procedures, 189 specialty consults and 18 physician medical record reviews.</td>
</tr>
<tr>
<td>Metrics Used to Evaluate the program/activity/initiative</td>
<td>We will look at metrics including (but not limited to) number of people served, type of surgeries provided, anecdotal stories and other successful linkages.</td>
</tr>
<tr>
<td>Name of program/activity/initiative</td>
<td>Society for the Blind</td>
</tr>
<tr>
<td>Description</td>
<td>Society for the Blind is a comprehensive rehabilitative teaching center that provides low vision eye care and blindness skills education and services.</td>
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</tr>
<tr>
<td>Goals</td>
<td>Provide low vision evaluations to low income, under and/or un-insured patients, provide OrCam Readers, Electronic Magnifiers or other assistive devices, provide transportation to low vision clinics</td>
</tr>
<tr>
<td>Anticipated Outcomes</td>
<td>To empower individuals living with low vision or blindness to discover, develop and achieve their full potential.</td>
</tr>
<tr>
<td>2020 Impact</td>
<td>For this reporting period, the grant allowed Society for the Blind to provide low vision services to 93 individuals who would otherwise not have been able to receive these services due to being low income or a lack of insurance. They served nearly 4 times as many patients as they anticipated during this reporting period as the pandemic pushed more people into financial crisis and the impacts of vision loss had a greater impact on people due to the quarantine. The feedback received was that the services under this grant including the low vision devices, eye care and resources were of vital importance to improving independence, sense of safety and quality of life.</td>
</tr>
<tr>
<td>Metrics Used to Evaluate the program/activity/initiative</td>
<td>We will look at metrics including (but not limited to) number of people served, type of services provided, anecdotal stories and other successful linkages.</td>
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</tbody>
</table>

**ACCESS TO ACTIVE LIVING AND HEALTHY EATING**

<table>
<thead>
<tr>
<th>Name of program/activity/initiative</th>
<th>Midtown Parks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>To provide safety and maintenance services including outreach to homeless individuals, place making including health-focused free park activations and improvements such as lighting and business development in parks and public spaces, and advocacy related to infill development, alternative transportation, investment in infrastructure, and reducing homelessness.</td>
</tr>
<tr>
<td>Goals</td>
<td>To establish and maintain the quality of life in a community, ensuring the health of families and youth, and contributing to the economic and environmental well-being of the community.</td>
</tr>
<tr>
<td>Anticipated Outcomes</td>
<td>Anticipated outcome of this program is continued support of the well-being of the community by creating centrally-located public spaces designed to provide opportunities for recreation, leisure, and to build relationships with neighbors.</td>
</tr>
<tr>
<td>2020 Impact</td>
<td>Despite the continued challenges presented by COVID-19, Midtown Parks remained committed to the health and well-being of the community throughout the second half of 2020. They stayed in communication with the City of Sacramento to ensure that they could launch Fresh Air: Fremont Park and Workout at Winn from August through October. They believe that this programming was essential to the physical and mental health of the residents. By providing free community-based classes under physical distancing precautions - which included limiting class capacity, required pre-registration, physical distancing chalk circles as designated areas for each participant, and the requirement of face masks during check in and when leaving the area following the class - participants were able to exercise, get some fresh air, and utilize green urban space, all while engaging with their neighbors in a safe manner. In addition, the outreach on social media and in newsletters totaled over 1M reached through social media and over 90,000 social media engagements.</td>
</tr>
<tr>
<td>Metrics Used to Evaluate the program/activity/initiative</td>
<td>We will look at metrics including (but not limited to) number of children/families served, anecdotal stories and other successful program impacts.</td>
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</tr>
<tr>
<td>Name of program/activity/initiative</td>
<td>Food Literacy Program</td>
</tr>
<tr>
<td>Description</td>
<td>To teach elementary children in low-income schools cooking and nutrition to improve our health, environment, and economy.</td>
</tr>
<tr>
<td>Goals</td>
<td>To reach 700 elementary students during free 14-week afterschool programs. Provide hands-on cooking &amp; nutrition classes covering topics such as fiber, sugar, and fruit &amp; vegetable appreciation. Improve children’s attitude through repeated exposure to new foods through tasting education. Improve children’s behavior by repeating skills until they become habits, including sending recipes home to replicate with their families and training them to ask for veggies.</td>
</tr>
<tr>
<td>Anticipated Outcomes</td>
<td>Improve children’s knowledge toward healthy food to improve their attitude and develop the habit of eating healthy.</td>
</tr>
<tr>
<td>2020 Impact</td>
<td>With schools continuing distance learning through the fall of 2020, the program worked with three different schools and afterschool partners to reach students to pilot virtual food literacy classes. Throughout the 4-part series, 77% of students were food adventurers and tried the produce-of-the-day, and 76% of students said they would ask for this produce at home. 80% of students made and tried a new recipe, with 100% of those students saying they would make the recipe again at home. They will continue these virtual food literacy classes in the spring and target new schools and students. In addition, through the support of the SCUSD nutrition services department, they have distributed recipe kits alongside school lunch distribution. In total, over 2,000 individuals were served and 2,859 pounds of food was distributed.</td>
</tr>
<tr>
<td>Metrics Used to Evaluate the program/activity/initiative</td>
<td>We will look at metrics including (but not limited to) number of children served, active schools, anecdotal stories and other successful program impacts.</td>
</tr>
</tbody>
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**ACCESS TO MEETING FUNCTIONAL NEEDS (TRANSPORTATION AND PHYSICAL MOBILITY)**

<table>
<thead>
<tr>
<th>Name of program/activity/initiative</th>
<th>Evaluating Fare-Free Transit</th>
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</thead>
<tbody>
<tr>
<td>Description</td>
<td>RydeFreeRT waives youth fares on bus, light rail, and SmaRT Ride microtransit service across SacRT’s service area, which includes the cities of Sacramento, Folsom, Citrus Heights, and Rancho Cordova and parts of Sacramento County. Approximately 220,000 students in grades TK through 12, home-schooled students, and foster and homeless youth are all eligible.</td>
</tr>
<tr>
<td>Goals</td>
<td>The program aims to decrease truancy and eliminate obstacles for young people to get to school, after-school activities, sports, clubs, and jobs.</td>
</tr>
<tr>
<td>Anticipated Outcomes</td>
<td>The program will make transportation to and from school, work, and activities, much more reliable and accessible for thousands of students in the region. In addition, the program will help reduce absenteeism and improve student success in our high poverty district.</td>
</tr>
<tr>
<td>2020 Impact</td>
<td>This program did not start in 2020.</td>
</tr>
<tr>
<td>Metrics Used to Evaluate the program/activity/initiative</td>
<td>We will look at metrics including (but not limited to) number of young people served and anecdotal stories.</td>
</tr>
</tbody>
</table>
### SYSTEM NAVIGATION

<table>
<thead>
<tr>
<th>Name of program/activity/initiative</th>
<th>Community Navigator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>The Community Navigator connects with homeless individuals. The Community Navigator slowly builds relationships with these people and helps wrap them with services, such as housing, a medical home, a PCP/mental health provider, alcohol and drug treatment and other social services. The Community Navigator is integrated with both the Street Nurse and the SMCS/SCP ED, Case Management and Social Work staff, to ensure a continuum of care for homeless patients both within the walls of the hospital and out in the community.</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>This effort seeks to provide homeless individuals with a medical home, linkages to health and social resources and a successfully connection to housing/shelter.</td>
</tr>
<tr>
<td><strong>Anticipated Outcomes</strong></td>
<td>The anticipated outcomes is a lower number of homeless people in the greater Sacramento region.</td>
</tr>
<tr>
<td><strong>2020 Impact</strong></td>
<td>In 2020, 45 individuals were served, 15 of which obtained permanent housing and 5 established a primary health provider.</td>
</tr>
<tr>
<td><strong>Metrics Used to Evaluate the program/activity/initiative</strong></td>
<td>We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories from staff and patients, number of people successfully housed, number of successful referrals to primary, mental/behavioral health care and/or alcohol and drug treatment, type of resources provided and other successful linkages.</td>
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<table>
<thead>
<tr>
<th>Name of program/activity/initiative</th>
<th>Pediatric Navigation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Pediatric navigation provides health navigation services, including but not limited to assistance with scheduling timely discharge appointments of newborns, adding newborns to Medi-Cal case, plan selection/changes to assigned provider or health plan, primary dental or vision care appointments, transportation services, interpreting services, education on health coverage and nutrition program, and referrals to other resources.</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>The goal of Pediatric Navigation is to provide newborns with health and social services.</td>
</tr>
<tr>
<td><strong>Anticipated Outcomes</strong></td>
<td>The anticipated outcomes is to successfully connect newborns with a primary care provider and social services, in turn, helping to inform and educate caregivers and families about how to access services, work with providers and manage the various aspects of special needs caregiving.</td>
</tr>
<tr>
<td><strong>2020 Impact</strong></td>
<td>In August, Sacramento Covered (SC) expanded the pediatric navigator program at Sutter Hospital’s Labor and Delivery Department by adding another full-time Pediatric Health Navigator. To begin the second Pediatric Health Navigator started part-time (Wednesday, Thursday and Friday) to assess the need, but was quickly expanded to full time. The Pediatric Health Navigator provides health navigation services that include scheduling appointments for newborn follow-up, primary care, and dental or vision, connecting patients to community resources, and providing education services. The Pediatric Health Navigator also internally refers clients to other SC health navigators for additional health navigation support. During this reporting period, the Pediatric Health Navigator at Sutter Hospital assisted 675 newborns and 196 family members, in addition to providing 2,388 services and 292 internal referrals.</td>
</tr>
</tbody>
</table>
### CULTURAL COMPETENCE

<table>
<thead>
<tr>
<th>Name of program/activity/initiative</th>
<th>World Relief Refugee Women’s Integration Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Over 13,000 refugees have arrived in northern California in the past five years. An especially vulnerable subset of this group are women, many of whom are not literate in any language. The health literacy-based English classes will address the issues around social isolation, language barriers, health access among refugee women, and create a scalable model to serve this population, thus creating healthier communities.</td>
</tr>
<tr>
<td>Goals</td>
<td>The goal of this program is to have 120 refugee women enroll in Women’s Education programs and complete a health literacy curriculum over a 12-month period.</td>
</tr>
<tr>
<td>Anticipated Outcomes</td>
<td>Anticipated outcomes include participants can explain the steps in accessing medical care, participants can demonstrate English ability to schedule an appointment, request interpretation, and provide basic personal information and participants will report increased confidence about living in the U.S. and a greater sense of integration.</td>
</tr>
<tr>
<td>2020 Impact</td>
<td>World Relief Sacramento hosted four Refugee Women’s Integration Groups (three Afghan and one Slavic), providing vulnerable refugee women in Sacramento County with access to instruction on English literacy, cultural integration, and health. The Afghan groups saw their first graduation of 39 women completing the program in December 2020. During this reporting period, they launched a new Refugee Women’s Integration Group for new Russian and Ukrainian arrivals, bringing the total number of enrollees for 2020 to 63 out of the planned 75, with 18 additional participants already enrolled for the new January 2021 groups.</td>
</tr>
</tbody>
</table>

### Metrics Used to Evaluate the program/activity/initiative

We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories from staff and patients, type of resources provided and other successful linkages.

<table>
<thead>
<tr>
<th>Name of program/activity/initiative</th>
<th>LGBTQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>The Sacramento LGBT Community Center works to create a region where LGBTQ people thrive. It supports the health and wellness of the most marginalized, advocates for equality and justice, and works to create a culturally rich LGBTQ community.</td>
</tr>
<tr>
<td>Goals</td>
<td>The goals of this organization will support increased access for LGBTQ+ people to preventive sexual health and mental health support, homeless and at-risk LGBTQ+ youth support services, youth development activities, and cultural competency education.</td>
</tr>
<tr>
<td>Anticipated Outcomes</td>
<td>To create a region where LGBTQ people can focus on all aspects of their health and well-being. Hundreds of LGBTQ+ youth experiencing homelessness who will have access to food, clothing, survival supplies, showers, transportation, life skills development, mental health respite, crisis intervention, counseling, case management, emergency shelter and transitional housing on a pathway to self-reliance.</td>
</tr>
<tr>
<td>2020 Impact</td>
<td>The Sac LGBT Community Center continued to operate their youth shelter, transitional living home, and host home programs with 24-7 wraparound support. A total of 7,489 bed nights were provided in 2020,</td>
</tr>
</tbody>
</table>
81 people were housed over the whole year, with 82% remaining in stable housing. The youth drop-in center reopened in August for in-person services. The online Discord youth chat continued to operate 7-days per week and saw participation of up to 80 youth per day online. 200 gender affirming care packages were sent to transgender and nonbinary youth to help improve their mental health while sheltering at home with sometimes unaffirming families. Regular online youth enrichment events continued weekly and they held an online Q-Prom event for youth in October, which included more than 125 youth. They also launched a support group for parents of LGBTQ+ youth in addition to their youth support groups. They re-opened the in-person mental health respite center for adults two days per week with COVID-19 precautions in place. The program saw an increase in participation each week with increase basic needs. Staff delivered groceries weekly to several clients and the Center provided $25,000 in financial assistance to community members who needed help with rent, utilities, groceries, medical bills, and other necessities due to COVID-19. They also started telehealth counseling services with their new in-house therapist and launched a new grief support group for all those who have experienced loss in 2020.

| Metrics Used to Evaluate the program/activity/initiative | We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories from staff and patients, type of resources provided and other successful linkages. |
| Name of program/activity/initiative | Gender Health Center |
| Description | The Gender Health Center provides counseling/therapy services to anyone who expresses the need as well as anyone who self identifies or is perceived to be gender variant. The services embrace the psychological well-being and self-fulfillment of individuals coming out and/or beginning or in the transition process in a safe, supportive and welcoming environment. |
| Goals | The Gender Health Center aims to affect change that alleviates the systematic oppression of transgender people- especially those at intersections of identities- through advocacy and direct services, while using a mental health-centered model and social justice lens |
| Anticipated Outcomes | Participants will have greater knowledge of their healthcare options and have increased access to healthcare services. |
| 2020 Impact | The impact of this program on the trans and queer population has proven essential during a time of increased isolation, administrative violence, and overloaded healthcare systems. GHC’s online access to services has provided remote navigation, advocacy, harm reduction, and mental health services. Some of the virtual events include virtual transgender job fairs, trans-centered self defense training, music events featuring local artists, and guided meditation. Throughout 2020, 499 people received services such as mental health appointments, specialty care, counseling sessions, crisis services and general basic needs including meals and clothing. The center helped 305 individuals establish either a primary health care home, mental health provider or enrolled them in health care coverage. |
| Metrics Used to Evaluate the program/activity/initiative | We will look at metrics including (but not limited to) number of people served, type of surgeries provided, anecdotal stories and other successful linkages. |
Needs Sutter Medical Center Sacramento and Sutter Center for Psychiatry Plan Not to Address

No hospital can address all of the health needs present in its community. Sutter Medical Center, Sacramento (SMCS) and Sutter Center for Psychiatry (SCP) are 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. Injury and Disease Prevention and Management: While many of our programs expand access to primary care, in turn, connecting patients with disease prevention, management and treatment resources, this is not a primary focus in the SMCS/SCP.

2. Safe and Violence Free Environment: SMCS/SCP plans to identify partnerships and strengthen relationships with organizations in the near future to collaborate on initiatives to address safe and violence free environments in Sacramento Counties.

Approval by Governing Board

The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Health Valley Area Hospital Board on November 21, 2019.
Appendix: 2020 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.

The graph of Sutter Medical Center Sacramento community benefit investments on the following page includes Sutter Center for Psychiatry.
Sutter Medical Center Sacramento
& Sutter Center for Psychiatry
2020 Total Community Benefit
& Unpaid Costs of Medicare

2020 unpaid costs of Medicare were $130,685,091

Total Community Benefit 2020
$126,260,773

Government-Sponsored Healthcare
(Unpaid Costs of Medi-Cal)
$64,673,788

Government-Sponsored Healthcare
(Unpaid Costs of Other Public Programs)
$40,125,921

Other Community Benefits
$281,678

Health Professions Education
$509,705

Research
$389,878

Community Health Improvement Services
$1,019,748

Cash and In-Kind Donations
$7,148,438

Subsidized Health Services
$1,521,022

Financial Assistance
(Charity Care)
$10,590,595

Cash and In-Kind Donations
$7,148,438

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$1,521,022

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(Charity Care)
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