Sutter Health

Sutter Center for Psychiatry

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

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Introduction

The Implementation Strategy Plan describes how 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 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.

Executive Summary

Sutter Center for Psychiatry (SCP) is affiliated with Sutter Health, a not-for-profit public benefit corporation that is the parent of various entities responsible for operating health care facilities and programs in Northern California, including acute care hospitals, medical foundations and home health and hospice, and other continuing care operations. Together with aligned physicians, our employees and our volunteers, we're creating a more integrated, seamless and affordable approach to caring for patients.

The hospital's mission is to enhance the well-being of people in the communities we serve through a not-for-profit commitment to compassion and excellence in health care services.

Over the past five years, Sutter Health and its affiliates have committed nearly $4 billion to care for patients who couldn't afford to pay, and to support programs that improve community health. Our 2018 commitment of $734 million includes unreimbursed costs of providing care to Medi-Cal patients, traditional charity care and investments in health education and public benefit programs. For example:

- In 2018, Sutter invested $435 million more than the state paid to care for Medi-Cal patients. Medi-Cal accounted for nearly 19 percent of Sutter's gross patient service revenues in 2018.
- Throughout Sutter, we partner with and support community health centers to ensure that those in need have access to primary and specialty care. Sutter also supports children's health centers, food banks, youth education, job training programs and services that provide counseling to domestic violence victims.

Every three years, Sutter Health affiliated hospitals participate in a comprehensive and collaborative Community Health Needs Assessment, which identifies significant community health needs and guides

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

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

1. 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 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 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.[i] 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 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.

Prioritized Significant Health Needs the Hospital will Address: The Implementation Strategy Plan serves as a foundation for further alignment and connection of other 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

Name of program/activity/initiative	Area Wide Mental Health Strategy
Description	The need for mental health services and resources, especially for the underserved, has reached a breaking point across the Sutter Health Valley Operating Unit. This is why we are focused on building a comprehensive mental health strategy that integrates key elements such as policy and advocacy, county specific investments, stigma reduction, increased awareness and education, with tangible outreach such as expanded mental health resources to professionals in the workplace and telepsych options to the underserved.
Goals	By linking these various strategies and efforts through engaging in statewide partnerships, replicating best practices, and securing innovation grants and award opportunities, we have the ability to create a seamless network of mental health care resources so desperately needed in the communities we serve.
Anticipated Outcomes	The anticipated outcome is a stronger mental/behavioral safety net and increased access to behavioral/mental health resources for our community.
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.
Metrics Used to Evaluate the program/activity/initiative	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.

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.
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. 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

Name of program/activity/initiative	Emergency Department Navigator (ED Navigator)
Description	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.
Goals	The goal of the ED Navigator is to connect patients with health and social services, and ultimately a medical home, as well as other programs (like T3) when appropriate.
Anticipated Outcomes	The anticipated outcome of the ED Navigator is reduced ED visits, as patients will have a medical home and access to social services, in turn, reducing their need to come to the ED for non-urgent reasons and making the patient healthier overall.
Metrics Used to Evaluate the program/activity/initiative	The ED Navigator program has proven to be effective in improving access to care for the underserved community. 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.

Name of program/activity/initiative	Health Navigation: Reducing Barriers to Care
Description	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.
Goals	The overall goal of the project is to establish medical homes, thereby reducing dependence on emergency room systems of care.
Anticipated Outcomes	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.
Metrics Used to Evaluate the program/activity/initiative	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.

Name of program/activity/initiative	Interim Care Program (ICP)
Description	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.
Goals	The ICP seeks to connect patients with a medical home, social support and housing.
Anticipated Outcomes	The anticipated outcome of the ICP is to help people improve their overall health by wrapping them with services and treating the whole person through linkage to appropriate health care, shelter and other social support services.
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. SCP will continue to evaluate the 12 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 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.
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 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.
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. 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.
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. 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.
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. 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.

Name of program/activity/initiative	Ongoing Clinic Investments
Description	With access to care, including primary, mental health and specialty care continuing to be a major priority area in the 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.
Goals	The goal is to expand access to care, especially for underserved populations who have barriers to receiving proper medical care.
Anticipated Outcomes	The anticipated outcome is expanded capacity to serve the underserved population with primary care, behavioral/mental health care, and dental and other specialty services.
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.
Metrics Used to Evaluate the program/activity/initiative	Internal reports. Number of nights stayed. Number of families / people served.
Name of program/activity/initiative	Serial Inebriate Program
Description	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.
Goals	The goal is to get serial inebriates off the streets and into housing and alcohol and drug treatment.
Anticipated Outcomes	The anticipated outcomes are reduced ED visits, reduced arrests, better health and improved sobriety.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories from staff and patients, number of people successfully housed, type of resources provided, reduced arrests and other successful linkages.
Name of program/activity/initiative	Community College Promise Scholarship Program
Description	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.
Goals	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.
Anticipated Outcomes	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.
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 students.

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.
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

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.
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

Name of program/activity/initiative	Clean Air Partnership (CAP)
Description	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.
Goals	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.
Anticipated Outcomes	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
Metrics Used to Evaluate the program/activity/initiative	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.

ACCESS TO SPECIALTY AND EXTENDED CARE

Name of program/activity/initiative	SPIRIT
Description	The Sacramento Physicians' Initiative to Reach out, Innovate and 14 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.
Goals	The overall goal of the project is to provide uninsured patients with outpatient surgeries they otherwise couldn't afford.
Anticipated Outcomes	Patients will live happier, healthier and more productive lives.
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.

Name of program/activity/initiative	Society for the Blind
Description	Society for the Blind is a comprehensive rehabilitative teaching center that provides low vision eye care and blindness skills education and services.
Goals	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
Anticipated Outcomes	To empower individuals living with low vision or blindness to discover, develop and achieve their full potential.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, type of services provided, anecdotal stories and other successful linkages.

ACCESS TO ACTIVE LIVING AND HEALTHY EATING

Name of program/activity/initiative	Midtown Parks
Description	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.
Goals	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.
Anticipated Outcomes	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.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children/families served, anecdotal stories and other successful program impacts.

Name of program/activity/initiative	Food Literacy Program
Description	To teach elementary children in low-income schools cooking and nutrition to improve our health, environment, and economy.
Goals	To reach 700 elementary students during free 14-week afterschool programs. Provide hands-on cooking & nutrition classes covering topics such as fiber, sugar, and fruit & 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.
Anticipated Outcomes	Improve children's knowledge toward healthy food to improve their attitude and develop the habit of eating healthy.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of children served, active schools, anecdotal stories and other successful program impacts.

ACCESS TO MEETING FUNCTIONAL NEEDS (TRANSPORTATION AND PHYSICAL MOBILITY)

Name of program/activity/initiative	Evaluating Fare-Free Transit
Description	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.
Goals	The program aims to decrease truancy and eliminate obstacles for young people to get to school, after-school activities, sports, clubs, and jobs.
Anticipated Outcomes	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
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of young people served and anecdotal stories.

SYSTEM NAVIGATION

Name of program/activity/initiative	Community Navigator
Description	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 15 and drug treatment and other social services. The Community Navigator is integrated with both the Street Nurse and the SMCS 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.
Goals	This effort seeks to provide homeless individuals with a medical home, linkages to health and social resources and a successfully connection to housing/shelter.

Anticipated Outcomes	The anticipated outcomes is a lower number of homeless people in the greater Sacramento region.
Metrics Used to Evaluate the program/activity/initiative	We will look at metrics including (but not limited to) number of people served, number of resources provided, anecdotal stories from staff and patients, number of people successfully housed, number of successful referrals to primary, mental/behavioral health care and/or alcohol and drug treatment, type of resources provided and other successful linkages.

Name of program/activity/initiative	Pediatric Navigation
Description	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.
Goals	The goal of Pediatric Navigation is to provide newborns with health and social services.
Anticipated Outcomes	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
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.

CULTURAL COMPETENCE

Name of program/activity/initiative	World Relief Refugee Women's Integration Program
Description	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.
Goals	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.
Anticipated Outcomes	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.
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	LGBTQ
Description	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.

Goals	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.
Anticipated Outcomes	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
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.
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 Center for Psychiatry (SCP)** Plans Not to Address

No hospital can address all of the health needs present in its community. Sutter Center for Psychiatry (SCP) 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. 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 SCP.

2. Safe and Violence Free Environment: 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.