Sutter Health
Sutter Davis Hospital

2019 – 2021 Community Benefit Plan
Responding to the 2019 Community Health Needs Assessment
Submitted to the Office of Statewide Health Planning and Development May 2022

2000 Sutter Place, Davis, CA 95616
FACILITY LICENSE # 30000124
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 Davis Hospital (SDH), 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.

SDH 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 the not-for-profit parent of not-for-profit and for-profit companies that together form an integrated healthcare system located in Northern California. The system is committed to health equity, community partnerships and innovative, high-quality patient care. Our over 65,000 employees and associated 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 2021 was $872 million. This amount includes traditional charity care and unreimbursed costs of providing care to Medi-Cal patients. This amount also includes 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 mission and help serve some of the most vulnerable in its communities, the Sutter Health network has implemented charity care policies to help provide access to medically necessary care for all patients, regardless of their ability to pay. In 2021, Sutter Health invested $91 million in charity care. Sutter's charity care policies for hospital services include, but are not limited to, the following:

1. Uninsured patients are eligible for full charity care for medically necessary hospital services if their family income is at or below 400% of the Federal Poverty Level ("FPL").

2. Insured patients are eligible for High Medical Cost Charity Care for medically necessary hospital services if their family income is at or below 400% of the FPL and they incurred or paid medical expenses amounting to more than 10% of their family income over the last 12 months. (Sutter Health's Financial Assistance Policy determines the calculation of a patient's family income.)

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 2021, Sutter Health invested $557 million more than the state paid to care for Medi-Cal patients.

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.

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

1. Access to mental/behavioral/substance abuse services
2. Injury and disease prevention and management
3. Access to basic needs such as housing, jobs and food
4. Active living and health eating
5. Access to quality primary care health services
6. Access and functional needs
7. Access to specialty and extended care
8. Safe and violence-free environment
9. Pollution-free living environment
10. Access to dental care and preventive services

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

2019 Community Health Needs Assessment Summary

The purpose of this joint community health needs assessment (CHNA)/community health assessment (CHA) was to identify and prioritize significant health needs of the Yolo County community. The priorities identified in this report help to guide health improvement efforts of both Woodland Memorial Hospital, Sutter Davis Hospital and Yolo County Health and Human Services, Community Health Branch.

This CHNA report meets requirements of the Patient Protection and Affordable Care Act (and, in California, Senate Bill 697) that not-for-profit hospitals conduct a CHNA at least once every three years, as well as the Public Health Accreditation Board (PHAB) CHA requirements. The CHNA/CHA was conducted by Community Health Insights (www.communityhealthinsights.com). Multiple other community partners participated in and collaborated to conduct the CHNA, including CommuniCare Health Centers and Winters Healthcare.

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.1 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 and secondary data. Primary data included interviews with 61 community health experts, social-service providers, and medical personnel in one-on-one and group interviews, as well as one town hall meeting. Further, 132 community residents

participated in three focus groups across the county, and 2,291 residents completed the community health assessment survey.

Using a social determinants focus to identify and organize secondary data, datasets included measures to described mortality and morbidity and social and economic factors such as income, educational attainment, and employment. Further, measures also included indicators to describe health behaviors, clinical care (both quality and access), and data to describe the physical environment.

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

Definition of the Community Served by the Hospital

Yolo County was one of California's 27 original counties when it became a state in 1850, and is home to well over 200 thousand residents. It is located directly west of Sacramento, and sits along both the Interstate 5 and 80 corridors. The county is considered a part of the Greater Sacramento metropolitan area and is located in the Sacramento Valley. Yolo County covers over 1,000 square miles, and a large portion is dedicated to agriculture. The County is known for growing and processing tomatoes. The University of California, Davis, is located in the County and has received world-wide recognition for its research and education. It is also the county's largest employer.

Yolo County is governed by a board of supervisors and contains four incorporated cities: Davis, West Sacramento, Winters, and Woodland. While Davis is the largest in terms of population, Woodland serves as the County Seat. West Sacramento is home to the Port of West Sacramento, an inland port some 80 nautical miles from San Francisco. The port exports many of the agricultural products grown in the County. The Yolo Causeway connects Davis and Sacramento along Interstate 80, and crosses the Yolo Bypass, a large floodplain and wildlife area that received national attention in the late 1990's as a national model for public/private restoration projects.

Community service providers and community members described Yolo County during primary data collection for the CHNA/CHA as "diverse in income, race/ethnicity, and rural and urban status" with many "longtime county residents." A map of Yolo County is shown in Figure 4. Yolo County was selected as the geographical area for the CHNA/CHA because it is the statutory service area of the public health department and the primary service area of the two hospitals participating in the joint assessment.

Significant Health Needs Identified in the 2019 CHNA

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

1. Access to mental/behavioral/substance abuse services
2. Injury and disease prevention and management
3. Access to basic needs such as housing, jobs and food
4. Active living and health eating
5. Access to quality primary care health services
6. Access and functional needs
7. Access to specialty and extended care
8. Safe and violence-free environment
9. Pollution-free living environment
10. Access to dental care and preventive services

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 health assessments with area hospitals. Data were analyzed to discover which, if any, of the PHNs were present in the area. After these were identified, the health needs were prioritized based on an analysis of primary data sources that identified the PHN as a significant health need (SHN).

2019 – 2021 Implementation Strategy Plan

The implementation strategy plan describes how SDH 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 SDH 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. Injury and disease prevention and management
3. Access to basic needs such as housing, jobs and food
4. Active living and health eating
5. Access to quality primary care health services
6. Access and functional needs
7. Access to specialty and extended care
8. Safe and violence-free environment

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 tele psych 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.
2021 Outcomes	In 2021, the mental health strategy helped with the following initiatives: • Launch the 988 crisis line going live on July 26, 2022 • Pass SB803 for peer certification. • Secure funding for SB71/Bring CA Home in amount of $2 billion over two years and an unspecified amount future funding. • Advocate for funding for board and care with the County Behavioral Health Directors Association and other organizations

	serving people living with severe mental illness and/or substance use disorder. Resulting in securing $803 million, with program details still to be fleshed out. • Propose Children and Youth Initiative and assist Secretary Ghaly to develop what became one of the Governor's signature budget achievements: $4.5 billion over five years to meet the behavioral health needs of children.
Name of program/activity/initiative	Health and Wellness Program (Formerly Suicide Prevention Follow Up Program)
Description	In 2020, the program was redesigned as the Health and Wellness Support program to include an upstream approach that treats not only those in crisis, takes action in those with low-level indicator to prevent crisis from occurring. The program provides individuals with mental or physical health support and connection to community resources. The program has the unique ability to serve a wide range of patient needs from navigating services and friendly check-in calls to dealing with more complex issues, like managing a mental health crisis. The goal of early intervention is to give clients a support system by having a live person to speak to when needed and help mitigate stressors before they become difficult to manage. The frequency of check-ins with patients depend on individual needs and can vary from multiple times a week to once per month. The program is completely voluntary and patients can discontinue follow-up services at any point.
Goals	The goal of the Health and Wellness program is to have an upstream approach by intervening with support for patients with low level indicators to prevent crisis from occurring and for those experiencing crisis to help the patient get to a manageable place with their health. This is accomplished by wrapping patients with services and support to alleviate additional stressors that when left unaddressed may lead to suicide attempts or ideations.
2021 Outcomes	In the first half of 2021, 57 patients received supportive services totaling 456 connections and were referred to 68 community resources.
Name of program/activity/initiative	Employ and Empower Case Management Services
Description	Newly funded program in 2021. 3SGF will provide case management services to survivors of human trafficking or individuals at risk of exploitation between the ages of 16 and 50. Social workers will assist with goal setting, mental health services, childcare, obtain legal documentation, career development, job skills and education. Each client is assessed to allow for accurate case plan goals. Clients are connected to mental health resources and support at no cost. Financial assistance is provided to clients to help secure daycare until they remain consistently employed. Career development includes helping clients access documents necessary for employment, transportation education, purchasing professional clothing, promoting financial literacy skills, career goal setting, job readiness skills, job training, job placement and retention services.
Goals	The goal is to provide mental health and wrap around services to survivors or human trafficking or individuals at risk for exploitation, as well as obtain job placement.
2021 Outcomes	In the first half of 2021, the program provided 24 services and connections to 6 community resources.
Name of program/activity/initiative	School Based Mental Health Services
Description	School Based Mental Health Services targets Sacramento City Unified School District (nearly 50,000 students) and Washington Unified School District (over 8,000 students). Student outreach is conducted through education around mental health wellness to reduce stigma related to

	mental health and promote access to mental health services. Students are provided referrals and linkages to appropriate mental health services. The program includes Family & Youth Partnership, which is peer partner services and support groups designed to inform, educate, support, and empower parents/caregivers to be able to advocate and be fully engaged with their child/youth's educational and social well-being. Access is given to skill building and targeted behavior groups and Sutter Health's funding will cover group costs for students who do not qualify for Medi-Cal. Sutter's funding will also help provide school supplies for low-income students and Life Fund, which offers strategic, targeted assistance to at-risk youth and families by providing financial resources to meet basic needs (i.e. access to food, clothing, housing, and/or transportation) and/or provide educational or social opportunities as youth work toward completing treatment and recovery goals.
Goals	The goal is to provide provided referrals and linkages to appropriate mental health services.
2021 Outcomes	In the first half of 2021, the program served 593 individuals in Yolo County.
Name of program/activity/initiative	Salud Clinic Outdoor Play Area
Description	Newly funded program in 2021. Sutter Health is funding the rebuild of the preschool's outdoor play space at the Salud Clinic in West Sacramento. They recently experienced a tragic fire that rendered the space unusable. The area is used for hands on learning and outdoor play therapy for children of patients receiving treatment through the Perinatal Day Program, which is for pregnant and parenting mothers struggling with substance use issues and is the only program of its kind in Yolo County.
Goals	The goal is to rebuild play area to allow children to experiencing hands on learning and outdoor play therapy while parents receive treatment through the Perinatal Day Program.
2021 Outcomes	As a result of the pandemic, the space is still in the planning stages. Demolition is anticipated to begin in 2021 and then construction. There is no program data or demographics to report at this time.
Name of program/activity/initiative	Haven House Interim Care Program
Description	In partnership with Dignity Health, Sutter Health invests in the Haven House with Yolo Community Care Continuum (YCCC). Haven House is an interim care program that offers people experiencing homelessness a safe place to recover after hospitalization. Haven House offers four respite beds for up to 29 days. During their stay, the homeless will be assisted by YCCC, who will work with them to provide connections to other services. Services include health insurance enrollment, substance abuse and mental health services, and placement in permanent housing.
Goals	The goal is to allow a safe space for people experiencing homelessness to recover after hospitalization.
2021 Outcomes	In the first half of 2021, the program served 19 people with 2,784 services and connected to 112 community resources. In addition, 4 individuals obtained permanent housing.

INJURY AND DISEASE PREVENTION MANAGEMENT

Name of program/activity/initiative	Healthy Living with Diabetes
Description	Newly funded program in 2020. Funding will help expand the existing Healthy Living with Diabetes Program (HLDP), which aims to equip the low-income CommuniCare Health Center's patient with diabetes

	management skills and access to the healthy food. The expansion will include adding two new Paraprofessional Diabetes Educators (PDEs), a Registered Nurse (RN) who is also a Certified Diabetes Educator (CDE), and a Garden Coordinator to the HLDP team. PDEs will be bilingual, bicultural individuals cross trained as Comprehensive Perinatal Services Program (CPSP) providers. Coverage and coordination of diabetes-related services offered will improve the patient health with particular attention to addressing inequitable 2021 Outcomes in blood sugar management associated with poverty and ethnicity. There will be targeted efforts to increase access for our perinatal patients with diabetes through Centering Pregnancy groups and one-on-one diabetes case management at each site, in addition to implementing strategies to reach more of our vulnerable populations. Lastly, funding will also allow for the completion of construction of the garden and outdoor classroom and purchase supplementary produce from local farms and the Yolo Food Bank, which will further educate patients on how they can incorporate sustainable and affordable options at home.
Goals	The goal is to equip the low-income CCHC patient with diabetes management skills and access to the healthy food.
2021 Outcomes	In the first half of 2021, the program served 448 people with 2,123 services and connection to 1,491 community resources. In addition, provided 1,000 pounds of healthy food.
Name of program/activity/initiative	Street Medicine Program
Description	Newly funded program in 2020. The Yolo Street Medicine and Mobile Medical Unit Collaboration consists of partnership between SDH, County of Yolo Health and Human Services Agency, and Dignity Health. The program provides street-based medicine units. The community based provider, CommuniCare Health Center, will provide physical health, behavioral health, and social services to the target populations. In addition funding for the Mobile Medical Unit will help purchase a vehicle (van); and a mobile medical unit.
Goals	The goal is to provide physical health, behavioral health, and social services to individuals living homeless in Yolo County; individuals and families at education, faith and migrant farm community locations who are in need of mobile medical services; people in certain rural areas of Yolo County that are in need of health care services to individuals living homeless in Yolo County.
2021 Outcomes	In the first half of 2021, the program served 193 people with 1,654 services and connected to 347 community resources.
Name of program/activity/initiative	Vaccine Outreach
Description	This is a newly funded program in 2021. The Yolo County Children's Alliance will bring vital information and resources regarding the COVID-19 vaccine to all residents, focusing on hard-to-reach communities, living within Yolo County. These communities include non-English speaking communities, rural communities, and communities with limited or no access to the internet. YCCA will expand the communication and outreach approach to ensure a broader reach within these communities, with a goal of bringing greater awareness about the vaccine and its importance, creating better access to vaccine clinics, and increasing enrollment to the State's MyTurn vaccine clinic system.
Goals	Provide vaccine outreach and awareness to all residents, focusing on hard-to-reach communities, living within Yolo County.
2021 Outcomes	In the first half of 2021, the program served 4,000 children and 1,400 families with 6,800 educational services.
Name of program/activity/initiative	Nourish Yolo

Description	Sutter has awarded a five-year investment to the Yolo Food Bank for the Nourish Yolo Campaign. Our investment will help prevent chronic diseases by increasing access to fresh, healthy foods in Yolo County, increase awareness around the crisis that is food insecurity and create new/expand existing programs across Yolo County to ensure more people have consistent access to the food and resources they so desperately need.
Goals	Currently, there is an unmet need of 20-30% of Yolo County residents requiring food access and nutritious food options. With the help of our funding, the food bank will be able to fully meet that need.
2021 Outcomes	In the first half of 2021, the program served 99,000 people and distributed 12,000,000 pounds of food.
Name of program/activity/initiative	Nurture Yolo
Description	Newly funded program in 2021 and anticipated to be a one-time investment. Yolo Food Bank will increase storage space to prevent the damage or perish of goods to be utilized for the targeted expansion to rural communities and underserved populations that face greater inequities, including: Knights Landing, Madison, Esparto, Dunnigan and Winters. In addition, the home delivery service will be expanded for senior citizens and vulnerable, homebound residents in every portion of the county, especially remote rural areas.
Goals	Increase capacity to service more individuals and families in Yolo County, including expanded services for home delivery services.
2021 Outcomes	In the first half of 2021, the program served 99,000 people and distributed 12,000,000 pounds of food.

ACCESS TO BASIC NEEDS SUCH AS HOUSING, JOBS AND FOOD

Name of program/activity/initiative	Emergency Childcare and Wrap-Around Services for Families in Crisis
Description	Yolo Crisis Nursery (YCN) is one of only four crisis nurseries in CA and the only crisis nursery in Yolo County. They offer emergency child care and wrap-around services to families in crisis which ensure continued stability and the well-being of young children at risk for child abuse. YCN's early intervention services focus on building successful and resilient children, strengthening parents and preserving families. Their work helps to stop the cycle of child abuse and its long-term impact, contributing to a healthier community for everyone.
Goals	The goals of these programs/organizations include providing children with stable, loving environments, while wrapping the children and their families with services to help them end the cycle of violence, and live happy, healthy lives.
2021 Outcomes	In the first half of 2021, 431 children and 174 families received 4,692 services.
Name of program/activity/initiative	Mobile Client Navigator and Nursery Case Management Services
Description	This is a newly funded program in 2021. As homeless and domestic violence shelters reach maximum capacity during the pandemic, the Yolo Crisis Nursery is playing an even more essential role triaging victims of violence and families facing homelessness. Sutter Health's funding will support an increase in onsite staff at the Nursery to provide emergency triage services related to the pandemic and provide wrap around services to these families, such as case management, connection to community resources, and Safe Stays at the Nursery.

	In addition, funding will support building greater capacity for the Mobile Client Navigator through purchasing a much-needed vehicle that will allow the Nursery to reach more high-risk families in rural areas of Yolo County and expand services to RISE, Inc. in Woodland when construction is complete. The Mobile Client Navigator collaborates with local agencies to reach families where they are during an emergency to remove access as a barrier and is available 3 days/week on site at Empower Yolo in Woodland, 1 day/week at a shelter, and 1day/ week at a library, hospital or resource center. However, when locations are unavailable due to COVID, the Navigator is available remotely. The designated vehicle will allow for uninterrupted services for families in rural locations, such as delivery of essential supplies and transportation to the Nursery to be connected to wrap around services.
Goals	The goals of these programs/organizations include providing children with stable, loving environments, while wrapping the children and their families with services to help them end the cycle of violence, and live happy, healthy lives.
2021 Outcomes	In the first half of 2021, 500 children and 415 families received 915 services.
Name of program/activity/initiative	West Sacramento Family Resource Center (WSFRC)
Description	Sutter is funded the expansion of services at YCCA impacting the West Gateway Place apartments and the full-service West Sacramento Family Resource Center (WSFRC) located in a low income West Sacramento neighborhood, next to Riverbank Elementary School. Through Yolo County Children's Alliance's programs and services, immigrants, refugees, homeless and unstably housed families, and other under-resourced parents, children, seniors, and individuals in the community find a safe and nurturing space where they can get hands on personal assistance to access the resources they need in order to improve their lives. They also find a community space that fosters social connection between and among neighbors and other community members.
Goals	The goals of these programs/organizations include providing children with stable, loving environments, while wrapping the children and their families with services to help them end the cycle of violence, and live happy, healthy lives.
2021 Outcomes	In the first half of 2021, the program served 578 children and 534 families with 707 services and connected to 3,666 community resources. In addition, 10 families obtained permanent housing.
Name of program/activity/initiative	Paul's Place
Description	As part of Getting to Zero, Sutter Health has committed to match up to $2.5 million in private donations to Paul's Place – a multi-functional housing center designed to serve the most vulnerable individuals experiencing homelessness in Davis by providing housing and support services. Working with community leaders to leverage both public and private sector resources, we can come together as a community to raise the capital necessary to finance Paul's Place.
Goals	The goal is to complete the construction of Paul's Place.
2021 Outcomes	In 2021, Paul's Place is working toward obtaining project approval from both the city of Davis planning commission and city council.
Name of program/activity/initiative	Eviction Prevention Program
Description	The Eviction Prevention Program serves families and individuals to prevent homelessness by keeping clients housed during a short-term financial emergency. This objective is consistent with the "housing first" model supported by the US Department of Housing and Urban Development and widely used by nonprofits across America. All

	recipients of STEAC assistance are referred by one of the more than 20 public and nonprofit agencies. STEAC only works with agencies and organizations that have received training regarding STEAC programs, policies and procedures. After receiving the recommendation for service, prospective clients are screened by STEAC's staff and office volunteers using an intake form, accessing database records, reviewing support documents (income, tenant history, etc.) and following rental assistance policies. To qualify, clients must be low-income according to federal poverty guidelines, their rent cannot exceed 80% of their income, and they must prove they can be self-sufficient after they receive STEAC assistance. STEAC makes payments only to vendors, such as landlords, and never directly to clients.
Goals	The goal is to prevent homelessness by providing eviction prevention support.
2021 Outcomes	In the first half of 2021, the program served 301 individuals and 122 families.
Name of program/activity/initiative	Permanent Supportive Housing Project
Description	Newly funded program in 2020. Sutter Health is partnering with the City of West Sacramento, Mercy Housing California, Yolo County Health and Human Services and Yolo County Housing Authority to help fund the completion of the permanent supportive housing project (PSH). Mercy Housing has developed and operates 134 affordable communities in California with more than 9,190 homes serving lower-income seniors, families, and people who have experienced homelessness. Mercy Housing will develop and manage the 85-unit PSH project with Yolo County Health and Human Services providing the on-site supportive services such as case management and related health services. Yolo County Housing Authority will be a co-developer and has awarded 60 project-based vouchers. The project will aim to expand the available housing for individuals experiencing homelessness; and improve the overall well-being of people experiencing homelessness by targeting four social determinants of health, including housing stability, physical health, behavioral health, and self-sufficiency.
Goals	The goal is to complete the construction of the permanent supportive housing project.
2021 Outcomes	In the first half of 2021, the project is under construction and still anticipated to be completed in late August/early September 2021.
Name of program/activity/initiative	Employ and Empower Case Management Services
Description	Newly funded program in 2021. 3SGF will provide case management services to survivors of human trafficking or individuals at risk of exploitation between the ages of 16 and 50. Social workers will assist with goal setting, mental health services, childcare, obtain legal documentation, career development, job skills and education. Each client is assessed to allow for accurate case plan goals. Clients are connected to mental health resources and support at no cost. Financial assistance is provided to clients to help secure daycare until they remain consistently employed. Career development includes helping clients access documents necessary for employment, transportation education, purchasing professional clothing, promoting financial literacy skills, career goal setting, job readiness skills, job training, job placement and retention services.
Goals	The goal is to provide mental health and wrap around services to survivors or human trafficking or individuals at risk for exploitation, as well as obtain job placement.
2021 Outcomes	In the first half of 2021, the program provided 24 services and connections to 6 community resources.

Name of program/activity/initiative	Healthy Living with Diabetes
Description	Newly funded program in 2020. Funding will help expand the existing Healthy Living with Diabetes Program (HLDP), which aims to equip the low-income CommuniCare Health Center's patient with diabetes management skills and access to the healthy food. The expansion will include adding two new Paraprofessional Diabetes Educators (PDEs), a Registered Nurse (RN) who is also a Certified Diabetes Educator (CDE), and a Garden Coordinator to the HLDP team. PDEs will be bilingual, bicultural individuals cross trained as Comprehensive Perinatal Services Program (CPSP) providers. Coverage and coordination of diabetes-related services offered will improve the patient health with particular attention to addressing inequitable 2021 Outcomes in blood sugar management associated with poverty and ethnicity. There will be targeted efforts to increase access for our perinatal patients with diabetes through Centering Pregnancy groups and one-on-one diabetes case management at each site, in addition to implementing strategies to reach more of our vulnerable populations. Lastly, funding will also allow for the completion of construction of the garden and outdoor classroom and purchase supplementary produce from local farms and the Yolo Food Bank, which will further educate patients on how they can incorporate sustainable and affordable options at home.
Goals	The goal is to equip the low-income CCHC patient with diabetes management skills and access to the healthy food.
2021 Outcomes	In the first half of 2021, the program served 448 people with 2,123 services and connection to 1,491 community resources. In addition, provided 1,000 pounds of healthy food.
Name of program/activity/initiative	School Based Mental Health Services
Description	School Based Mental Health Services targets Sacramento City Unified School District (nearly 50,000 students) and Washington Unified School District (over 8,000 students). Student outreach is conducted through education around mental health wellness to reduce stigma related to mental health and promote access to mental health services. Students are provided referrals and linkages to appropriate mental health services. The program includes Family & Youth Partnership, which is peer partner services and support groups designed to inform, educate, support, and empower parents/caregivers to be able to advocate and be fully engaged with their child/youth's educational and social well-being. Access is given to skill building and targeted behavior groups and Sutter Health's funding will cover group costs for students who do not qualify for Medi-Cal. Sutter's funding will also help provide school supplies for low-income students and Life Fund, which offers strategic, targeted assistance to at-risk youth and families by providing financial resources to meet basic needs (i.e. access to food, clothing, housing, and/or transportation) and/or provide educational or social opportunities as youth work toward completing treatment and recovery goals.
Goals	The goal is to provide provided referrals and linkages to appropriate mental health services.
2021 Outcomes	In the first half of 2021, the program served 593 individuals in Yolo County.
Name of program/activity/initiative	Haven House Interim Care Program
Description	In partnership with Dignity Health, Sutter Health invests in the Haven House with Yolo Community Care Continuum (YCCC). Haven House is an interim care program that offers people experiencing homelessness a safe place to recover after hospitalization. Haven House offers four respite beds for up to 29 days. During their stay, the homeless will be

	assisted by YCCC, who will work with them to provide connections to other services. Services include health insurance enrollment, substance abuse and mental health services, and placement in permanent housing.
Goals	The goal is to allow a safe space for people experiencing homelessness to recover after hospitalization.
2021 Outcomes	In the first half of 2021, the program served 19 people with 2,784 services and connected to 112 community resources. In addition, 4 individuals obtained permanent housing.
Name of program/activity/initiative	Kids Farmers Market
Description	The Yolo Food Bank offers the Kids Farmers Market program to provide Yolo County preschool and elementary school children with ongoing access to fresh fruits and vegetables through a fun, interactive farmer's market-style distribution. The program provides a free weekly after school farmers' market for preschool and elementary school children at seven schools. It allows students the opportunity to use play money to "purchase" up to 10 pounds of produce from the onsite market.
Goals	The goal of this effort is for students to learn about and sample the available fruits and vegetables, and to take home the produce, recipes, and other information about healthy living.
2021 Outcomes	In 2021, the food bank transitioned funding for this program to general food drives due to demand tripling in size as a result of the pandemic.
Name of program/activity/initiative	Nourish Yolo
Description	Sutter has awarded a five-year investment to the Yolo Food Bank for the Nourish Yolo Campaign. Our investment will help prevent chronic diseases by increasing access to fresh, healthy foods in Yolo County, increase awareness around the crisis that is food insecurity and create new/expand existing programs across Yolo County to ensure more people have consistent access to the food and resources they so desperately need.
Goals	Currently, there is an unmet need of 20-30% of Yolo County residents requiring food access and nutritious food options. With the help of our funding, the food bank will be able to fully meet that need.
2021 Outcomes	In the first half of 2021, the program served 99,000 people and distributed 12,000,000 pounds of food.
Name of program/activity/initiative	Nurture Yolo
Description	Newly funded program in 2021 and anticipated to be a one-time investment. Yolo Food Bank will increase storage space to prevent the damage or perish of goods to be utilized for the targeted expansion to rural communities and underserved populations that face greater inequities, including: Knights Landing, Madison, Esparto, Dunnigan and Winters. In addition, the home delivery service will be expanded for senior citizens and vulnerable, homebound residents in every portion of the county, especially remote rural areas.
Goals	Increase capacity to service more individuals and families in Yolo County, including expanded services for home delivery services.
2021 Outcomes	In the first half of 2021, the program served 99,000 people and distributed 12,000,000 pounds of food.

ACTIVE LIVING AND HEALTHY EATING

Name of program/activity/initiative	Kids Farmers Market

Description	The Yolo Food Bank offers the Kids Farmers Market program to provide Yolo County preschool and elementary school children with ongoing access to fresh fruits and vegetables through a fun, interactive farmer's market-style distribution. The program provides a free weekly after school farmers' market for preschool and elementary school children at seven schools. It allows students the opportunity to use play money to "purchase" up to 10 pounds of produce from the onsite market.
Goals	The goal of this effort is for students to learn about and sample the available fruits and vegetables, and to take home the produce, recipes, and other information about healthy living.
2021 Outcomes	In 2021, the food bank transitioned funding for this program to general food drives due to demand tripling in size as a result of the pandemic.
Name of program/activity/initiative	Nourish Yolo
Description	Sutter has awarded a five-year investment to the Yolo Food Bank for the Nourish Yolo Campaign. Our investment will help prevent chronic diseases by increasing access to fresh, healthy foods in Yolo County, increase awareness around the crisis that is food insecurity and create new/expand existing programs across Yolo County to ensure more people have consistent access to the food and resources they so desperately need.
Goals	Currently, there is an unmet need of 20-30% of Yolo County residents requiring food access and nutritious food options. With the help of our funding, the food bank will be able to fully meet that need.
2021 Outcomes	In the first half of 2021, the program served 99,000 people and distributed 12,000,000 pounds of food.
Name of program/activity/initiative	Nurture Yolo
Description	Newly funded program in 2021 and anticipated to be a one-time investment. Yolo Food Bank will increase storage space to prevent the damage or perish of goods to be utilized for the targeted expansion to rural communities and underserved populations that face greater inequities, including: Knights Landing, Madison, Esparto, Dunnigan and Winters. In addition, the home delivery service will be expanded for senior citizens and vulnerable, homebound residents in every portion of the county, especially remote rural areas.
Goals	Increase capacity to service more individuals and families in Yolo County, including expanded services for home delivery services.
2021 Outcomes	In the first half of 2021, the program served 99,000 people and distributed 12,000,000 pounds of food.
Name of program/activity/initiative	Healthy Living with Diabetes
Description	Newly funded program in 2020. Funding will help expand the existing Healthy Living with Diabetes Program (HLDP), which aims to equip the low-income CommuniCare Health Center's patient with diabetes management skills and access to the healthy food. The expansion will include adding two new Paraprofessional Diabetes Educators (PDEs), a Registered Nurse (RN) who is also a Certified Diabetes Educator (CDE), and a Garden Coordinator to the HLDP team. PDEs will be bilingual, bicultural individuals cross trained as Comprehensive Perinatal Services Program (CPSP) providers. Coverage and coordination of diabetes-related services offered will improve the patient health with particular attention to addressing inequitable 2021 Outcomes in blood sugar management associated with poverty and ethnicity. There will be targeted efforts to increase access for our perinatal patients with diabetes through Centering Pregnancy groups and one-on-one diabetes case management at each site, in addition to implementing strategies to reach

	more of our vulnerable populations. Lastly, funding will also allow for the completion of construction of the garden and outdoor classroom and purchase supplementary produce from local farms and the Yolo Food Bank, which will further educate patients on how they can incorporate sustainable and affordable options at home.
Goals	The goal is to equip the low-income CCHC patient with diabetes management skills and access to the healthy food.
2021 Outcomes	In the first half of 2021, the program served 448 people with 2,123 services and connection to 1,491 community resources. In addition, provided 1,000 pounds of healthy food.

ACCESS TO HIGH QUALITY HEALTH CARE AND SERVICES

Name of program/activity/initiative	Uncompensated Care in Yolo County
Description	With access to care, including primary, mental health and specialty care continuing to be a major priority area in the SDH HSA, we will continue to make strategic investments in our local FQHC partners to increase clinic capacity and services offered. Our relationship with CommuniCare Health Center is one of our most valued partnerships in Yolo County. CommuniCare is an FQHC offering comprehensive primary medical and dental services, perinatal services, behavioral health services, substance abuse treatment, health education and outreach services to the culturally diverse, low-income, and uninsured and Medi-Cal populations of Yolo County and eastern Solano County, including migrant and seasonal farm workers and their families.
Goals	The goal is to expand access to care.
2021 Outcomes	This program discontinued in 2020.
Name of program/activity/initiative	Winter Shelter
Description	Newly funded program in 2020. CommuniCare Health Centers will partner with Mercy Coalition of West Sacramento to provide clinical services in the rotating homeless shelters in West Sacramento.
Goals	The goal is to provide clinical services to those in the rotating homeless shelters in West Sacramento.
2021 Outcomes	This program discontinued in 2020.
Name of program/activity/initiative	Salud Clinic Outdoor Play Area
Description	Newly funded program in 2021. Sutter Health is funding the rebuild of the preschool's outdoor play space at the Salud Clinic in West Sacramento. They recently experienced a tragic fire that rendered the space unusable. The area is used for hands on learning and outdoor play therapy for children of patients receiving treatment through the Perinatal Day Program, which is for pregnant and parenting mothers struggling with substance use issues and is the only program of its kind in Yolo County.
Goals	The goal is to rebuild play area to allow children to experiencing hands on learning and outdoor play therapy while parents receive treatment through the Perinatal Day Program.
2021 Outcomes	As a result of the pandemic, the space is still in the planning stages. Demolition is anticipated to begin in 2021 and then construction. There is no program data or demographics to report at this time.
Name of program/activity/initiative	Haven House Interim Care Program
Description	In partnership with Dignity Health, Sutter Health invests in the Haven House with Yolo Community Care Continuum (YCCC). Haven House is an interim care program that offers people experiencing homelessness a

	safe place to recover after hospitalization. Haven House offers four respite beds for up to 29 days. During their stay, the homeless will be assisted by YCCC, who will work with them to provide connections to other services. Services include health insurance enrollment, substance abuse and mental health services, and placement in permanent housing.
Goals	The goal is to allow a safe space for people experiencing homelessness to recover after hospitalization.
2021 Outcomes	In the first half of 2021, the program served 19 people with 2,784 services and connected to 112 community resources. In addition, 4 individuals obtained permanent housing.
Name of program/activity/initiative	Street Medicine Program
Description	Newly funded program in 2020. The Yolo Street Medicine and Mobile Medical Unit Collaboration consists of partnership between SDH, County of Yolo Health and Human Services Agency, and Dignity Health. The program provides street-based medicine units. The community based provider, CommuniCare Health Center, will provide physical health, behavioral health, and social services to the target populations. In addition funding for the Mobile Medical Unit will help purchase a vehicle (van); and a mobile medical unit.
Goals	The goal is to provide physical health, behavioral health, and social services to individuals living homeless in Yolo County; individuals and families at education, faith and migrant farm community locations who are in need of mobile medical services; people in certain rural areas of Yolo County that are in need of health care services to individuals living homeless in Yolo County.
2021 Outcomes	In the first half of 2021, the program served 193 people with 1,654 services and connected to 347 community resources.
Name of program/activity/initiative	Yolo Cares
Description	Newly funded program in 2020. YoloCares Program is comprehensive, 24/7, 360-degree, community-based palliative care (including behavioral health services, disease management and improved access to care) to patients throughout Yolo County. YoloCares serves as the primary care physician for YoloCare patients in need and will work with partners to coordinate care. Peer-to-peer education will be offered to area physicians about the YoloCares program to help create a streamlined continuum of care and referral process between YoloCares, Yolo Adult Day Health Center, CommuniCare, and Fourth & Hope through educational workshops. The program will work to expand the knowledge of palliative care, YoloCares services, and advance care planning through YoloCares workshops for our community faith leaders by holding advance care planning workings for community partners, the general public, and faith leaders. In addition, YoloCares' one-of-a-kind, caregiver relief program, Citizens Who Care (CWC) will provide caregiver relief through professionally trained volunteers.
Goals	The goal is to provide palliative care to low-income and homeless populations, as well as provide peer to peer education for how to access palliative care for patients.
2021 Outcomes	In the first half of 2021, the program served 160 people with 1,319 services and connected to 147 community resources. Due to scheduling issues, the virtual conference on palliative care is tentatively scheduled for June 2022.

ACCESS AND FUCTIONAL NEEDS

Name of program/activity/initiative	School Based Mental Health Services
Description	School Based Mental Health Services targets Sacramento City Unified School District (nearly 50,000 students) and Washington Unified School District (over 8,000 students). Student outreach is conducted through education around mental health wellness to reduce stigma related to mental health and promote access to mental health services. Students are provided referrals and linkages to appropriate mental health services. The program includes Family & Youth Partnership, which is peer partner services and support groups designed to inform, educate, support, and empower parents/caregivers to be able to advocate and be fully engaged with their child/youth's educational and social well-being. Access is given to skill building and targeted behavior groups and Sutter Health's funding will cover group costs for students who do not qualify for Medi-Cal. Sutter's funding will also help provide school supplies for low-income students and Life Fund, which offers strategic, targeted assistance to at-risk youth and families by providing financial resources to meet basic needs (i.e. access to food, clothing, housing, and/or transportation) and/or provide educational or social opportunities as youth work toward completing treatment and recovery goals.
Goals	The goal is to provide provided referrals and linkages to appropriate mental health services.
2021 Outcomes	In the first half of 2021, the program served 593 individuals in Yolo County.
Name of program/activity/initiative	Mobile Client Navigator and Nursery Case Management Services
Description	This is a newly funded program in 2021. As homeless and domestic violence shelters reach maximum capacity during the pandemic, the Yolo Crisis Nursery is playing an even more essential role triaging victims of violence and families facing homelessness. Sutter Health's funding will support an increase in onsite staff at the Nursery to provide emergency triage services related to the pandemic and provide wrap around services to these families, such as case management, connection to community resources, and Safe Stays at the Nursery. In addition, funding will support building greater capacity for the Mobile Client Navigator through purchasing a much-needed vehicle that will allow the Nursery to reach more high-risk families in rural areas of Yolo County and expand services to RISE, Inc. in Woodland when construction is complete. The Mobile Client Navigator collaborates with local agencies to reach families where they are during an emergency to remove access as a barrier and is available 3 days/week on site at Empower Yolo in Woodland, 1 day/week at a shelter, and 1day/ week at a library, hospital or resource center. However, when locations are unavailable due to COVID, the Navigator is available remotely. The designated vehicle will allow for uninterrupted services for families in rural locations, such as delivery of essential supplies and transportation to the Nursery to be connected to wrap around services.
Goals	The goals of these programs/organizations include providing children with stable, loving environments, while wrapping the children and their families with services to help them end the cycle of violence, and live happy, healthy lives.
2021 Outcomes	In the first half of 2021, 500 children and 415 families received 915 services.

ACCESS TO SPECIALTY AND EXTENDED CARE

Name of program/activity/initiative	Yolo Cares
Description	Newly funded program in 2020. YoloCares Program is comprehensive, 24/7, 360-degree, community-based palliative care (including behavioral health services, disease management and improved access to care) to patients throughout Yolo County. YoloCares serves as the primary care physician for YoloCare patients in need and will work with partners to coordinate care. Peer-to-peer education will be offered to area physicians about the YoloCares program to help create a streamlined continuum of care and referral process between YoloCares, Yolo Adult Day Health Center, CommuniCare, and Fourth & Hope through educational workshops. The program will work to expand the knowledge of palliative care, YoloCares services, and advance care planning through YoloCares workshops for our community faith leaders by holding advance care planning workings for community partners, the general public, and faith leaders. In addition, YoloCares' one-of-a-kind, caregiver relief program, Citizens Who Care (CWC) will provide caregiver relief through professionally trained volunteers.
Goals	The goal is to provide palliative care to low-income and homeless populations, as well as provide peer to peer education for how to access palliative care for patients.
2021 Outcomes	In the first half of 2021, the program served 160 people with 1,319 services and connected to 147 community resources. Due to scheduling issues, the virtual conference on palliative care is tentatively scheduled for June 2022.

SAFE AND VIOLENCE FREE ENVIRONMENT

Name of program/activity/initiative	Emergency Childcare and Wrap-Around Services for Families in Crisis
Description	Yolo Crisis Nursery (YCN) is one of only four crisis nurseries in CA and the only crisis nursery in Yolo County. They offer emergency child care and wrap-around services to families in crisis which ensure continued stability and the well-being of young children at risk for child abuse. YCN's early intervention services focus on building successful and resilient children, strengthening parents and preserving families. Their work helps to stop the cycle of child abuse and its long-term impact, contributing to a healthier community for everyone.
Goals	The goals of these programs/organizations include providing children with stable, loving environments, while wrapping the children and their families with services to help them end the cycle of violence, and live happy, healthy lives.
2021 Outcomes	In the first half of 2021, 431 children and 174 families received 4,692 services.
Name of program/activity/initiative	Mobile Client Navigator and Nursery Case Management Services
Description	This is a newly funded program in 2021. As homeless and domestic violence shelters reach maximum capacity during the pandemic, the Yolo Crisis Nursery is playing an even more essential role triaging victims of violence and families facing homelessness. Sutter Health's funding will support an increase in onsite staff at the Nursery to provide emergency triage services related to the pandemic and provide wrap around services to these families, such as case management, connection to community resources, and Safe Stays at the Nursery.

	In addition, funding will support building greater capacity for the Mobile Client Navigator through purchasing a much-needed vehicle that will allow the Nursery to reach more high-risk families in rural areas of Yolo County and expand services to RISE, Inc. in Woodland when construction is complete. The Mobile Client Navigator collaborates with local agencies to reach families where they are during an emergency to remove access as a barrier and is available 3 days/week on site at Empower Yolo in Woodland, 1 day/week at a shelter, and 1day/ week at a library, hospital or resource center. However, when locations are unavailable due to COVID, the Navigator is available remotely. The designated vehicle will allow for uninterrupted services for families in rural locations, such as delivery of essential supplies and transportation to the Nursery to be connected to wrap around services.
Goals	The goals of these programs/organizations include providing children with stable, loving environments, while wrapping the children and their families with services to help them end the cycle of violence, and live happy, healthy lives.
2021 Outcomes	In the first half of 2021, 500 children and 415 families received 915 services.

Needs SDH Plans Not to Address

No hospital can address all of the health needs present in its community. SDH 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. Pollution-Free Living Environments: While this is an important issue, this is not something that we are able to greatly affect through community benefit; therefore, we are focusing our resources elsewhere, especially given that regional community partners like SACOG, the Cleaner Air Partnership and others, are working on these vital issues.

2. Access to Dental Care and Preventative Services: We are continuously looking for opportunities to provide collaborative dental care options to the underserved communities; however, we have not yet found the perfect fit in Yolo County. Although we don't have current plans to address dental care and preventative services, there is always a chance that one may develop in the years ahead.

Approval by Governing Board

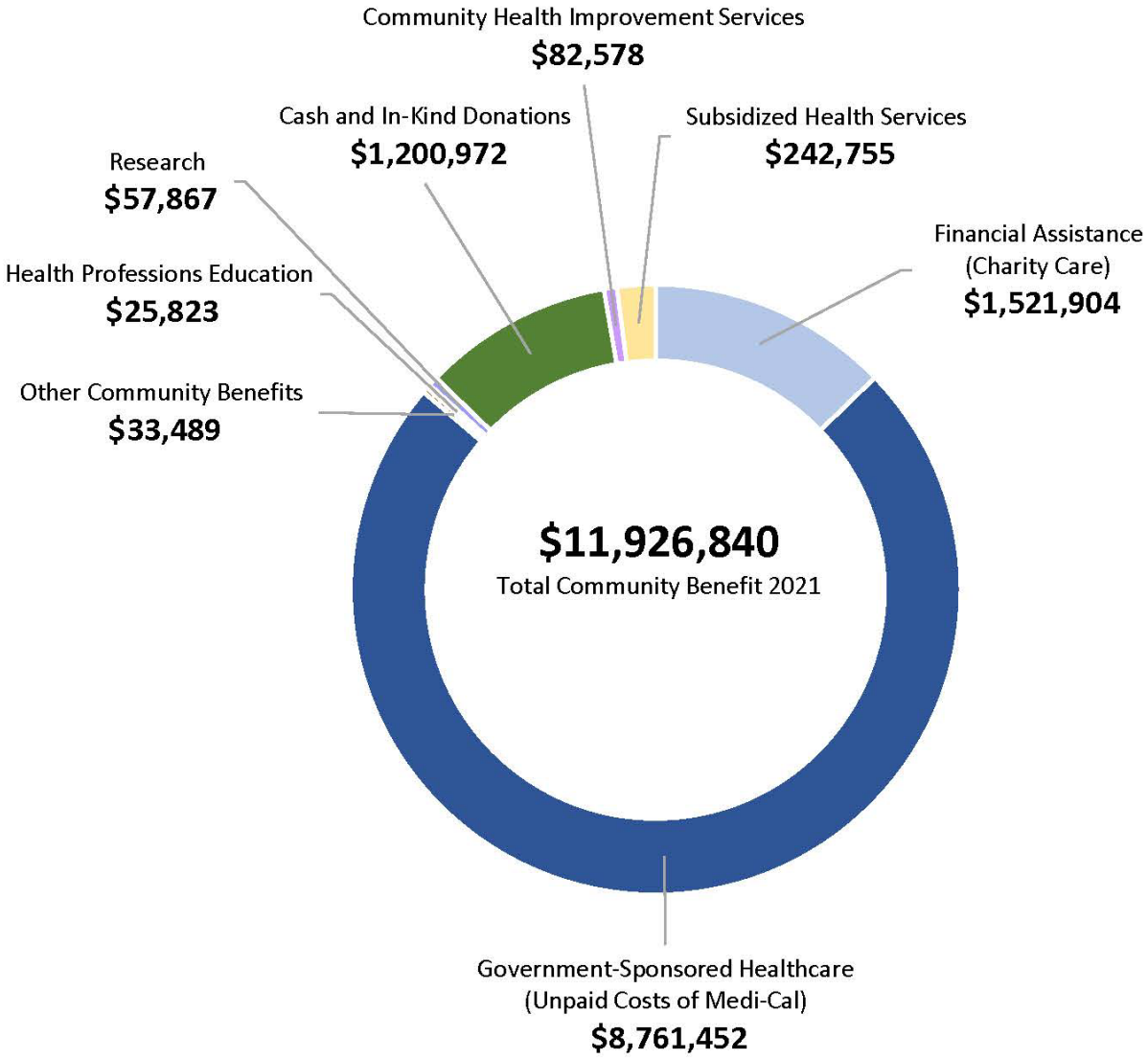
The Community Health Needs Assessment and Implementation Strategy Plan was approved by the Sutter Health Valley Hospitals Board on November 21, 2019.

Appendix: 2021 Community Benefit Financials

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

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

Sutter Davis Hospital
2021 Total Community Benefit
& Unpaid Costs of Medicare



2021 unpaid costs of Medicare were $15,519,076